



Neutral Citation Number: [2025] EWCOP 31 (T3)

Case No: COP20017687

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12 August 2025

Before:

MRS JUSTICE THEIS DBE
VICE PRESIDENT OF THE COURT OF PROTECTION

Between:

The Hillingdon Hospitals NHS Foundation Trust

Applicant

- and -

**(1) YD (By his litigation friend, the Official
Solicitor)**

(2) JG

(3) MB

Respondents

Eloise Power (instructed by **Clyde and Co**) for the **Applicant**
Katie Gollop KC for the **First Respondent**
Andrew Hockton (instructed by **Advocate**) for the **Second – Third Respondents**

Hearing date: 4 August 2025
Judgment date: 12 August 2025

Approved Judgment

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This judgment was delivered in public but a transparency order dated **12 August 2025** is 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 YD 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.

Mrs Justice Theis DBE:

Introduction

1. Prior to October 2024 YD was a much loved and admired independent minded person. He guarded his privacy and has been described by his family as a calm, compassionate and intelligent man, with a natural curiosity about life in its widest sense, he was a voracious reader with many wider interests, in particular long held beliefs and a deep interest in natural remedies and the spiritual world.
2. Tragically, YD suffered a bleed to the brain In October 2024 that has resulted in him being in a prolonged disorder of consciousness (PDOC). He has been in hospital since then and is currently in a rehabilitation ward, where he has been since January 2025.
3. The issue before the court is whether it is in his best interests to continue to receive clinically assisted nutrition and hydration (CANH). His partners, JG and MB, have been described as being devoted to YD, are both at his bedside each day, provide emotional and physical care for him, have each been effective advocates for YD and are very well attuned to his physical needs.
4. The application by The Hillingdon Hospital NHS Foundation Trust (Trust) seeks orders that permit them to withdraw CANH from YD. This is opposed by YD's partners, JG and MB and the Official Solicitor, on behalf of YD.
5. On 4 August 2025 oral evidence was given by Dr N, Consultant in Rehabilitation Medicine at the hospital where YD is, JG and MB (YD's partners), NT (YD's long standing friend) and Dr Hanrahan, Consultant in Rehabilitation Medicine at a specialist hospital, who was instructed by the Trust to provide a second opinion. The oral evidence concluded late on 4 August 2025, the parties filed written submissions the following day. A short hearing was listed on the afternoon of 5 August 2025 for any oral submissions. The parties agreed that it was not required, the hearing was vacated and directions made leading to the handing down of this judgment.
6. The court is extremely grateful to all the witnesses for the careful and dignified way they gave their oral evidence, in particular JG, MB and NT. The court is also grateful to the experienced legal representatives who have represented each of the parties, in particular Mr Hockton who has so skilfully represented JG and MB pro bono.

Relevant background

7. YD, age 60 years, was admitted to the Trust's hospital in October 2024, having been found by JG on the floor with left sided weakness. CT scans revealed acute intraparenchymal haemorrhage, YD was admitted to ICU. A scan the following day showed a new focus of bleed on the brain. YD was suffering from extensive bleeding in the right side of the brain which at the time was causing swelling and pressing on the left side. A tracheostomy was inserted shortly afterwards as YD was unable to protect and maintain his airway due to reduced level of consciousness. An EEG confirmed ongoing epilepsy was not a cause of his reduced awareness.
8. In early November 2024 YD's resuscitation status was changed to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) as he remained in a low awareness state

and the medical view was that if he became so unwell that his heart stops, this will cause more brain damage and he would be less conscious and CPR would be inappropriate and futile.

9. In November 2024 he was stepped down from intensive care, transferred to another hospital and entered the rehabilitation unit in January 2025, where he remains.
10. A PEG tube was inserted in January 2025, which remains in place. This was inserted as YD's awareness was not improving to be able to initiate swallowing. YD receives all his nutrition and medications through the PEG.
11. In March 2025 the tracheostomy was removed. YD has continued to breathe independently since.
12. Throughout his time in the rehabilitation unit he has been under the care of Dr N, Consultant in Rehabilitation Medicine.
13. Between January and May 2025 the clinicians at the rehabilitation unit have undertaken structured assessment using the measures recommended by the Royal College of Physicians' guidelines on PDOC (the Guidelines). The results suggest a diagnosis of vegetative state.
14. At a Best Interests meeting in April 2025 it was noted that YD had a strong belief in *'healing and determination...[YD] believed in the power of healing, and that healing can take many different forms'*.
15. A neurology MDT meeting took place in May 2025. An MRI scan was performed at the end of May. That confirmed extensive periventricular chronic small vessel disease, but could not rule out normal pressure hydrocephalus.
16. The Trust obtained a second opinion from Dr T, Consultant Neurologist at Imperial College Healthcare NHS Trust. Following Dr T's review of the MRI scan the conclusion was that the damage is irreversible.
17. In early June 2025 a neurosurgical opinion was sought from Professor W, Consultant Neurosurgeon, who did not recommend acute neurosurgical intervention but recommended consideration of a lumbar puncture *'if concerned about hydrocephalus affecting his consciousness level'*. A few days later a lumbar puncture was attempted. This was unsuccessful due to YD's raised BMI/body habitus.
18. Following that Dr N liaised with Dr T and Dr Hanrahan. They considered that it was unnecessary to repeat the lumbar puncture as they did not consider it essential to explain his PDOC. Dr Hanrahan stated *'In the circumstances it cannot be anything greater than a non-therapeutic (academic) activity followed to a logical end, having started down the route of persevering with obtaining an MRI, in the first place. There are in effect five specialist medical opinions (Dr N, Neurology, Neuroradiology, Neurosurgery and me), and several other nursing and therapy ones. I therefore do not see any barrier to now concluding all clinical issues around diagnosis and assessment and proceeding to discharge to a suitable location'*.

19. These proceedings were commenced on 18 June 2025. A directions hearing took place on 25 June 2025 when directions were made leading to this hearing.
20. JG and MB, YD's partners, were joined as parties and have had the benefit of being represented by Mr Hockton, who has acted pro bono. They have both filed written statements.
21. Dr Hanrahan's report is dated 3 July 2025 following his visit to see YD in May 2025. His first supplemental report is dated 10 July 2025, following a further visit to YD on 4 July 2025, where further discussions took place with JG and MB, he reviewed videos provided by them and spoke to the staff. His second supplemental report provided further comment on the videos that had been provided by JG and MB.
22. As part of the enquiries made on behalf of the Official Solicitor NT was spoken to. He is a longstanding friend of YD's and a detailed attendance note was made of the discussion with him.

The evidence

23. In his written evidence Dr N tracked through the treatment YD has received and states '*...given [YD] has been in a prolonged disorder of consciousness with a static trajectory for 6 months, he is unlikely to make any significant neurological recovery and regain a quality of life that reflects the values he held...He will have a permanent significant disability and will have significant lifelong care needs. Additionally, he is also at risk of developing complications related to be immobile for a long period of time including pressure sores, spasticity and contractures.*'
24. In his opinion YD may continue in PDOC for over five years, for those in a vegetative state (VS) their life expectancy is significantly reduced to a few years '*at best, with the most common cause of death being a chest infection or urine infection. The Trust's view is that it is more likely than not, that [YD] will only suffer negative experiences (pain, infections and neurological complications) from this point forward.*' His written statement continues '*the Trust has carefully considered on going treatment with clinical artificial nutrition and Hydration (CANH) via his PEG and feel that, given [YD's] poor prognosis the most compassionate approach is to focus on palliative care and withdraw CANH.*'
25. This position has been discussed with YD's family at Best Interest meetings in January and April 2025.
26. Dr N reports that following YD's tracheostomy being removed he did not require treatment for a chest infection. His blood pressure is stable. Increasing spasticity was noted in his right upper limb that was painful to stretch and occasional spasms in lower limbs whilst being washed and baclofen has been started to help with that. In May 2025 YD had focus seizures affecting the right side of his face when medication had to be increased but he is now back on maintenance levels and he has not experienced any further seizures.
27. Dr N described his current position as that he remains in PDOC, receiving CANH through a PEG, has a catheter in situ and is totally dependent on nursing staff. He requires the assistance of at least three members of nursing staff for four hourly turning

to relieve pressure and prevent pressure sores. Since admission he has had breaks in the skin due to moisture lesions on two occasions, both of which have healed. He requires at least three members of nursing staff to wash and clean him in bed each morning and when he is incontinent of faeces and/or urine. He needs oral suction on an hourly or two hourly basis.

28. The clinical team has undertaken 13 serial assessments of YD's consciousness using the Guidelines. He was assessed with 11 serial Wessex Head Injury Matrix (WHIM) and Coma Recovery Scale revised (CR-R) scores over a period beginning 27 January 2025. His CRS-R has stayed the same from between 4 – 7 and so has his WHIM score. In Dr N's opinion this means *'he has been assessed to be in a permanent vegetative state'* (PVS).
29. Dr N recognises that the family have felt YD has a purposeful grasp with his hand and will occasionally follow an object with his eyes but those have not been seen as a feature in the assessments. Any signs they have seen are considered reflexive or automatic and are not sustained, or occur spontaneously with no clear cause or purpose. In his view *'We have not seen any purposeful response to indicate [YD] is conscious or aware of his surroundings'*. They have reduced his sedation medication to make sure the results of the serial assessments have not been impacted and he did not have any infections during his assessment period. Dr N refers to the Guidance on CANH and adults who lack capacity where it states *'The perceived importance of obtaining a precise and definitive diagnosis has reduced over time, as it is increasingly recognised by clinicians and the courts that drawing a firm distinction between VS and MCS is often artificial and unnecessary'*. As Dr N states *'it is possible [YD] may change from a vegetative state to show some minimally conscious behaviours. This does not change our recommendations...'*. In oral evidence he was asked about the videos provided by the family, Dr N's view was that they did not demonstrate that what was being done was purposeful or repeated on command, so did not consider much weight can be placed on them.
30. Dr N accepted he only saw YD for relatively brief periods other than when matters are brought to his attention, then he will undertake a more detailed assessment. He agreed YD was *'pretty good'* from a medical point of view. He agreed YD had eye opening and sleep/awake cycle and agreed the reference in his statement to YD being in a coma was a mistake. Dr N was taken by Mr Hockton to the references in JG and MB's evidence of the responses by YD they have witnessed, he agreed in relation to some that if they were repeatable and observed by the clinical team they could indicate MCS. In his view the cause and effect of opening his eyes for eye drops or his mouth for suction is not established as his eyes are open all the time and he has rhythmic movements with his mouth. Dr N acknowledged the timelines in the Guidance for PVS and acknowledged it was not impossible to move to MCS.
31. Dr N was taken by Mr Hockton to specific pages in the medical records that recorded what the family observed and, on occasion, was observed and recorded by one of the medical team, but Dr N remained of the clear view regarding the observations seen that he had to see it objectively and consistently to assess the trajectory and consider the wider context of the medical teams observations. However he recognised that patients can over time drift between PVS and MCS but as things stand he considers YD is *'predominantly VS on occasion touching MCS'*.

32. Dr N agreed if the application was refused YD should move to a nursing home as early as possible. Their unit is a rehabilitation unit, with only limited beds and they take patients to assess if they emerge. He recognised these proceedings had caused some tension between the family and the medical team.
33. When considering the option of continuing CANH, which Dr N does not support, Dr N considers a patient surviving years in PDOC may be intolerable *'[YD] was independent in all his activities prior to the stroke. He was obese, hypertensive and non-compliant with his hypertensive medications due to his beliefs. He is now very stable since transfer to the rehabilitation ward.'* Dr N assessed YD has a 50% probability of being alive for another 5 to 6 years. Dr N considers this is a *'very long time for a person of his belief who is totally dependent on nurses for everything with no positive experience of any nature. We cannot be certain if he is [in] pain at rest, but it is very evident that he has markedly increased tone in his upper limbs and grimaces when his limbs are stretched. He has also developed moisture lesions in his back which would be painful'*.
34. Dr N considers it futile to continue with CANH and other life prolonging measures in view of the poor prognosis of recovery of consciousness and positive health outcomes (for example meaningful levels of autonomy, participation in previously valued activities and positive life experiences). In the event that CANH is withdrawn Dr N considered YD would pass away within 1 – 3 weeks.
35. Dr N summarises in his statement the key considerations for the Trust in reaching their position are the following:
- (1) YD has suffered a very severe, irreversible brain injury.
 - (2) 7 months post the brain injury and despite multiple assessments and attempted interventions, the most consistent category of PDOC that is applicable to YD is PVS.
 - (3) There is no hope of YD making a functional recovery.
 - (4) YD will only continue to have negative experiences.
36. JG has known YD for 20 years. Until October 2024 she was unaware of YD's relationship with MB. In her oral evidence she described YD as *'easy to get on with, humorous, determined and unique. Very supportive, likes to help people...usually quite positive regardless of the situation...a pleasure to be around'*. She did not consider he was religious but was deep into spirituality, he loved to learn *'deep into his spirituality, how things are, why they are'*. JG described YD as being well into this before she met him and he took it seriously. In her statement JG said that *'The fact that he agreed for me to call the ambulance to take him to the hospital after I found him in October 2024, proves to me that he chose conventional medicine and wants to heal as much as he can'*. The WhatsApp messages in the papers are from the medium. JG said she only gets the ones about YD. They are forwarded to her by MB. She said that her view was that whatever is said about his current circumstances YD will *'work with himself and prove them wrong'*. JG felt there is communication with YD via the medium and the Reiki healer and gave the example of the sore throat where through a Reiki session in June his throat was shown as red which corresponded with the discomfort it was felt YD had

through throat suctioning. She described this as an accompaniment to medical healing not a replacement.

37. In her statement JG states *'Knowing YD as I do, it is my perception that he is doing everything he can to move as much of himself as he can and is continuing to improve. This indicates to me that he refuses to give up on his life and wants to continue living as long as he is able. It is my conviction that YD has **NOT** given up on himself and would absolutely want to continue living, with any chance to improve (however small), until he passes away in a natural and unforced way'*.
38. JG considers it is communication from YD from the way it is expressed and she said it confirms that YD *'is trying to heal himself, this is like he could be'*. JG did not consider YD would be a sceptic about this *'he would have taken them at face value'*. Her view was that YD wants to heal himself saying *'I base that on his determination – sore knee and it disappear – he has ability to heal. He can reduce discomfort'*. JG considers since January 2025 she has seen improvement. She visits for 6 hours each day and has observed his hands have improved in that he squeezes, not for a long periods but does it every day. JG described in her statement that the nurses ask YD to lift his head, he does and keeps it forward. JG said she started making videos since June, as there was not much activity before then. JG described how he opened his right eye wide when he had difficulty going to the toilet and there was found to be a blockage. JG feels he can communicate an issue that needs to be resolved.
39. When asked by Ms Power how JG thought YD would tolerate the level of care he currently receives she replied *'He would accommodate what needs to be done. He doesn't make a fuss, he is quite tolerant, not agitated or angry, so he is accepting this is what needs to be done'*. She accepted the communications via the medium and Reiki healer are not communication in the medically provable sense. When asked whether what she reports as seeing regarding his movements were down to her being desperate to see these improvements, she responded in a calm and measured way she sees what she sees and feels what she feels. She said regarding the information from the medium *'it fits with who I know him to be...'* and stated one of the reasons why they gave him the ball was because it makes it easier to see and is not in their imagination. JG said she feels *'he is still striving to improve his condition as much as he can. He aware what going on but strives to continue to improve'*. She agreed she had never discussed with YD what he would want if he was in a state of VS/MCS. JG described her interest in spiritual matters prior to meeting YD. JG described her dreams regarding the future of YD improving, they include MB who she was not aware of until October 2024. JG was asked by Ms Gollop KC why she thinks YD can physically improve, feel he is and this is what he wants, she said *'he has helped a lot of people...I feel his mind is more intact'*.
40. MB has known YD for 24 years, they got engaged 7 years ago and lived together for about 4 years. They had daily contact when they were not together and she describes a very close and loving relationship. Their respective families are close. MB, like JG, visits for 6 hours each day. She has worked in the NHS for over 20 years starting as a Health Care Assistant and then moved to administration in a clinical area. In her statement she said the delayed decision by YD in October 2024 to call an ambulance was YD choosing medical help and medication to help get him better and improve his situation. She states *'YD would say of there is a chance big or small of any kind of recovery, he would take this chance as time is a great healer, and life is everything to him. YD always says he is going to live a very long life and that he values life. YD does*

not believe in giving up and would see this through to the end. He wouldn't want his life taken before he is ready, he hasn't chosen to give up on life yet. YD is still very strong and determined'.

41. In her statement she describes the improvements she has observed which she considers *'YD is healing himself'*. She considers YD enjoys the Reiki sessions. She and JG massage his limbs daily and have noticed that he has been able to squeeze with his hand and has been lifting his wrist. She feels he does follow commands, such as to open his mouth and his eyes. He opens his eyes when she gives him a kiss on arrival and can track her with his eyes. They have shown him videos of birds on an iPad and feel his eyes follow the birds on the screen. She recognises the doctors only see YD for a relatively short period of time, some of these changes have been recorded on the nursing records, such as when a nurse asked YD to lift his head forward so the nurse could turn his pillow to make him more comfortable, YD moved his head forward to help the nurse.
42. As regards YD's spiritual beliefs MB said these are beliefs YD has held for many years and were held by him before she and YD met. MB states they are communicating with YD via a medium who he has known for over 6 years. MB feels the messages are coming from YD as they include detail only she and YD would know. MB reports the messages she is receiving back via the medium are that YD is working hard to heal himself, he informs the medium when he is in discomfort and sends messages about where and how massage should take place, and responds back when it has helped relieve tension or discomfort. MB describes YD as having a strong will power and never gives up, nothing phases him no matter how hard or challenging it is. YD would see a situation through, staying focussed and in control. MB reports that YD has also had a long standing interest in Reiki, there have been a number of remote Reiki sessions since June and the Reiki practitioner has attended the hospital on one occasion to see YD.
43. MB describes YD's wide range of interests including music, nature, the natural world and his love of being outside. She said *'YD loves reading, studying subjects of interest in depth as he takes studying very seriously...'*. She continues later in her statement *'YD would like the opportunity to heal and not be forced to end life, he would choose to leave when he is ready and naturally or when the body chooses to give up, he would choose life over death. We used to talk about end of life pathways when I was a Health Care Assistant and YD would say that's not right a person will pass when they're good and ready'*. She agreed the end of life discussions did not specifically include withdrawal of CANH. In her view it would be wrong to withdraw treatment, which would end YD's life *'when he is still strong and determined to heal himself. YD has not had any infections for more than 6 months and his body has not broken down in any way for months. YD is continuing to improve each day. YD is not suffering any pain and when in discomfort for only short periods of time he will tense his face between his eyes as if he is frowning and we are able to calm him down and he relaxes again. I don't feel YD is ready to give up.'* MB described his high tolerance of pain with examples of when he damaged his hand and his foot and did not require medical attention, YD has an ability to heal himself. Even though YD is a private person she did not consider YD would mind the high level of nursing care he is receiving as *'he would take it as part of the process of getting better'*. MB is clear that YD *'has not given up yet'* and disagrees *'to some extent'* with the medical opinions that he has no prospect of recovery as she has seen some small improvements. In response to the

question that she is seeing changes as she is wishing YD is getting better she said *'At the start just a flicker, now squeezing and holding, longer and stronger periods, that's the difference'*. MB recognises how difficult these situations are and thanks the care, compassions and attention the clinical team give to YD.

44. NT has been a friend of YD's for over 20 years and confirmed the note of his discussion with the Official Solicitor's representative. He and YD met through work. NT described YD as someone who had a lot of presence, NT felt drawn to him and he admired the way he calmly handled the difficult situations they often had to deal with through their work. They became close friends, describing a father/son type relationship and NT described that through their friendship he had a deeper understanding of YD, YD's spirituality and understood the depth of YD. NT said that YD is *'very well-studied'*. When he helped move YD his books took up more than 3 van loads and YD would discuss the books he had read with NT. NT considered the most important things to YD were his studying and the ability to practice his spirituality. NT considered the things YD enjoyed in life were *'Finding out new things; finding out and sharing new things; new knowledge; new books; new viewpoints and challenging viewpoints; he liked to challenge me...'*. NT said *'I wish everyone could have a friend like [YD]'*. NT said he had never seen YD down. He described the support YD gave to NT when he was caring for his grandmother and at other times of difficulty in his life. NT feels through his long standing knowledge of YD and his close friendship with him that YD would want to be given a chance to prove people wrong, YD's strong belief is the mind is in control, it can repair itself. They discussed things the body can do, and heal itself. NT said *'He had views on how the body can heal itself, and how the mind is always in control; the mind tells the body what to do, the capability of the body is way beyond human comprehension'*. He told the Official Solicitors representative that he knew YD would want to be given a chance to prove people wrong.
45. NT visits YD regularly and has noticed the small improvements seen by JG and MB. He accepted they had not discussed this particular situation (withdrawal of CANH) but from, his knowledge of YD he considered YD *'has a lot of work to do'*. He took his improvements as being *'him wanting to live – he has had plenty of opportunities to check out'*.
46. When asked by the Official Solicitor's representative whether YD would want to live in the state he is in now he responded that he disagreed with the doctors views stating *'if he chooses to go and shut his body down, then that is one thing, that is his choice, even though he may not be able to articulate it; when somebody wants to go, they go. I have been around death. I would leave that decision to him; whilst he is here and still breathing he should have every fighting chance, he should have the same chances that everyone else would have'*.
47. In May 2025 Dr Hanrahan was instructed by the Trust to provide a second opinion. He visited YD on 23 May 2025 and met JG, MB and the clinical team. He had further updates on 30 May 2025 and 26 June 2025 and visited YD again on 4 July 2025. In his reports he did not disagree with the medical analysis or conclusions reached by Dr N regarding diagnosis and prognosis. He concludes YD remains in PDOC secondary to his extensive strokes and complications, he is at the most severe end of the spectrum, namely in a VS. VS has a poor prognosis of survival and there is no prospect of recovery of any consciousness and none of recovery to any state of independence. This is now a chronic state in keeping with the Guidelines. His view is that with no trajectory of

behaviours to declare even minimal awareness, this is also a permanent state, more than six months from onset. Dr Hanrahan considers YD condition; general, systemic and neurological he considers is 'poor'. Dr Hanrahan recognises the complexity of the burdens/benefits analysis in his report but in the end supports the conclusions reached by Dr N's team that it is no longer in YD's best interests to continue CANH. In his second report although he emphasised that YD was deteriorating week on week, even if not grossly visible but accepted that *'there does not appear to be great burdensomeness evident'*. Dr Hanrahan was able to be present in court and hear the oral evidence. He confirmed in oral evidence his opinion had not changed.

48. He was aware the family had reported improvements in YD. Dr Hanrahan reports his discussions with the senior occupational therapist who the family had raised this with. She reported to Dr Hanrahan that these were *'old behaviours with a new marginal increase in range, but did not in themselves indicate any emerging awareness, command following, purposeful movement, or would cause a shift in diagnostic category away from a vegetative state'*. Dr Hanrahan's view of the improvements noted by the family is *'These are entirely reflexive'*. He reviewed the videos, as set out in his two supplemental reports, but they had not changed his overall conclusion that YD is in a VS.
49. In his first report Dr Hanrahan stated *'The neurological truth of his condition is stark, in that the longer he remains in a vegetative state the less likely he is to emerge from it. In addition, should there be subtle changes in his presentation, even sufficient to change a diagnostic category from a vegetative state to a minimally conscious state minus (MCS-), the experience of this state would depend on the observed behaviours which may be a mixture of pain and pleasure. The probability of experiencing this state is at the lowest level of probability and is likely to be a negative one. If asked whether it would be possible to rule out any negative experience as observed by distress behaviours (or even experienced distress – in the absence of any behaviours) it would not be possible to rule it out, simply on the premise that it is unknowable. Though the definition of a vegetative state rules out any awareness, it cannot guarantee the absence of any experience, most notably of pain or suffering.'* In considering whether YD is able to experience pain or pleasure Dr Hanrahan notes that behaviourally YD has not been observed to score highly with mild grimacing noted on stretches and personal care, mild restlessness and an at risk skin from pressure and friction.
50. From the records Dr Hanrahan notes that the multi-disciplinary team (MDT) concluded that YD required a nursing home placement while an application to the Court of Protection was made. When he visited YD he notes *'He has been medically stable for a while without any recent complications like infections...'* and notes that it takes constant intervention to keep him stable which should not be minimised or marginalised.
51. In his oral evidence Mr Hockton took Dr Hanrahan to the medical records where, for example, YD had been noted to move his legs and body many times. Dr Hanrahan said these are complex arousal phenomena but are isolated incidences and they need to happen more than by chance. The recordings, in Dr Hanrahan's view, are not inconsistent with a VS as they are a few instances in a much larger picture. In his view they lack what the Guidelines consider are important, namely the trajectory and consistency. These observations, which he recognised are not limited to the family, do not change his opinion regarding the overall diagnosis and prognosis.

Legal Framework

52. There is no significant dispute about the relevant legal framework between the parties. It can be summarised as follows.
53. Under s 1(5) Mental Capacity Act 2005 (MCA 2005) where a person is unable to make a decision for themselves there is an obligation to act in their best interests.
54. Section 4 MCA 2005 sets out the framework for that test to be applied.
55. Part 5 of the Mental Capacity Act Code of Practice sets out how that framework should be considered. In particular at paragraphs 5.31 – 5.33 and 5.53 matters the decision maker should have in mind and, if required, try to find out.
56. The classic statement of how the court should undertake this task in reaching a decision as to what is in the person's best interests under the MCA 2005 is set out by Baroness Hale in *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67 at [39] – [45].
57. It is clear that wider considerations than merely clinical ones are engaged in cases of this nature and by definition these cases are highly fact specific.
58. In addition to Articles 2 and 8 ECHR, Article 9 (2) is also likely to be engaged. It states '*Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protections of the rights and freedom of others*'.
59. The Equality and Human Rights Commission states of Art 9: '*Importantly, this right protects a wide range of non-religious beliefs including atheism, agnosticism, veganism and pacifism. For a belief to be protected under this article, it must be serious, concern important aspects of human life or behaviour, be sincerely held, and be worthy of respect in a democratic society*'.
60. In their submissions the Official Solicitor sets out as a useful cross check regarding Article 9 the criteria set out in *Grainger plc v Nicholson* [2010] ICR 360 which are that:
 - (i) The belief must be genuinely held;
 - (ii) It must be a belief and not an opinion or viewpoint based on the present state of information available;
 - (iii) It must be a belief as to a weighty and substantial aspect of human life and behaviour;
 - (iv) It must ascertain a certain level of cogency, seriousness, cohesion and importance; and
 - (v) It must be worthy of respect in a democratic society, be not incompatible with human dignity and not conflict with the fundamental rights of others.

Submissions

61. In their written closing submissions the Trust set out that they had reflected on the evidence but maintained their position that it is not in YD's best interests to continue to provide CANH. The Trust submits *'there is no medical benefit nor would [YD's] best interests be served by putting off the decision to another day.'* They rely in particular on Dr Hanrahan's view that recovery of function or independence he can say *'with the highest degree of certainty is highly unlikely'*. In his supplemental report he stated that *'This would be the same, but with an even higher degree of certainty in six months time. Almost as certain would be his inevitable physical deterioration'*. Ms Power submits Dr Hanrahan's evidence is the diagnosis is *'stark'*, he cannot think of any prospects of recovery and absent that treatment will *'hydrate and nourish him...From a neurological perspective – it is this concept of stability and being calm. This will take a lot to keep him in this state'*. The Trust rely on the evidence that no further investigations are suggested and the medical consensus that having considered the evidence from the family of any improvements they have noted they remain of the view that YD is in a VS.
62. The Trust recognise the nursing notes that are relied upon by JG and MB but submit that these fourteen or so selected pages are part of a much larger clinical record of over 1,200 pages of notes. The notes and observations relied upon by did not change either Dr N or Dr Hanrahan's opinion. Dr Hanrahan distinguished between the concept of improvement and change and suggested the interpretation by the family was understandable as they were in a situation of hope, in his view what had been observed were pure arousal and/or motor phenomena rather than any indication of a trajectory for meaningful recovery.
63. Ms Power submits that the continuation of treatment can be regarded as imposing a burden on a patient's dignity and can be burdensome, even in circumstances where the patient is unable to feel pain and has no conscious awareness. She submits that regardless of whether he can experience pain YD faces multiple burdensome interventions daily in relation to all aspects of his life and there is a possibility he could experience pain. Ms Power submits that whilst YD is physiologically stable the life expectancy is 3 – 5 years, although it could be sooner if YD succumbs to one of the complications he is at risk of all the while Dr Hanrahan's evidence is his body is deteriorating week on week.
64. She submits the test under the MCA 2005 is a best interests test. Ms Power recognises YD's spiritual beliefs engage Article 9 EHCR and the evidence described a belief system which was sincerely and deeply held by YD. The beliefs are long standing and were well established when MB met YD 24 years ago. Ms Power submits the evidence did not provide a direct answer to the question of what YD would have wanted to do in the specific circumstances he is in now, in particular concerning being on CANH. She submits the court needs to be alert to the danger of confusion between the values, beliefs wishes and feelings of loved ones and the values, beliefs, wishes and feelings of YD. This is particularly in circumstances where the loved ones are experiencing loss and complex grief.
65. Ms Power submits whilst more is now known about YD's beliefs and values she submits it is doubtful that YD would have wanted to accept artificial and burdensome treatment to keep his physical body alive in circumstances where the prognosis was so poor and where there is no prospect of regaining consciousness in this physical world. The Trust acknowledge that CANH prolongs life of the physical body but in the

circumstances of this case is qualitatively futile, as Ms Power submits *'it cannot restore [YD] to any level of personhood'*. She relies on the words of Lord Goff in *Bland*, as cited in *Aintree* *'I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life, when such a treatment has no therapeutic purpose of any kind, as when it is futile because the patient is unconscious and there is no prospect of any improvement in his condition'*. Ms Power acknowledges the concept of futility cannot displace the best interests test.

66. On behalf of JG and MB Mr Hockton submits JG and MB's evidence was focussed on what YD would want in his current circumstances. He submits their evidence was not coloured by *'emotion or false hope'*. Whilst he acknowledges the evidence was supported by the communication through the spiritual medium and the Reiki practitioner, it was not dependent on it. They made it clear through their own respective experiences of YD's wishes and beliefs would have led them to being opposed to the withdrawal of CANH. Mr Hockton submits JG and MB's evidence was *'powerfully supported'* by that of NT. Mr Hockton rejects any suggestion that their evidence was coloured by false hope, he submits *'they had a good grasp of YD's predicament and a realistic understanding of his situation'*. Mr Hockton submits *'There is ample evidence before the court that YD is, in certain respects not only a deeply sympathetic, strong and charismatic figure but someone who might be regarded as holding non-mainstream, and unconventional views. He is clearly deeply spiritual and has a long-standing interest in the spiritual world. He has been described as a medium, a healer (by hands) and someone who engages in astral travel'*. Mr Hockton submits this evidence is important as it is clear YD would attach some weight to the communications with the medium, who he knew prior to October 2024, and Reiki healer due to his long standing interest in such practices. Also, YD would have approached the decision-making in this case in a very different way from the doctors who gave evidence. The court can conclude on the evidence that YD would have rejected the withdrawal of treatment.
67. Mr Hockton submits the medical evidence has partially evolved, with some recognition that if the family were correct regarding their observations the degree of awareness may suggest YD is MCS. Dr Hanrahan was pressed on the references in the Guidance to the criteria for diagnosis of MCS and the reference in the medical records to the OT's observations regarding visual tracking which is recorded as having been reproduced a number of times and the record states *'suggesting that patient may be in MCS'*. Whilst Mr Hockton recognises Dr Hanrahan attached little weight to this observation he submits it is *'potentially significant'* as it has been noted by the OT.
68. Mr Hockton submits an unusual feature of this case is the level of devoted care and attention provided to YD by his family members. The evidence suggests that will continue. Their attendance is not just of an emotional and psychological nature the evidence establishes that JG and MB tend to YD's practical needs, seeking to provide physical comfort where possible. Mr Hockton realistically acknowledges that any awareness on the part of YD, if present, is extremely limited and there may be little or no further improvement but the evidence is not clear that YD would regard his continued existence as a burden. In these circumstances, Mr Hockton submits, treatment is not futile insofar as it keeps YD alive. The evidence establishes that it is the view of YD's family members, supported by those who know him best, that YD would not wish CANH to be withdrawn. Mr Hockton submits on the facts of this case

the strong presumption in favour of preserving life has not been rebutted. He submits *'The family would support transfer to a nursing home and recognise that there may be a future need to re-appraise his position in the light of any further developments: not least, their understanding as to what YD would wish to happen in any future circumstances'*.

69. On behalf of YD through his litigation friend the Official Solicitor Ms Gollop KC submits that there is sufficient evidence of sufficient clarity to give a *'rounded picture of the values and beliefs that would be likely to influence his decision if he had capacity, and the other factors that he would be likely to consider if he were able to do so. There is also sufficient reliable evidence of his past wishes and feelings, to enable the court to draw conclusions about what his present wishes and feelings would be given his current medical condition (persistent vegetative state) and prognosis (no prospect of any improvement in consciousness and, per Dr Hanrahan, only opportunities for deterioration)'*.
70. Ms Gollop submits that when considering the Article 9 ECHR rights that are engaged and *Grainger* it is relevant that YD's beliefs are genuinely held, they are long standing beliefs, they are beliefs as to a weighty and substantial aspect of human life and behaviour, they have a certain level of cogency, seriousness, cohesion and importance and are worthy of respect in a democratic society, are not incompatible with human dignity and do not conflict with the fundamental rights of others. Whilst some may feel some of YD's beliefs are not worthy of respect *'Belief in such communication between divine beings and humans is part of many religions. It could not properly be said, the Official Solicitor suggests, that the former is not worthy of respect but the latter is'*. Ms Gollop continues *'Taken as a whole...YD's beliefs, and the values informed by his beliefs of sustaining others in difficult times, encouraging others to do good, and being positive and avoiding doing harm are worthy of respect. There is powerful evidence that his values and beliefs encompassed dignity for dependent persons with disordered consciousness towards end of life'*.
71. The Official Solicitor considers the magnetic factor of the medical evidence are the results of the structured PDOC tests which inform the high degree of confidence Dr N and Dr Hanrahan have in their conclusions. Ms Gollop submits the court needs to carefully weigh in the best interests evaluation the burden of treatment to the patient. Dr Hanrahan's opinion was that he considered there *'does not appear to be great burdensomeness evident'*. Ms Gollop expresses some caution of the court accepting or relying on what Dr Hanrahan said about the impression of YD, Dr Hanrahan had been given to see he *'has permanently departed. I don't take into consideration the 'other plane''*. Ms Gollop submits that on the facts of this case the MCA 2005 requires the best interest evaluation to include 'the other plane' because of the evidence that it was and is key to YD's beliefs and values, wishes and feelings. Ms Gollop submits as a consequence the court cannot rely on his opinion regarding best interests (although it can on other matters) as it is *'materially incomplete'*. Ms Gollop stresses *'For the Official Solicitor, all of this serves to underline the necessity of the Court being the sole arbiter of the ultimate best interest issue...Where a patient is at the coma to MCS- end of the scale, medical professionals will almost invariably consider that continued treatment is purposeless, will make physical deterioration an inevitability, and would be unwanted by the patient'*.

72. Ms Gollop submits it is acknowledged JG and MB are highly attuned to YD's presentation and they had noticed some changes which had been observed and noted by the OT. Ms Gollop submits what they were seeing were *'the behavioural counterparts of rudimentary and limited recovery in the brain stem'*. Dr Hanrahan *'explained that [YD's] nervous system has been consistently aroused for the last few months and that it is trying to repair itself in some way'*.
73. In considering what YD's decision would be if he had capacity Ms Gollop submits JG and MB have known him for over 20 years. Each of them were aware, without knowing names or numbers that YD was *'a central part of a community of people with shared beliefs that there was more to life than the material, and...that there are more things in heaven and earth that are dreamt of in the philosophy of NHS treatment. They had a shared belief that each person has psychic abilities but not every person can access them.'* They each had an experience of YD that was not scientifically explicable and all explained that understanding the universe outside the material and *'exploring and developing his own transcendental powers, was [YD's] life's work'*. NT emphasised the serious nature of YD's scholarship in this regard. Ms Gollop submits the evidence establishes that YD *'believed that one's spiritual belief system is a personal matter and one of continuous development'*. YD believed in *'self-improvement, giving thanks and doing good...that we have multi-dimensional existence outside linear time and he reported that he experienced that existence when asleep and unconscious. He believed we can communicate thoughts in an extrasensory way and his beliefs were manifest in waking life personal experiences. He believed in life after death'*.
74. Each of JG, MB and NT shared what they knew of YD's beliefs and practices that he had shared with them recognising that YD compartmentalised his relationships and they could not provide a complete picture. From their perspectives they were each clear that YD as a multi-dimensional person and believed in the power of the mind to heal the body, and the healing power of energy with his preference to heal himself but he knew his limits and would seek NHS treatment when needed. Each of JG, MB and NT were clear in their view that YD would have wished to have his physical existence maintained by CANH and would have wanted the continued opportunity to heal himself. As Ms Gollop states NT recounted *'the support and spiritual nourishment [YD] provided to him in the five years he cared for his grandmother when she had advanced dementia and did not recognise him. These were hard years but [YD] helped him work through his distress by enabling him to see that his love and care brought her dignity'*. The Official Solicitor considers the matters that YD would be likely to consider relevant to the decision would include the fact that JG and MB visit daily, NT visits, he is provided with the services of a medium, is being provided with Reiki therapy, is in receipt of high quality medical care, the doctors assess him as not experiencing pain and that in lay terms Dr Hanrahan there does not appear to be great *'burdensomeness evidence'*. Ms Gollop reminds the court of the need when considering the evidence to look at the wide picture regarding assessment of best interests.
75. In summarising the submissions on behalf of the Official Solicitor Ms Gollop submits the court can conclude on the evidence that:
- (1) *'While [YD] might not dispute Dr Hanrahan's opinion that recent physical changes are the manifestation of involuntary, rudimentary new connections in the brainstem,*

- he would be likely to see that opinion as a limited and incomplete explanation of what has caused those changes;*
- (2) He would be likely to believe the changes are evidence of the healing power of the mind, spirit or soul;*
 - (3) He would be likely to feel that they are positive changes;*
 - (4) He would be likely to believe he has the potential to make further changes;*
 - (5) The changes would be a factor relevant to his decision, if he had capacity, and would probably be a factor in him wishing and feeling that he wanted to continue to be provided with CANH;*
 - (6) Another relevant factor in making the same choice would be the evidence that others believe they are in communication with him, and that the Reiki Master believes he has a powerful spirit, and that his continued physical presence is an ongoing source of spiritual sustenance to others;*
 - (7) The understanding of what the persistent vegetative state is and the inevitable medical prognosis, would not have caused [YD] to wish or feel that CANH should be withdrawn;*
 - (8) His present feeling would be that his life now is dignified because of the love and care provided to him by his partners, and he would wish to continue in this way until the life of his body was ended by a process such as a heart attack, further stroke, or infection.'*

76. Ms Gollop has raised the issue as to how sustainable it is long term for JG and MB to continue to visit at the level that they have but submits their evidence about this was compelling *'they have thought about and planned for this, and they will be with [YD] every day for the rest of his life'*.

Discussion and decision

77. This case raises difficult and challenging issues for the court to consider.

78. There is no dispute that YD lacks capacity to make the decision about whether to continue receiving CANH. In those circumstances the legal framework is clear that where a person is unable to make a decision for themselves there is an obligation to act in their best interests (s1(5) MCA 2005).

79. When considering what is in YD's best interests it should be considered in its widest sense. Consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence their decision if they had capacity, and to the other facts that they would be likely to consider if they were able to do so (s4(6) MCA 2005). Account must be taken of the views of anyone engaged in caring for the person or interested in their welfare

(s4(7) MCA 2005). In considering whether treatment is in the best interests of the person concerned, the decision-maker must not be motivated by a desire to bring about the person's death (s4(5) MCA 2005).

80. The focus must be on whether it is in YD's best interests to continue to have the treatment, rather than whether it is in his best interests to withhold or withdraw it. The purpose of the best interests test is to consider matters from the patient's point of view, however that does not mean they are determinative.
81. The medical evidence from Dr N and Dr Hanrahan unite in their conclusion that YD is in a PDOC. They both conclude he is in a VS in accordance with the assessments that have been undertaken following the RCP Guidelines. They were each firm in their evidence about the diagnosis and the prognosis. Each were pressed by Mr Hockton about the relatively small changes that had been noted by JG and MB since June, some of which is noted in the nursing records, including by the OT. They did not dispute what JG and MB saw, or what was recorded, but attached no evidential significance to it regarding diagnosis as it lacked the consistency over a period of time and the other features as set out in the RCP Guidelines to be of significance. In his written report Dr Hanrahan stated that when considering the burdens of continuing with CANH there does not appear to be great *'burdensomeness evident'*. That accords with the medical evidence of YD's relatively stability, he has not suffered from infections. Whilst Dr Hanrahan stated that in broad terms by virtue of his current condition the trajectory is he would continue to deteriorate, however he did not detract from the view set out in his report due to the high quality of care, both medical and from the family, that he is receiving. The evidence about pain is equivocal. There is evidence of YD grimacing whilst his limbs are being stretched and both JG and MB describing being aware when it appears he is in discomfort.
82. I agree with the Official Solicitor that the court now has a rounded picture of the values and beliefs that would be likely to influence YD's decision if he had capacity. I reject any suggestion that JG, MB or NT sought to bring their values, beliefs, wishes and feelings over those of YD, or risked conflating them. They each gave compelling evidence with dignity and composure and maintained the clear blue line between what they felt and their evidence about YD's values, beliefs, wishes and feelings. This is despite their obvious deep affection for YD. They were each able to bring their own perspective of YD's beliefs and values. I reject the submission on behalf of the Trust that the evidence *'did not provide a direct answer to the question of what [YD] would have wanted to do in these specific, extreme circumstances'*. In my judgment, that is considering YD's best interests through too narrow a lens. If there is no evidence of such a conversation the court needs to carefully look at the relevant evidence as a whole, evaluate it and see what, if any, conclusions can reliably be drawn.
83. What has been so striking about the evidence about YD from JG, MB and NT is that, certainly in relation to JG and MB, even though they had each known YD for 20 and 24 years respectively, they had not known each other prior to October 2024, and were unaware of each other's existence. Yet despite that separation over such an extended period of time they were each able to independently confirm many common features about YD's wishes and beliefs. In particular, regarding the depth of his interest in the spiritual world and his limitless curiosity about such matters that he held strong beliefs about. YD has long held beliefs about the healing power of the mind, body and soul and to understand and, if required, push established boundaries based on his learning

and understanding. From their descriptions YD was compassionate, private person who was a fiercely independent thinker about a wide range of issues, in particular regarding the spiritual world and healing.

84. I agree with the Official Solicitor that the evidence establishes that whilst YD *'might not dispute Dr Hanrahan's opinion that recent physical changes are the manifestation of involuntary, rudimentary new connections to the brainstem, he would be likely to see that opinion as a limited and incomplete explanation of what had caused those changes'*. His long standing interest in the healing power of the mind, spirit or soul would very likely be values that would inform his decision if he had capacity. The changes that have been observed he would regard as positive signs and that he had the potential to make further changes. These are likely to be relevant factors that would inform his decision if he had capacity, and would be likely to be a factor in him wishing and feeling that he wanted to continue to be provided with CANH. YD would also likely factor in, due to his long standing beliefs in such matters, that others believe they are in communication with him.
85. When looking at what evidence the court has about what decisions he has made in the past, the understanding of what VS is and the medical prognosis by Dr N and Dr Hanrahan it is unlikely to have caused YD to wish or feel that CANH should be withdrawn. When considering the evidence about the past YD is likely to value the devotion shown by JG and MB. Their evidence when asked about how YD would feel about the amount of nursing care he requires, bearing in mind the evidence about what a private person he was, was powerful, as they each responded that YD would take it as part of the process of getting better or healing. They both described YD's high threshold for experiencing pain or discomfort in the past. This is consistent with his actions in the past (for example seeking the assistance of the NHS when he chose to) and his wider views of the holistic healing process. I agree with Mr Hockton, that from the evidence the court has about YD he would have approached the decision-making in this case in a very different way from Dr N and Dr Hanrahan.
86. Having stood back and considered through a wide best interests lens whether it is in YD's best interests to continue to receive CANH I have reached the conclusion that it is.
87. In my judgment the burdens do not outweigh the benefits. I have carefully considered each of the burdens it is said continuing with that treatment would involve for YD, both in the short and the long term, but I have to balance that with the benefits of such treatment continuing. Most importantly it would preserve his life. I depart from the evidence of Dr N and Dr Hanrahan as in the particular circumstances of this case I place greater weight on YD's past and present wishes, feelings, beliefs and values than they do. I accept the picture of YD painted by the evidence of JG, MB and NT. I do not regard the continuance of CANH in this case as futile where it sustains life. Having looked at the wider evidential picture I do not accept the narrow view taken by Dr Hanrahan as it did not pay sufficient regard to the evidence of YD's beliefs and values and wishes and feelings. Whilst it is recognised that any awareness on the part of YD, if present, is extremely limited and there may be little or no further improvement and a trajectory of general deterioration it is far from clear that in the circumstances YD is in he would regard his continued existence as a burden. There is a strong presumption in favour of preserving life which, in my judgment, having carefully evaluated the evidence in this unusual case, the Trust has not discharged.

Wider aspects

88. The focus of this judgment has been on YD. It is right that during the evidence the wider issue of the impact of cases such as this was raised. The Trust acknowledge there is scope for further work in relation to the timing of applications of this nature: on the one hand, there is a well-recognised need to bring cases of this kind promptly if treatment is not regarded as being in P's best interests, but on the other hand, there is the risk of unintended consequences if this leads to patients having prolonged admissions to acute neurorehabilitation beds versus a community placement. There has been no suggestion in this case that the Trust delayed in making this application.
89. The issues raised are (i) whether the ICB should be a party to proceedings of this nature, or (ii) whether the ICB's engagement in matters (without party status; as occurred in this case) satisfies their need to be actively involved in withdrawal decision, and (iii) whether patients should, where possible, be placed in community beds, pending the outcome of an application.
90. The Official Solicitor considers there is a lack of clarity in this case whether Dr N considered that YD should have been transferred to a nursing home some time ago and court proceedings initiated whilst he was there, or that he would not stand in the way of YD's CANH continuing so long as it did so at a nursing home not at the rehabilitation unit.
91. It is clear that on a case by case basis these issues should be proactively and carefully considered at each stage, full disclosure must be made of any such concerns or considerations raised so that the Official Solicitor and the Court are fully appraised of the issues. The relevant ICBs should take a proactive interest in any such issues, taking such steps as are required to avoid delay and making sure all relevant parties are represented in any court proceedings and, if required, urgent directions sought from the court in any ongoing proceedings.
92. None of these observations detract from the very clear message in cases such as *NHS South East London Integrated Care Board v JP and others* [2025] EWCOP 8 and *NHS North Central London Integrated care Board v Royal Hospital for Neuro-Disability & XR* [2024] EWCOP 66 about the need for effective decision making structures being in place for those who are in a PDOC, the need for careful and regular review and evaluation about what is in their best interests and, where required, an application being made to the Court of Protection for a decision as to what is in the patient's best interests.