Neutral Citation Number: [2025] EWCOP 4 (T3)

Case No: 1421086T

**COURT OF PROTECTION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/01/2025

**Before** :

**THE HONOURABLE MR JUSTICE HAYDEN**

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**Between :**

**NHS South East London Integrated Care Board**

**Applicant**

**- and -**

**(1) JP**
**(by his litigation friend, the Official Solicitor)**

**(2) The Royal Hospital for Neuro-disability**

**(3) TP**

**(4) VP**

**(5) OP**

**Respondents**

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**Arianna Kelly** (instructed by **Capsticks LLP**) for the **Applicant**
**Fiona Paterson KC** (instructed by **the Official Solicitor**) for the **First Respondent**
**Katharine Scott** (instructed by **Bevan Brittan LLP**) for the **Second Respondent**
**Third Respondent appeared remotely**
**Fourth and Fifth Respondents appeared in person**

Hearing dates: 13th and 14th January 2025

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# APPROVED JUDGMENT

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**Mr Justice Hayden :**

1. This application concerns JP, who is 64 years of age. On 15th January 2016, JP suffered a ventricular fibrillation cardiac arrest. He had been feeling unwell that morning and had mentioned this to his son (TP). Nonetheless, he cycled to work as usual. JP was a man who very rarely missed work due to illness. He was a keen cyclist, often cycling at weekends with his brother. JP was also a fit man who worked out regularly at his home gym. Despite this, he suffered from hypertension for which he received medication. On the way to work, he collapsed at the roadside, by his bicycle and suffered a severe hypoxic brain injury. At least 25 minutes passed before the return of spontaneous circulation following defibrillation. JP was admitted to St Thomas' Hospital where imaging revealed anoxic brain injury. JP was intubated in ITU but later had a tracheostomy inserted as he was experiencing aspiration pneumonia. He became self-ventilating on 24th January 2016.

2. On 21st April 2016, JP was transferred to the Royal Hospital for Neuro-disability (RHN) to the Brain Injury Service (BIS). The purpose of the transfer was for assessment and disability management. A percutaneous endoscopic gastrostomy tube (PEG) was inserted prior to JP's transfer and has remained in situ to date. In August 2016, he was transferred to a General Practitioner led ward at the RHN. The ward is effectively run as a nursing home rather than a hospital. The RHN is not part of any NHS Trust, it is a charity.

3. Dr Andrew Hanrahan was JP's Consultant Neuro-Rehabilitation Specialist whilst he was with BIS between April and August 2016. He re-examined JP on 6th January 2025, for the purpose of providing up-to-date evidence for this court. Professor Lynne Turner-Stokes, Consultant in Rehabilitation Medicine has filed an independent expert report, having examined JP on 4th December 2023 and prepared a supplemental desktop-based report on 10th January 2025. Dr Hyder, JP's GP has prepared a statement which has been filed in these proceedings, dated 8th March 2024. Each of the Clinicians has concluded that JP has been in a prolonged disorder of consciousness (PDOC) since his injury in January 2016. Dr Hanrahan describes JP as being in a *"permanent vegetative state (PVS)"*. All agree that term is used accurately. Dr Hanrahan, recognising that it is a term that can generate distress, explained in oral evidence that he used it to indicate

compliance with the National Guidelines prepared by the Royal College of Physicians, October 2020 (these are now pending review). Dr Hanrahan reported that this was also a term used repeatedly with JP's family and with which they were familiar. In **North West London Clinical Commissioning Group v GU** ***[2021] ECOP 59***, I deprecated the RHN's inaction and the unsupportable delay in failing to assess GU's best interests. I expressly endorsed the submission made on behalf of the Official Solicitor, representing GU to the effect that:

> *"as soon as there is any doubt over whether it is in the patient's best interests to continue to receive CANH, appropriate steps must be taken in every case to ensure that a timely decision is made on that issue, one way or the other. If it is not possible to achieve unanimity amongst the treating team and all those with an interest in the patient's welfare, or if it is considered that the decision is finely balanced, then steps must be taken to bring the matter before the Court, in a timely way, for a determination."*

4. Mindful that GU had been in PDOC for 7 years, I emphasised that:

> *"Regular, sensitive consideration of P's ongoing needs, across the spectrum, is required and a recognition that treatment which may have enhanced the patient's quality of life or provided some relief from pain may gradually or indeed quite suddenly reach a pivoting point where it becomes futile, burdensome and inconsistent with human dignity. The obligation is to be vigilant to such an alteration in the balance."*

5. In that case, as in this, the RHN made no attempt to justify the delay in 'best interests' decision taking, nor there, as here, did they seek to proffer explanation which might have justified the delay in bringing the matter to court. In neither case could they have done so. I also record that they have made a clear and unambiguous apology to JP and his family. I have received cogent and compelling evidence that JP, notwithstanding his religious beliefs, would not have wished to have been left as he has been. I also record that these views had become known to the RHN many years ago, most explicitly through what JP's partner of thirty years had told them. Sadly, JP's partner died in 2022.

My focus, in this judgment, is unswervingly on JP. I do not, therefore, propose to say anything further about the delay. I will do so in a separate judgment at a later date. I do, however, consider it important to repeat my observations in GU (supra) as to the obligation on all those concerned to have regard to the centrality of respect for human dignity.

6. Recognising the challenge of identifying unifying principles underpinning the concept of human dignity, I drew the following themes from my survey of the international texts and instruments:
    i. Human dignity is predicated on a universal understanding that human beings possess a unique value which is intrinsic to the human condition;
    ii. An individual has an inviolable right to be valued, respected and treated ethically, solely because he/she is a human being;
    iii. Human dignity should not be regarded merely as a facet of human rights but as the foundation for them. Logically, it both establishes and substantiates the construction of human rights;
    iv. Thus, the protection of human dignity and the rights that flow therefrom is to be regarded as an indispensable priority;
    v. The inherent dignity of a human being imposes an obligation on the State actively to protect the dignity of all human beings. This involves guaranteeing respect for human integrity, fundamental rights and freedoms. Axiomatically, this prescribes the avoidance of discrimination; and
    vi. Compliance with these principles may result in legitimately diverging opinions as to how best to preserve or promote human dignity, but it does not alter the nature of it nor will it ever obviate the need for rigorous enquiry.

7. I analysed the legal framework extensively in GU. I do not propose to repeat it here, each of the advocates, having framed it as the basis for this application.

8. Professor Turner-Stokes concluded in her Supplementary Report, dated 10th January 2025:

> *"I agree with Dr Hanrahan that [JP] is in a permanent vegetative state from which he will not now emerge.*

> *Fortunately, there is no evidence of severe pain and distress, but I agree that there are significant burdens of ongoing life-sustaining treatment (including CANH), which are not balanced by any evidence of positive experience, nor by any realistic hope of meaningful improvement or recovery.*
>
> *As previously noted, I understand the different viewpoints expressed by members of [JP]'s family regarding his best interests and these will be for the Court to weigh up on [*JP*]'s behalf.*
>
> *I would however re-iterate that the view expressed by some family members that [JP] 'would want a natural death and to let nature take its course' is not compatible with continued artificial life-sustaining treatment, as, without that intervention, [JP] would naturally have died at the time of the initial injury, or soon afterwards. CANH does not form part of any natural condition.*
>
> *I therefore agree with Dr Hanrahan that it is no longer in [JP]'s best interests to continue to receive CANH, and that it has not been for some time."*

9. I have been told that JP remains entirely dependent on nursing care, including in the management of his double incontinence. He has not required any recent significant medical intervention. His skin is fragile but intact. He demonstrates, on the consensus of medical evidence, only the most low-level responses. These are either spontaneous or reflexive, with no evidence of localising or purposeful behaviours. Dr Hanrahan told me that in consequence of a spinal cord reflex, information may be transmitted to the brain. It is the brain, not the spinal cord, that is responsible for the integration of sensory information. The spinal cord may elicit some basic reflexes and those responses are transmitted via motor neurons. This is most likely, having regard to the broad canvas of the neurological evidence, to be an entirely understandable misinterpretation of the reflexive responses. JP's eyes are mainly closed, opening briefly in response to stimulation.

10. Some similarly brief abnormal extensor movement has been observed in response to pain. An auditory startle response has been noted but no *"visual startle"*. The various assessments that have been conducted to evaluate the level of consciousness, i.e. the validated tools of the Wessex Head Injury Matrix (WHIM) and Coma Recovery Scale

(CRS-R) have demonstrated only three behaviours over a 10-minute period, the highest being Item 2 of 62 (*"Eyes open for an extended period"*). The medical consensus is that JP can probably not experience pain, however, it is impossible to be certain. The fact that it is impossible conclusively to discount experiencing pain weighs particularly heavily with TP (JP's son). TP told me, in evidence, how terribly his mother had suffered with pain in her own protracted illness, and how much distress it had caused him, his father, and the family. TP reported his father saying: *"living like that is like living in hell"*. He went on to say that his father added to that: *"I would never want to go through that"*. I recognise that there is an elision here between TP's own views and those he believes to be shared with his father. However, as others also relate JP making similar comments, I find that TP's account is a reliable articulation of his father's views.

11. Both Professor Turner-Stokes and Dr Hanrahan have concluded that clinically-assisted nutrition and hydration (CANH) is a 'futile' treatment for JP. This requires to be understood. CANH will preserve JP in his present condition. With CANH and good nursing care, Dr Hanrahan is of the view that JP's actuarial life expectancy could be between 5 and 10 years. However, CANH will not reverse his profound brain injury, nor restore him beyond his presently disordered consciousness, which has persisted for 9 years. It will most decidedly not restore him either to the person he was or to the life he enjoyed, with such vigour, prior to his brain injury. Alongside this, it is necessary to balance the obvious burdens of continuing treatment, which include the difficulty in managing his PEG and tracheostomy site. JP requires 24/7 care to keep him stable which is burdensome for him. In addition, JP requires care for the ongoing challenges of his cardiac condition and any acquired infection.

12. On withdrawal of CANH, JP will not survive longer than between one and three weeks. The following list summarises the Proposed Palliative End-of-life (EoL) Care Plan:

    (i) The PEG tube will remain in place, but will not be used for any access whatsoever;

    (ii) Tracheostomy interventions will be minimised;

    (iii) Unnecessary medications (e.g. antihypertensives) will be stopped;

    (iv) Anti-epileptic medications will be stopped and replaced with an appropriate dose of Midazolam, given through a 24-hour continuous subcutaneous syringe-driver;

(v) Glycopyrronium will be stopped in the first instance, but will be added to the syringe-driver if secretion management becomes problematic;

(vi) Morphine sulphate 1.25-2.5 prn SC/IM up to 1 hourly will be prescribed for pain or shortness of breath;

(vii) Midazolam 2.5mg SC prn 1 hourly will be prescribed for agitation/distress/second line for shortness of breath, or 5-10 mg SC prn up to 1 hourly for seizure activity; and

(viii) Spiritual care and bereavement support will be provided as needed by the RHN Chaplain and Bereavement team. This will involve contact with the Pastor who the family would wish to contact.

13. Expressly, Dr Hanrahan concludes *"it is no longer in [JP]'s best interests, and has not been for some time, to continue to receive CANH"*. Professor Turner-Stokes agrees. The medical evidence permits of no real challenge, as the family have largely recognised. JP's daughter (VP) plainly loves her father deeply, but some three years ago, she stopped attending the hospital. She told me that her father was *"simply not there anymore"*. She described him as having become *"unrecognisable"*. Dr Hanrahan also commented on his recent physical decline.

14. However cogent and compelling the medical evidence may be, it is always important to recognise that medicine evolves and develops. Both the Court of Protection and the Family Court have experienced this over the years. The case law in both jurisdictions is testament to it. Today's medical shibboleths may become tomorrow's heresies. It is important therefore, where necessary, even for a strong consensus of medical opinion to be put to the assay, especially where the consequences of accepting the opinion are so profound. Ms Paterson KC, on behalf of the Official Solicitor, has tested the evidence thoroughly and sensitively, primarily to assist the family in their understanding of JP's medical circumstances. The medical evidence is never determinative. Where there is a conflict, it is the Court's obligation to resolve it. As has been said, it is judges not doctors who are charged with the responsibility of deciding cases.

15. In resolving a ‘best interests’ decision, the judge must always consider the broader evidential canvas and the imperative to determine, to the extent that it may be possible, what the protected party (P) would want for themselves. JP did not make any advanced decision, and so it is his family who must be the conduit by which his views are understood and articulated in the courtroom.

16. This has been a hybrid hearing. JP’s mother and sister have attended via video link from Jamaica. TP (who now has children of his own) attended (remotely) from Michigan, USA. JP’s cousin gave evidence from Birmingham. JP’s sister (OP) and JP’s daughter (VP) gave evidence in the witness box in the courtroom. Her youngest sister sat beside her during the course of the case, both live at home and are plainly very close. Additionally, JP’s other sister attended via a link from Manchester.

17. JP was born in December 1960, in England, to parents of Jamaican origin. He was the second of nine children, only six of whom survived early infancy. JP’s mother returned to Jamaica with her children when JP was five years old. Her husband continued to work in the United Kingdom for a number of years and then followed her to Jamaica. JP’s father was a Deacon of the Church of the New Testament of God, where his mother, sang in the choir. He remained in Jamaica until he was fifteen years of age; attending school there. The family lived on a farm. JP’s sister describes him caring for the family’s animals, which consisted of “*pigs, chickens, goats, cows, donkeys, dogs, cats and one hundred pigeons*.” I have been told, from his family, that his interest in the natural world, both plants and animals, was life long and one of his greatest pleasures, second only to his family.

18. When he was fifteen, JP returned to England and lived with his uncle in Birmingham, who was also a pastor in the Church of the New Testament of God. JP remained there until he was nineteen years old. I note that regular attendance at church was part of the family’s weekly routine. After completing secondary education here in the UK, JP trained to be a welder at a college of higher education and then worked with his uncle. In fact, JP went on to spend much of his adult life working in the hotel industry, undertaking various skilled jobs such as electrical repairs.

19. Notwithstanding the tradition in his family, JP drifted away from organised religion. That is not to say this reflected any diminishment in his faith or values. He chose instead to pray when alone and would take himself off to do so. Neither was this a choice to keep his faith private. He would tell people when he was going off to pray. He would also read passages from the Bible to his children. The children remember this with affection and, it struck me that they too shared their father's faith in a similar, though evolved way.

20. JP had two long term relationships; the first with B, the mother of his two elder sons, EP and FP and the second with T, with whom he remained for thirty years and had three children; TP, VP and AP. After the relationship with B ended, JP moved from Birmingham to London, where he lived initially with his brother, CP, with whom he was very close.

21. Throughout his life, JP maintained regular contact with his extended family. They all describe his integrity, strong work ethic and sense of discipline, which they hinted bordered on perfectionism. He liked to get things right and enjoyed the opportunity to do so that his work provided. All this, however, was counter-balanced by his wide range of interests and obvious sense of fun. He was, I have been told a keen Marvel fan who collected comics. He liked to tease his family about having *"superpowers"*, his favourite character was *"Wolverine"*, who I have been told is a very physical character, as JP plainly was himself. JP's children have clearly given much thought and reflection to what their father would have wanted. They have recalled how in his conversations with them about the Marvel Universe, he referred to a character called *"Professor X"*. Professor X had been a wheelchair user, who it transpires got into battle with Cyclops and survived only by transferring his consciousness into the mind of a comatose man. They told me how JP said on several occasions that he would never choose to have that power, even if he was stronger than the rest, because he values the physical aspect of life most. It is not difficult to see why this now resonates with JP's children. It may have little, if any, significance by itself, but it does factor into the wider evidence illuminating JP's own likely wishes in his present circumstances.

22. JP has been described to me as having a fierce sense of independence. He was always determined to accomplish tasks on his own. His drive for self-reliance was evident in

how he approached challenges, preferring to solve problems without assistance. This trait is not described as a mere preference, but rather as a deep-seated value, reflecting his belief, almost as an article of faith, in the importance of personal effort. Even when challenged, he would try to find a solution on his own, sometimes preferring to leave a task at least temporarily unfinished rather than seek help.

23. As Ms Paterson has observed, perhaps the most strikingly consistent feature of the accounts is his unremitting devotion to the care of his late partner, T. He cared for her throughout a lengthy illness, while looking after the children and working full time. I agree with Ms Paterson's observation, to the effect that JP's partner and family were the centre of everything he did. All agreed that he was lucky to have had such a happy relationship, and that he recognised and appreciated his good fortune.

24. In these proceedings, the family have proffered their views in writing. The extent of their careful reflections really requires me to set these out in some detail. TP (son), VP (daughter) and AP (daughter) expressed their shared views:

> *"Dad's deep faith taught him to believe in possibilities and the importance of timing, including the natural end of life. He saw dignity not just in living but in the quality of that life. Watching mom's health decline had a profound impact on him. He often said he couldn't bear living in a condition where he couldn't enjoy life's simple pleasures or maintain his independence. He was a man who solved problems on his own and thrived on his ability to navigate life freely. The thought of being bed-bound, dependent, and without a clear consciousness is a stark contrast to everything he valued.*
>
> *In the early days of his hospitalisation, there were moments that seemed like awareness, but these have become less clear over time. Now, it's hard to tell if there's real recognition or just reflexes. This uncertainty and the emotional toll it takes only reinforce my belief that he wouldn't want to cling to a life that's so far removed from the one he loved and the values he held dear.*
>
> *Based on these observations and understanding of his values, it's my heartfelt conclusion that my dad, if he could express his wishes, would prefer not to undergo prolonged medical intervention that doesn't lead to a significant recovery or allow*

> *him to live as he once did. His life was full of passion, independence, and a love for physical freedom, all of which are currently unattainable."*

25. What I find particularly impressive about this passage is its striking maturity, but even more than that, I am struck by the way they engage with the central issue. These young adults phrase the question not as to whether CANH should be withdrawn, but as whether JP would *"prefer not to undergo prolonged medical intervention that doesn't lead to a significant recovery or allow him to live as he once did."* This is precisely the way the question requires to be formulated. It echoes the careful passages of Lady Hale in *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67 at [22]:

> *"Hence 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."*

26. JP's eldest son, EP expresses very similar views when he spoke to the representatives of the RHN in 2023. Again, EP engages with the benefits of giving the treatment, concluding as others have, and as I have set out in the passages below that he would have stopped this treatment long ago because his father would not have wanted it. EP is engaging directly with what he thinks his father would want now, and how that would be in his best interests. The full note records:

> *"If [JP] could tell us, would he want to continue or discontinue? Asked [EP]'s views or any questions. Main points [EP] reported:*
>
> *"I would of stopped this long time cus I know my dad wouldn't want this."*

> *He felt other family would have a difficult time with this decision but noted "I see things more clearer – and I don't think he'd want this".*
>
> *If it was me, I would want to stop, "I am similar to dad and he is similar to me, and he wouldn't want this".*
>
> *He noted that he and [JP] had not had a specific conversation on this, and noted Re: opinions shared .... "but going off of who he was as a person".*
>
> *Noted [JP] was not a burden on him ([EP]) but may be on other family that live closer (such as other children) and this may be stressful for them, hence noted "he ([JP]) wouldn't want this burden on his kids or anyone else".*
>
> *[EP] reported*
>
> *"Is he gonna be wanting to sit there fed through tube, is this what he'd want – no."*
>
> *Explained [JP] as very healthy and active, always training, cycling etc. and wouldn't be accepting of current presentation as an acceptable quality of life.*
>
> *He also noted, he had been thinking of this for years, and expected this to come up – as [JP] not showing difference in his actions. He noted that he had left the decisions with his half siblings and their mother who lived with him at the time."*

27. JP's brother (CP) has recorded as giving the following views:

> *"[CP] noted "deep down I don't think [JP] would like to be like that", referring to his current condition.*
>
> *[JP] was always fit, active, and never sick prior to his brain injury.*
>
> *He "wouldn't want to be a cabbage"."*

28. Two of JP's sisters KP and IP, and his mother proffer a very different view:

> *"[IP]: "should continue treatment", [Z] of the RHN asked whether that is what [JP] would say and [IP] indicated yes.*

> *[KP]: "He would want a natural death, natural, let God take him when its time", "I think its most likely what he would tell us - yes".*
>
> *[Z] asked about whether [JP] is a religious person and his denomination.*
>
> *Family reported: Christian, New Testament Church of God, and that he prayed every day, his mother noted that he prays at 10:00 daily.*
>
> *…*
>
> *[KP]: concerned about the feed, "if it is removed, it's like he's going to be starving".*
>
> *…*
>
> *Family indicated they wanted time to go away and think about it, agreed to arrange a follow up call.*
>
> *[IP]: "I haven't seen him since he was age 16." Indicated that she wants to see him but hasn't been able to get a visa to visit.*
>
> *[Z] asked about their relationship and [IP] reported she was the first born and [JP] the second and they spoke as often as possible.*
>
> *[JP's Mother]: "I am a child of God .... he's my second child, when he had the accident, he was going to work, he didn't feel good and pulled to the side, he collapsed, they took him to hospital....", "we were told he was going to die", "God give life and take it".*
>
> *"I don't want to go to hell", "The bible says God should not kill, I am a child of God", "anyone that does murder goes to hell, I am a child of God", "I pray for him".*
>
> *…[JP's Mother]: "I hope God will do some miracle."*
>
> *[KP] reported they had thought about it and spoke with their brother [CP]. She reported they felt "treatment should continue until God's ready for him". [Z] asked if that was the opinion of [JP's Mother] and [KP] - both responded "yes".*
>
> *…[KP] said "I don't think it is fair to have the treatment he had stopped... it's like suicide... it's like starving him to death", she further added "it's like feeding a baby with a bottle then just stopping".*

> *[Z] explained the law in the UK regarding discontinuance of a medical treatment, explaining that it is not considered assisted suicide or euthanasia, but rather a discontinuance of a treatment that is actively being provided. [Z] and [N], also from the RHN, explained that despite the law, it is appreciated that it is very difficult to separate what is written in the law with spiritual values and practical beliefs. [Z] explained that if the decision were to discontinue, then he would be referred to a hospice, and a robust terminal care plan would be set up to ensure his comfort and to avoid any pain. [N] explained that we feel it is important to explain this so that concerns around what he would go through are alleviated and ensuring that misunderstanding about his physical feeling through the process do not influence the decision/ opinions. [Z] asked given this (the law/ palliation input), "what would he say?"*
>
> *[KP] said he would say: "let nature take its course"…*
>
> *[Z] asked that by them indicating that [JP] would want "to let nature take its course", they meant to continue with CANH? Both indicated yes - to carry on…*
>
> *[JP's Mother] said "I am not going to make the decision to unplug the feed, I'm not going to do that." [Z] explained that the decision was a medical decision, and ultimately the responsibility lies with the doctors. She explained that if the family did not want to be part of the decision that it was also ok. [JP's Mother] expressed "I want to be part of it" and "I'm not going to say to plug it out". She explained that she has been a carer for many years and nobody ever said to stop treating someone, were just look after to the end, "so I'm not going to say to plug it out". [Z] asked if that is what [JP] would say, [JP's Mother] responded -yes.*"

29. JP's niece (DP) shared the views of her mother, aunt, and grandmother:

> *"[JP] is "the type never to give up hope, even if there is no light at the end of the tunnel" - he was always wise - never sick, healthy and active - they spoke together about God , and how you never know what can happen to you but things can change - he was active with an at home gym, liked marvel, took them to the cinema - looked after his wife and children , doing the girls hair etc, as his wife was unwell, he managed both of their roles Asked [DP] given the person she described active etc. and the*

> *fact that he is unable to perform those roles, would he want to continue with this medical treatment? [DP] answered " he would say - let nature take its course", "I feel if god is ready for you , you will go" - no matter what medications. Explained that we need to try to separate family's personal views from what [JP] may think/want where possible, asked again if she felt she had an idea of what he might want. [DP] explained that when his wife was unwell and needed blood transfusion and refused, he encouraged her to have medical treatments in another way. [DP] said he would say "still continue", and explained if the roles were reversed and he were being asked this about her, then he would also likely say that she ([DP]) should continue treatments - "I don't think he would say for me to stop".*
>
> *Asked about whether she felt his faith would influence his thoughts on this, noting that there is a spectrum of faith and impact on persons thoughts/practices etc. [DP] said that yes - his faith would definitely influence his thinking on this, noting again that when god is ready for you, you will go*."

30. As EP (son) anticipated, those family members who hold a strong Church based faith have struggled with identifying JP's best interests in any terms other than his faith. Their own faith delivers them certainty as *"children of God"*, who alone *"can give life and take it"*. It permits of little ambiguity and reflects a facet of faith which emphasises belief with complete trust and strong conviction. This thinking is reflected in many religions and is certainly encountered in the Judeo-Christian tradition. Faith is, however, elusive to prescriptive definition. It is also frequently characterised as a 'grace' or 'gift from God' which imposes an obligation to struggle and to seek understanding. These two concepts generate an obvious tension.

31. This is a tension which JP's children have identified and grappled with. Each of them has reviewed the code and principles by which their father has lived his life, explicitly recognising the importance and centrality of his faith to him. Their views are all focused on him and directed to the central question of his best interests. By contrast, some of the other members of the family provide few, if any, illustrations of why they consider that JP would wish to wait until *"God was ready"*. Equally notable is the presence of the first personal pronoun in the expression of their views. Strikingly, they talk of 'I', and not 'him'. I hope they do not regard that as a discourteous observation, it is certainly

not intended to be. Such is the strength of their own faith, that they struggle to contemplate that JP might have landed, as a consequence of his life experiences, at a different point on what is a spectrum of belief.

32. JP's children have not only been able to recognise this, but they have also identified evidence which supports and illustrates their father's views. I find, as I have foreshadowed, that the exercise they have been engaged with has been rigorous, sensitive, and reflective. It is also a matter which they have considered over a significant period. I am left with the clear view that it is their analysis and evidence which most accurately reflects JP's authentic wishes and approach to life. They are extremely impressive young people, features of their father's personality, as it has been described to me, ripple to the surface in the evidence of each of them and in different ways. In some ways, perhaps paradoxically, this serves to reveal JP's views even more clearly.

33. To the above must be added a paragraph from the report of Dr Hanrahan dated 8th January 2025:

> *"However, normatively, CANH for him is a "futile" treatment (to the extent that it will never achieve a goal of restoring [JP] to the identity he treasured and the person he was). It will not, in the slightest, reverse the profound, irreversible and permanent brain damage done in January 2016. It therefore cannot be of any benefit to [JP] (who is more than just his body – a tapestry of tissue or a tandem of organs), in the sense of restoring him to the person he was and life he enjoyed prior to his brain injury, no matter how long he receives it. I am aware that there is case law that considers "futility" to be where the treatment has no prospect of being effective in treating the condition/issue for which it is prescribed rather than for the person who seeks to benefit from it."*

34. The remark, in parenthesis, in the above paragraph reveals, in my judgement, the consistent sensitivity that Dr Hanrahan has shown to his patient. Neither can there be any doubt that JP's physiological resilience reflects the very high quality of the nursing care that he has received. Dr Hanrahan is right to highlight, in my view, that JP is *"more than just his body"*. Though he has no level of awareness, his human dignity is respected and protected by all around him. Poignantly, all those involved with JP, both

family and professionals, have alighted on a particular incident, which is both moving and intensely personal. Indeed, it is so personal, in context, that I have hesitated to include it within this judgment. However, it is part of the evidential canvas that has been so frequently referred to, that to excise it from the judgment would be remiss.

35. JP's partner, because of her arthritis, was unable to braid her daughters' hair. Braiding in this community is not simply a matter of style or beauty, it is an assertion of culture. JP took on this responsibility. This is no small task. It took most of the day, once every three weeks, for both girls, i.e. a day each. It is, in its own way, a testament to JP's love and commitment to his daughters and it says so much about him that is too obvious to require comment. As the sisters told me, none of their other friends' fathers, of his generation, ever became involved in this task. It is also obvious that JP enjoyed it. He told his girls that their hair was *"their crowning glory"*. The children had an affectionate name for their father, they called him *"the lion"*. This was due to his mane of dreadlocks. There is little doubt that JP was very proud of his locs (I adopt the family's preferred spelling) and took great care with them. They were intrinsic both to his identity and to his culture. It was also hinted to me that there was an element of male vanity involved. This was said humorously and accompanied by a reminiscence of JP's enthusiasm for being on trend with the right jeans and trainers. VP (daughter) told me that he aspired to be a *"cool dad"*.

36. JP retained his locs following his accident, but a few years ago, it became impossible to manage them in his circumstances. VP told me her father's locs fanned against the pillow of his bed when she visited him. A decision was taken that they would have to be cut off. This decision was arrived at with fastidious sensitivity, everybody reluctantly agreeing that it was necessary. It is plain, however, that it signalled to the family, and perhaps more widely, the final departure for JP from the man he had been. All agreed he would have hated this. He is unrecognisable now. The sensitivity of all involved, at least to my mind, guarded JP's dignity. I am, however, left with a sense that he may not have agreed with this view.

37. My summary of the Proposed Palliative End-of-life (EoL) Care Plan (see Para. 12 above) reveals both the thought and expertise that has been put into it. It provides for the discontinuation of medications not necessary at the end of life; it minimises

tracheostomy interventions; as pain cannot be definitively excluded, it provides for Midazolam subcutaneously and continuously, supplemented by Morphine Sulphate when required. As Dr Hanrahan has explained, the nutrition and hydration received by JP at present, is involuntary. There will be no instinct for either at the end of life. This plan is constructed to provide a peaceful and dignified death for JP, with a real prospect of his family by his side, if they feel able to be there.

38. Having surveyed the full panoply of both the lay and medical evidence, I have come to the clear conclusion that it would be contrary to JP's best interests to be provided with hydration and nutrition at this stage in his life. Such treatment would be both futile and burdensome, and, I am satisfied, particularly on the evidence of his children and late partner, not what he would have wanted. I note that the ICB remained neutral on the application but stated in its closing submissions that *"it would find it difficult to see that JP would have considered it in his best interests to continue to live life in his present condition indefinitely without any realistic prospect of improvement"*. I record for completeness, though it is clear from the analysis above, that the Official Solicitor has, from the outset of the hearing, also supported the Declaration on JP's behalf that CANH is not in his best interests.