Neutral Citation Number: [2026] EWCA Civ 195

Case No: CA-2026-000361

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE COURT OF PROTECTION
The Hon Mrs Justice Theis DBE
COP20019348

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 3 March 2026

Before :

LORD JUSTICE NEWEY
LADY JUSTICE ASPLIN
and
LORD JUSTICE BAKER

- -

Between :

LESLEY BARNOR TOWNSEND	**Appellant**
- and -	
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	**Respondent**

- -
- -

Bruno Quintavalle (instructed by **Andrew Storch Solicitors**) for the **Appellant**
Parishil Patel KC (instructed by **Capsticks LLP**) for the **Respondent**
Claire Watson KC (instructed by the **Official Solicitor**) as **Advocate to the Court**

Hearing date : 23 February 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 3 March 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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LORD JUSTICE BAKER :

1. Two weeks ago, on 17 February 2026, Theis J, sitting as Vice-President of the Court of Protection, refused an application by Mrs Lesley Townsend for permission under s.50(2) of the Mental Capacity Act 2005 ("MCA") to bring an application relating to medical treatment for her father, Robert Barnor. On Monday of the following week, 23 February, this Court heard an application for permission to appeal against that order, with appeal to follow if permission was granted. At the conclusion of the hearing, we reserved our decision and judgment. On the following day, we informed the parties that permission to appeal would be granted on two grounds, that the appeal would be allowed on one ground, and that permission would be granted to the appellant to bring the application relating to medical treatment for her father. We directed the matter to be listed before another Tier 3 judge in the Court of Protection on 27 February. We refused an application by the appellant for interim relief under s.48 of the MCA. We indicated that the reasons for our decision would be given in judgments to be handed down as soon as possible.

2. This judgment sets out my reasons for joining in those decisions.

3. Very sadly, Mr Barnor died on the morning of 27 February. At the hearing later that day, the judge relaxed the transparency order which Theis J had made at the start of the proceedings. As a result, the names of Mr Barnor and his daughter can now be published in this judgment. The transparency order remains in place for the time being only to preclude publication of the names of the treating clinicians.

Summary of background and proceedings

4. The background to this appeal is as follows. At the date of the appeal hearing, Mr Barnor was aged 68. He was a member of a loving family, happily married with five children. Mrs Townsend was his eldest daughter.

5. In April 2025, apparently without warning, he collapsed after suffering a stroke. A further series of strokes followed as a result of which he suffered extensive and irreversible brain damage. He never recovered consciousness. After admission to the Trust's hospital, he remained in the intensive care unit. According to the statement in the proceedings signed by the consultant in intensive care medicine leading the clinical team, hereafter referred to as Dr D, "repeated specialist neurological assessments have consistently found no meaningful neurological recovery." By the start of these proceedings, he was in a condition variously described by doctors as a "prolonged disorder of consciousness" ("PDOC") or "terminal decline in consciousness" ("TDOC"). Dr D reported that "while RB has periods of eye opening and reflex responses, there is no reliable evidence of communication, consistent interaction, or purposeful behaviour. Overall, there has been no sustained positive neurological trajectory over many months of careful observation and multidisciplinary care". The unanimous view of his treating clinicians (as summarised by Theis J) was "that he has no prospect of regaining consciousness or achieving any recovery that would allow a return to independent life or to a level of quality of life he could experience".

6. Members of his family, however, had a different view. It was not disputed that he lacks capacity to conduct proceedings or make any decisions about his care and treatment. From May 2025, however, they saw signs of improvement in his condition. According

to Mrs Townsend's statement in these proceedings, they had often seen him awake and responsive. She described him as tracking the family and nurse with his eyes, squeezing his wife's hand, responding to requests that he squeeze it harder, blinking on request, reacting to music, pointing when he wants help. At one stage, Mrs Townsend took video recordings of his movements, but according to her they were then asked by hospital staff to stop filming.

7. In her statement, Mrs Townsend made a number of complaints about the hospital's failure to consult with the family. In August and September, members of the family challenged the hospital's decision to keep Mr Barnor on a ventilator. It was their aim for him to be discharged from the intensive care unit and in due course to return home or alternatively to be discharged to a care home. Mrs Townsend asserted that they were impeded by the hospital's failure to comply with their request to see Mr Barnor's medical notes. Efforts were made to arrange mediation between the clinical team and the family, but in the event, none took place before the crisis which precipitated these proceedings.

8. Before his collapse, Mr Barnor suffered from kidney disease and following his collapse developed severe acute kidney injury which required renal replacement therapy and dialysis. Attempts to wean him away from dialysis were unsuccessful and he was placed back on dialysis in the latter part of 2025. A central line was fitted and treatment administered twice a week.

9. In October 2025, the hospital obtained "second opinions" from three independent specialists – Dr John Prowle, consultant in intensive care medicine at the Royal London Hospital, who in addition to reviewing the papers and speaking with members of the treating team, conducted an examination of Mr Barnor on 13 October 2025 and prepared a report dated 15 October; Dr Rob Elias, consultant kidney doctor at King's College Hospital, who also examined Mr Barnor and prepared a report dated 19 November 2025, and Professor Lynne Turner-Stokes, consultant in rehabilitative medicine at Northwick Park Hospital and national clinical lead for PDOC, who spoke to members of the treating team but did not visit the hospital and never examined Mr Barnor, but prepared a report dated 8 November 2025. Although Mrs Townsend and her mother met Dr Prowle, neither Dr Elias nor Professor Turner-Stokes had any contact with members of the family.

10. Although these three reports were obtained in October and November 2025, it is the family's case that they were not disclosed to them at the time. There is a dispute as to whether Dr Prowle's report was disclosed at the time it was obtained. We were told that Mr Barnor's clinical records suggest that it was. According to his daughter's statement, the family were not told that the reports had been received until January 2026, and they were not disclosed until 11 February which was shortly before the planned mediation.

11. The reports prepared by Dr Prowle and Dr Elias can properly be described as providing a "second opinion" about Mr Barnor's condition. Professor Turner-Stokes' report, however, is of a different character.

12. In his recommendations at the conclusion of his report, Dr Prowle said:

> "(1) As a Critical Care Physician I am specifically focused on interventions provided in the intensive care unit. Based on Mr

> Barnor's current condition and irreversible injuries I expect stepwise deterioration will occur. In my opinion a return to invasive ventilation by endotracheal tube or tracheostomy, circulatory support with vasopressors, or continuous renal replacement therapy (if intermittent dialysis is not tolerated) would be futile, as they would not work to achieve the therapeutic goal of recovery from critical illness, but at best would restabilise Mr Barnor's condition in the same or a worse state.
>
> (2) I am also of the opinion that endotracheal intubation or a tracheostomy to facilitate deep endobronchial suction would be invasive interventions that can only be experienced as noxious stimuli. I understand that the family recognise the potential for pain and distress with these interventions and perceive them as invasive. While I recognise the concept of best interests can extend beyond individual's ability to perceive quality of life to that of a wider family group - I can't see it being in anyone's interests to inflict invasive interventions on a loved one with no prospect of sustained benefit.
>
> (3) Furthermore, I would also support a decision to not provide further haemodialysis but to focus care on comfort and dignity of Mr Barnor and his family. In my opinion dialysis is an intermittent intervention that is objectively only drawing out a prolonged dying process."

13. At the end of his report, Dr Elias set out his opinion:

> "The team at King's would not offer kidney replacement therapy of any sort in these circumstances.
>
> We do not believe it would be right to offer a treatment to support someone where deterioration and complications are inevitable, starting from a very low level of consciousness.
>
> In practice, Mr Barnor is dependent on high intensity nursing care in a hospital environment to remain well. Any move out of that setting will result in deterioration. Dialysis treatment, even if it were technically and logistically possible, would serve only to prolong inevitable deterioration, without benefit.
>
> Can I extend my sympathies to Mr Barnor's family. Having met him sitting out in the intensive care unit I feel I can begin to imagine the kind of person he was and so can begin to imagine how awful the situation must be for them."

14. Given the urgency of these proceedings, it has not been possible to establish the precise circumstances of Professor Turner-Stokes' instruction. No letter of instruction has been disclosed. As stated above, she is the national clinical lead for PDOC, the chair of the group that produced National Clinical Guidelines for PDOC (2020) and has in the past

been instructed in many cases to conduct assessments of patients in that condition. From her report, however, it seems that this was not the reason for her instruction in this case. She wrote:

> "The clinical team on the ICU is in agreement that further treatment is futile and clinically inappropriate to offer. However, despite multiple detailed discussions, his family has not accepted the irreversible nature of his brain injury and prognosis, and continue to demand ongoing treatment, including dialysis.
>
> You have asked me for advice regarding the clinical decision-making process for withdrawal of treatment in line with the National Clinical Guidelines."

15. Before giving that advice, however, Professor Turner-Stokes expressed an opinion on Mr Barnor's condition:

> "First of all, on a clinical level, I confirm that sadly RB will not regain consciousness. He is clearly dying and would not survive for more than a few days/weeks without the ongoing life-sustaining treatments that you are giving him, which include dialysis and clinically assisted nutrition and hydration (CANH). He could not live outside of the hospital environment and I agree with your team's view that any further active medical treatment at this point is futile and clinically inappropriate."

As I understand her report, this opinion was based on conversations with the clinical team. It is unclear whether the professor had access to Mr Barnor's medical records.

16. Professor Turner-Stokes continued by explaining the difference between PDOC and TDOC, that the guidelines for detailed assessment of patients with PDOC do not apply in TDOC, and that in her view Mr Barnor was in the latter not the former, he having suffered not a sudden onset brain injury but multiple strokes which caused progressive degenerative brain injury. She advised:

> "I would recommend that your records should be amended to replace any references to 'PDOC' 'and 'Minimally conscious state (MCS)' with 'TDOC'."

We were not informed whether Mr Barnor's medical records were amended in line with this advice.

17. Professor Turner-Stokes then turned to the apparent reason for her instruction. Under the heading "Decision-making and the legal framework", she stated "I have sent separately advice on the 10 steps to follow when making decisions about life-sustaining treatment in patients who lack the mental capacity to make decisions for themselves". Mr Quintavalle told us that this separate document had not been disclosed to the family.

18. The report continued:

> "Key points that I would highlight are as follows:

1. It is the giving, (and not the withdrawing) of treatment that needs to be justified. Just because you can give a treatment does not mean to say that you should.

2. It is first up to the clinical team to decide which treatments are on offer. A clinician may decide that a given treatment would be futile or clinically inappropriate within the particular context of a patient's presentation, in which case they are under no obligation to offer it, and such decisions are made routinely as part of everyday clinical practice.

3. If a treatment is not on offer, the family must be informed of the decision and the reasons for it, but it is not a best interests decision, and neither the patient nor their family can demand it.

4. If the family disputes the decision, the treating team should seek a second opinion and do due diligence to determine whether another provider would offer it. Importantly, the question to the second opinion is not whether they agree with and support the approach taken by the current treating team, but whether they would take a different view and be prepared to take over the patient's management and offer the treatment themselves.

5. If they would, then the team should take the necessary steps to transfer the patient to their care (if that is agreed to be in the patient's best interests).

6. If a treatment is on offer, then there needs to be a 'best interests decision' to determine whether it is in the patients best interests to receive it.

7. If there is a dispute about whether or not it is in the patient's best interests, the matter should be referred to the Court of Protection to decide and the treating organisation is responsible for making that application.

8. However, the Court of Protection can only decide whether or not a treatment that is on offer is in the patient's best interests (or on which treatment, if more than one alternative is available). The Court of Protection cannot compel a clinician or a Trust to deliver a treatment that they believe to be clinically inappropriate.

9. If there is continued dispute about a decision not to offer treatment, then the family may make an application to the courts, but such disputes are normally dealt with by the Administrative Court by way of a judicial review. The treating organisation should inform the family of their legal rights, but is not under any obligation to brings the case itself.

> I note that you are seeking legal advice in this case which is entirely appropriate. However, when seeking legal advice, it is extremely important that you, as a clinical team, are absolutely clear about whether you are making:
>
> a) a clinical decision not to offer treatment because you consider it to be clinically inappropriate, or
>
> b) a best interests decision because you do not believe it to be in the patient's best interests.
>
> This is important because disputes are dealt with by different legal frameworks as described above. However, it is often my experience that clinicians muddle the language and write in the notes that a treatment "is not on offer because it is not in the patient's best interests". As soon as you do that, any dispute about it becomes a matter for the Court of Protection and should be referred by the Trust without delay.
>
> My understanding from our discussion is that you are not prepared to offer further treatment because it is clinically inappropriate, but the initial approach to me by [Dr S] stated: "The consensus is that further escalation of care would not be in his best interest". So, once again, I recommend that you examine your clinical documentation to determine whether or not you have recorded this decision accurately."

19. The report continues with detailed practical advice to the Trust about a number of issues, including mediation, treatment escalation planning, step down or discharge, palliative care, and staff support, including frank warnings about the impact on staff of court proceedings.

20. Although it contained advice to the hospital trust, this report was plainly not a conventional "second opinion". It is also interesting to note that it was headed "Without Prejudice". Mr Patel was unable to explain the reason or significance of this marking.

21. Returning to the clinical history, the central line through which dialysis was administered became blocked and, on 30 January 2026, a temporary line, called a vascath, was fitted for short term use. Dr D's evidence was that this was only suitable for short-term use and "was inserted to avoid an abrupt interruption of dialysis while the team met with the family and communicated the established clinical decision and the reasons for it".

22. The "established clinical decision" to which Dr D referred was that RB was "not suitable" for long-term dialysis, that no dialysis access would be carried out and no new tunnelled line inserted.

23. The reasons for this decision were subsequently set out in Dr D's statement in the following terms:

"a. Irreversible terminal neurological condition (TDOC): Mr Barnor's brain injury is severe, widespread, and longstanding. There has been no meaningful recovery over many months. In TDOC there is no realistic potential for improvement, and continuing burdensome life-sustaining treatments cannot achieve the intended goals of intensive care (recovery or restoration of an acceptable level of awareness and function).

b. Dialysis cannot deliver a meaningful benefit for Mr Barnor: Dialysis cannot improve or reverse [his] neurological condition. In this context it serves only to prolong the process of dying, without the prospect of recovery or a quality of life Mr Barnor could experience.

c. Increasing burdens and harms: Continued dialysis requires ongoing invasive line access. Mr Barnor's long-term tunnelled dialysis catheter has now failed. The usual life-expectancy of tunnelled dialysis catheters is approximately six months, and almost all fail eventually due to a build-up of biofilm and clots. On occasion, these clots can be removed by administering 'clot busting drugs', but these were unsuccessful, despite repeated administration. Between the time of tunneled dialysis catheter failure on 30 January 2026 and his last dialysis session on 11 February 2026, Mr Barnor was dialysing via a temporary groin catheter (a "Vascath"), which carried significant risks. Vascaths are intended only for short-term use. Repeated line insertions and replacements would expose Mr Barnor to avoidable harm (notably infection, bleeding, thrombosis, and procedural complications) with no counterbalancing prospect of clinical recovery.

d. No pathway to discharge or outpatient dialysis: Because of his profound and irreversible impairment of consciousness and high dependency needs, Mr Barnor cannot safely receive outpatient dialysis or live outside an acute hospital environment. Local and independent renal expert opinion confirms that long-term dialysis (haemodialysis or peritoneal dialysis) would not be offered in these circumstances, as he is not medically suitable for outpatient dialysis and would not survive in an environment outside of the acute hospital setting.

e. For these reasons, the consensus of Mr Barnor's treating teams (Intensive Care, Renal, Neurology) and three independent external experts is that continued dialysis is futile, clinically inappropriate and is prolonging the process of dying rather than providing therapeutic benefit. The clinical plan is therefore to focus on comfort, dignity, and symptom control, with palliative care support, recognising that Mr Barnor is nearing the end of life."

24. At a meeting on 6 February, the family were informed of this clinical decision. Later that day, a solicitor instructed on their behalf, Mr Pavel Stroilov, wrote to the Trust's legal department. He stated he had been instructed that, at the meeting, the clinicians had suggested that it was for the family to make an urgent application to the Court of Protection if they continued to dispute the Trust's contention that continuation of treatment was not in Mr Barnor's best interests. Mr Stroilov described this as contrary to the well-established procedure for the party seeking to withdraw or withhold treatment to make the application. He added that it was "bizarre", given the fact that the Trust had contemplated making an application, the discussions about mediation, and the failure to disclose either Mr Barnor's medical records or the second opinions. He asked the Trust's lawyer to "confirm by return that the Trust will continue to provide life-sustaining treatment to Mr Barnor, including dialysis, until and unless its dispute with the family is resolved either by reaching an agreement or, as a last resort, by the Court's determination".

25. On 11 February, the Trust's solicitors, Messrs Capsticks, replied. They summarised the treating team's assessment of Mr Barnor's condition in terms similar to those subsequently set out in Dr D's statement quoted above. They enclosed copies of the reports of Dr Prowle, Dr Elias and Professor Turner-Stokes, described as "3 external second opinions". They continued:

> "The Trust has made a clinical decision not to provide further and long-term dialysis to this patient beyond a final dialysis session which will take place on Wednesday 11 February 2026 if the current temporary line is still working at that time. There are no other treatment options and without dialysis it is anticipated that Mr Barnor will die within a matter of days. He will of course be provided with palliative care by way of symptom management to the extent that his clinical condition requires it."

Under the heading "Legal Framework", they quoted extensively from a recent judgment of Henke J in *Re AA (Withdrawal of Life-Sustaining Treatment: No Best Interests Decision)* [2024] EWCOP 39 (T3), together with a brief citation from the judgment of Holman J in *An NHS Trust v MB* [2006] EWHC 507 (Fam). They continued:

> "The Trust has made a <u>clinical decision</u> that it is not appropriate to provide Mr Barnor with further dialysis. We acknowledge that there may have been some confusion caused with the use of language previously and we apologise for this. Having explored this today with the Trust and Counsel, we can confirm that there is no best interests decision available to be determined by the Court, but that a clinical decision has been made, and it is that dialysis will not continue to be provided by this Trust…. We reiterate that there is no best interests decision for the Court to make. As per the case law detailed above, it would therefore be inappropriate for the Trust to make an application to the Court of Protection and so the Trust will not be making an application."

26. On the afternoon of Friday 13 February, the appellant's solicitors filed an application in Form COP1 seeking permission to apply for declarations and orders relating to the withdrawal of Mr Barnor's treatment. The Court of Protection, not being able to deal with the matter before the close of the working day, advised the appellant to apply to the out-of-hours judge. This application was refused, the judge observing that "the proposed application does not satisfy the requirement for an urgent out-of-hours hearing" but that "if the application is pursued, it may be referred to a judge for directions on Monday". On Monday 16 February, the application was referred to the Vice-President of the Court of Protection, Theis J, who in view of the urgency made interim declarations and orders on the papers. The declarations included an interim declaration that Mr Barnor lacked capacity to conduct the proceedings and make decisions about his medical treatment. The judge invited the Official Solicitor to act as Mr Barnor's litigation friend, and listed the matter the following day for a hearing of the permission application, with appropriate case management directions. The judge also made a transparency order in the standard form prohibiting identification of Mr Barnor, members of his family, the hospital and the names of his treating clinicians. The authors of the "3 external second opinions" were not included.

27. In the event, the Official Solicitor responded that, as permission to bring the application had yet to be granted and there was no security for her costs, she would not, at that stage, accept the invitation to act as his litigation friend. The appellant then filed a certificate of suitability indicating that she would be willing to act in that capacity, though no order of appointment was made following receipt of the certificate. Instead, Theis J asked the Official Solicitor to act as Advocate to the Court. That invitation was accepted.

28. The hearing duly took place before Theis J on 17 February. The judge considered written statements from Mrs Townsend and Dr D, and written and oral submissions from Mr Stroilov for Mrs Townsend and from Parishil Patel KC for the Trust and Claire Watson KC for the Official Solicitor. The judge then delivered an ex tempore judgment refusing the application. Mr Stroilov applied for permission to appeal, which the judge refused for reasons set out in an addendum to the judgment.

29. At paragraph 19 of her ex tempore judgment, Theis J set out her reasons for declining to grant Mrs Townsend leave to bring the application:

> "(a) I acknowledge and have raised during hearing that there has been confusion in language used with the family, but the evidential reality is that the medical decision making process has concluded that dialysis will no longer be offered by the clinical treating team;
>
> (b) Secondly, if Mr Barnor had capacity, save for issuing proceedings for Judicial Review, getting leave for that and seeking orders, a person of capacity would not be able to compel a medical clinician for that treatment to be provided. The Court of Protection in its position acting as proxy for somebody who lacks capacity is in no different position when faced with the decision that has been made in this case as a person with capacity would have.

> (c) There is no option for the Court of Protection to consider and as a result the application in my judgment has no real prospects of success and in those circumstances leave should not be given under s.50 MCA."

30. Two days later, on 19 February, Mrs Townsend filed a notice of appeal to this Court seeking permission to appeal and interim relief. On the morning of 20 February (last Friday), I listed the matter for a preliminary hearing that afternoon for case management directions and consideration of interim relief. At that hearing, in view of the urgency of the situation, I listed the application for an oral hearing before a three-judge court on the next working day, Monday 23 February, with appeal to follow at the same hearing if permission was granted, and gave case management directions for the filing of skeleton arguments and appeal bundles. The urgent timetable was unavoidable because of Mr Barnor's serious medical condition – I was advised that it was possible, though on balance unlikely, that he would pass away over the weekend. After extensive argument, during which leading counsel on behalf of the Trust, after taking further instructions about treatment options over the weekend, informed me in effect that there was no practical basis on which dialysis could be reinstated, I declined to make an order for interim relief, but urged the Trust to take such steps as they reasonably could in their clinical judgment to ensure that Mr Barnor remained alive until the hearing on the following Monday.

31. Over the weekend, the parties' representatives worked tirelessly to comply with those directions to enable the Court to be able to conduct the appeal. This Court is extremely grateful to all the lawyers involved.

The application to this Court

32. The following grounds of appeal were put forward:

(1) By refusing to grant leave to bring proceedings pursuant to s.50 Mental Capacity Act 2005, the judge failed to comply with:

a. the State's positive Article 2 obligation to ensure a patient's access to the Court in order to resolve a dispute over the provision of life-sustaining treatment.

b. the common law requirement to ensure that disputes over the provision of life-sustaining treatment are brought before and resolved by the Court.

(2) The judge erred in not granting leave under s.50 Mental Capacity Act in circumstances where the application was made on behalf of the patient himself.

(3) The judge erred in holding that a "clinical decision" to withhold life sustaining medical treatment is not subject to best interests considerations and hence is not subject to the supervision of the Courts.

(4) In the alternative, if there is a legally significant distinction between *clinical* and *best interests* decision-making, such a distinction must be based upon objective criteria and in the event of a dispute the Court must examine whether these criteria

are met: in the circumstances the judge erred in not granting permission so that the court could establish whether such criteria were met.

33. The real issue here is the point raised in ground 3. The points of principle set out in ground 1 underpin, and are repeated within, the arguments in ground 3 but to my mind add little of substance. Ground 2 is misconceived. The application by Mrs Townsend was not made "on behalf of" Mr Barnor in the technical sense because Mrs Townsend was not acting as his litigation friend. In fact, it emerged in the course of argument that Mr Barnor had not actually been made a party in the proceedings under COPR 1.2(a) prior to the dismissal of the application for permission to apply. Ground 4 only arises if we conclude, contrary to ground 3, that there is a legally significant distinction between clinical and best interests decision-making.

34. Under ground 3, Mr Quintavalle submitted that the distinction drawn by the Trust's solicitors between clinical and best interests decision-making, at least within the context of decisions relating to the provision of life-sustaining treatment, is entirely misguided and is incompatible with case law, in particular the decision of the Supreme Court in *An NHS Trust & Ors v Y & Anor* [2018] UKSC 46, the Mental Capacity Act, the Mental Capacity Code of Practice, and the Practice Guidance. I shall consider these provisions below.

35. Mr Quintavalle also contended that the distinction drawn by the Trust was incompatible with the United Kingdom's Article 2 obligations. He relied on the three factors identified by the Grand Chamber of the ECtHR in *Lambert v France* (2016) 62 EHRR 2 (at paragraph 143) as relevant when determining whether the withdrawal of treatment was lawful under Article 2:

> "- the existence in domestic law and practice of a regulatory framework compatible with the requirements of art.2;
>
> - whether account had been taken of the applicant's previously expressed wishes and those of the persons close to him, as well as the opinions of other medical personnel; and
>
> - the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interests."

36. On behalf of the Trust, Mr Parishil Patel KC characterised the legal framework in these terms. There are three stages involved in any treatment decision – (1) a decision by the clinician, having assessed the patient's condition and using his or her specialist knowledge and expertise, to decide whether to offer any or a particular treatment as being clinically appropriate; (2) having identified particular treatment options, the clinicians must discuss the same with the patient to determine whether the patient has capacity to make a decision to consent to the treatment options offered by the clinician; (3) where a treatment is offered, whether that treatment is provided to the patient. In deciding whether the offered treatment can be provided, a capacitous patient can make his or her own decision to consent to its provision whereas, for a patient lacking capacity, that decision has to be made in his or her best interests, taking into account the patient's wider circumstances. Mr Patel submitted that these legally distinct stages of treatment decision-making are well-established by the authorities, in particular *R (Burke) v General Medical Council (Official Solicitor and other intervening)* [2005]

EWCA Civ 1003, [2006] QB 273. In particular, a doctor cannot be compelled by anyone, including the court, to provide treatment which he or she considers clinically inappropriate. This principle has been recognised by courts at all levels, including the Supreme Court in *An NHS Trust & Ors v Y* (supra), *N v ACCG and others* [2017] UKSC 22, [2017] AC 549 and most recently by this Court in *R v Spectrum Community Health Community Interest Co ex parte JJ* [2023] EWCA Civ 885, [2024] PTSR 1. The only process by which a clinical decision whether or not to offer treatment can be challenged is by judicial review. Mr Patel submitted that the principles derived from case law and guidance dealing with best interests decisions in medical treatment cases are confined to disputes about treatment options that are on offer.

37. Under ground 3, Mr Patel therefore submitted that the processes of clinical decision-making in determining what treatment is available to the patient and the provision of available treatment to the patient are distinct, and that the clinical decision-making process is a prior process to the provision of treatment. That legal framework applies equally to life-sustaining treatment. In those circumstances, Theis J was entitled and correct to conclude that the application in the Court of Protection before her concerned a decision taken by the Trust's clinicians not to offer dialysis treatment to Mr Barnor as it was no longer clinically appropriate and that the Court of Protection was not the correct forum to determine the lawfulness of that clinical decision.

38. Mr Patel's position was supported by Ms Watson on behalf of the Official Solicitor. Citing the decision in *Burke*, she submitted that there is a distinction between clinical decision-making and best interests decision-making, with the latter coming after the medical decision-making process has concluded and a medically informed determination has been made about what treatment options (if any) are to be offered to a patient. A medical decision not to offer a particular treatment on purely clinical grounds does not become a best interests decision because the patient lacks capacity and the legal framework established by the appellate authorities is clear that the Court of Protection can only scrutinise decisions about medical treatment where an evaluation of P's best interests is required.

Law and guidance

The MCA

39. In the present case it was not disputed that Mr Barnor lacked capacity. It was therefore unnecessary to consider those provisions of the MCA, or case law, relating to the determination of capacity.

40. The basic principles to be applied under the MCA are set out in s.1 and include, under s.1(4), the cardinal principle that "an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests".

41. The steps to be taken to determine what is in a person's best interests are set out in s.4 which provides inter alia:

> "(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of (a) the person's age or appearance or (b) a condition of his, or an aspect of his

behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider (a) whether it is likely that the person will at some time have the capacity in relation to the mater in question, and (b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable, (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity); (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind; (b) anyone engaged in caring for the person or interested in his welfare; (c) any donee of a lasting power of attorney granted by the person, and (d) any deputy appointed by the court.

…

(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) "Relevant circumstances" are those—

(a) of which the person making the determination is aware, and

(b) which it would be reasonable to regard as relevant."

42. S.5 provides, so far as relevant to this case:

> "(1) If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—
>
> (a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and
>
> (b) when doing the act, D reasonably believes—
>
> (i) that P lacks capacity in relation to the matter, and
>
> (ii) that it will be in P's best interests for the act to be done.
>
> (2) D does not incur any liability in relation to the act that he would not have incurred if P—
>
> (a) had had capacity to consent in relation to the matter, and
>
> (b) had consented to D's doing the act."

43. Under s.15(1)(c), the court may make declarations as to the lawfulness or otherwise of any act done, or yet to be done, in relation to that person. Under s.15(2), "act" includes an omission and a course of conduct. Under s.16(2), the court may, by making an order, make a decision or decisions on behalf of a person lacking capacity.

44. S.50(1) of the MCA identifies those persons entitled to apply to the Court of Protection under the Act without permission. They include a person who lacks, or is alleged to lack, capacity, the donor or donee of a lasting power of attorney, or a deputy appointed by the court of a person to whom the application relates. The list does not, however, include relatives of a person to whom the application relates. They must obtain the court's leave to apply under s.50(2). Under s.50(3), in deciding whether to grant leave, the court must, in particular, have regard to (a) the applicant's connection with the person to whom the application relates, (b) the reasons for the application, (c) the benefit to the person to whom the application relates of a proposed order or directions, and (d) whether the benefit can be achieved in any other way.

The Code of Practice

45. The MCA is supported by a Code of Practice. Under s.42(4)(g) of the MCA, any person acting in a professional capacity in relation to a person who lacks capacity is under a duty to have regard to the Code. It is important to note that the Code has not been updated since the implementation of the MCA in 2007. It is widely recognised that an update is overdue.

46. Chapter 5 of the Code is headed "What does the Code mean when it talks about 'best interests'?" The first paragraph of the introductory section to the chapter reads:

> "One of the key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests. That is the same

> whether the person making the decision or acting is a family carer, a paid care worker, an attorney, a court-appointed deputy, or a healthcare professional, and whether the decision is a minor issue – like what to wear – or a major issue, like *whether to provide particular healthcare*" [emphasis added].

47. Paragraphs 5.29 to 5.36 of the Code give specific guidance as to how to establish P's best interests when making decisions about life-sustaining treatment. Paragraphs 5.31 to 5.33 and 5.36 are relevant to the present case:

> "5.31 All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.
>
> 5.32 As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.
>
> 5.33 Importantly, section 4(5) cannot be interpreted to mean that doctors are under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen. Doctors must apply the best interests' checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests. If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide what is in the person's best interests.
>
> …
>
> 5.36 As mentioned in paragraph 5.33 above, where there is any doubt about the patient's best interests, an application should be made to the Court of Protection for a decision as to whether

> withholding or withdrawing life-sustaining treatment is in the patient's best interests."

Case law

48. The case law cited in these proceedings falls into two strands.

49. In *R (Burke) v General Medical Council (Official Solicitor and other intervening)* [2005] EWCA Civ 1003, [2006] QB 273 in dismissing an appeal from Munby J, this Court rejected the argument that a doctor is obliged, if the patient so requires, to provide treatment to a patient, or to procure another doctor to provide such treatment, even though the doctor believes that the treatment is not clinically indicated. In giving the judgment of the Court, Lord Phillips of Worth Matravers (at para 50) endorsed the following propositions put forward by the GMC

> "i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated (i.e. will provide overall clinical benefit) for his patient.
>
> ii) He then offers those treatment options to the patient in the course of which he explains to him/her the risks, benefits, side effects, etc involved in each of the treatment options.
>
> iii) The patient then decides whether he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases he will, of course, decide which treatment option he considers to be in his best interests and, in doing so, he will or may take into account other, non-clinical, factors. However, he can, if he wishes, decide to accept (or refuse) the treatment option on the basis of reasons which are irrational or for no reasons at all.
>
> iv) If he chooses one of the treatment options offered to him, the doctor will then proceed to provide it.
>
> v) If, however, he refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion."

50. *Burke* concerned an adult with capacity and was decided before the implementation of the MCA. The principle that a doctor cannot be required to provide treatment to a patient that he considers clinically inappropriate is well established and has been restated on many occasions.

51. The second strand of authority cited to us concerns the principles to be applied when considering whether to withdraw or withhold treatment from a patient lacking capacity. These principles date back to the decision of the House of Lords in *Airedale NHS Trust v Bland* [1993] AC 789 in which, as Mr Quintavalle reminded us, Lord Lowry at page 875 G to H, observed:

> "Procedurally I can see no present alternative to an application to the court such as that made in the present case. This view is reinforced for me when I reflect, against the background of your Lordships' conclusions of law, that, in the absence of an application, the doctor who proposes the cessation of life-supporting care and treatment on the ground that their continuance would not be in the patient's best interests will have reached that conclusion himself and will be judge in his own cause unless and until his chosen course of action is challenged in criminal or civil proceedings."

52. In *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591, the Supreme Court was concerned with a case involving the withholding of invasive support for circulatory problems, renal replacement therapy and cardiopulmonary resuscitation from an incapacitated adult. Baroness Hale of Richmond (at paragraph 18) reiterated the principle that neither the patient nor the court on his behalf can order a doctor to give a particular form of treatment. She added, however (paragraph 19), that "any treatment which the doctors do decide to give must be lawful" and that "generally it is the patient's consent which makes invasive medical treatment lawful". At paragraph 20, she continued:

> "where a patient is unable to consent to treatment it is lawful to give her treatment which is necessary in her best interests. Section 5 of the Mental Capacity Act 2005 now provides a general defence for acts done in connection with the care or treatment of a person, provided that the actor has first taken reasonable steps to establish whether the person concerned lacks capacity in relation to the matter in question and reasonably believes both that the person lacks capacity and that it will be in his best interests for the act to be done. However, section 5 does not expressly refer both to acts and to omissions, the giving or withholding of treatment. The reason for this, in my view, is that the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it."

After citing some passages from the judgments in *Bland*, she continued (at paragraph 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."

53. Thus doctors, like other decision-makers, have to evaluate treatment options by reference to the patient's best interests. Having cited paragraphs 5.31 to 5.33 of the Code of Practice, Lady Hale (at paragraph 29) noted: "As paragraph 5.33 makes clear, doctors have to decide whether the life-sustaining treatment is in the best interests of the patient."

54. At paragraph 39, Lady Hale summarised what best interests decision-making involved in this context:

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

She continued (at paragraph 45):

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

55. Mr Patel laid particular emphasis on the subsequent decision of the Supreme Court in *N v ACCG*, supra. I agree that this does provide useful insights though not quite in the direction he suggested.

56. The question arising in that case was articulated by Baroness Hale in paragraph 1 of her judgment (with which the other members of the Court agreed):

> "what is the decision-maker to do if he has reached the conclusion that a particular course of action is in the best

> interests of P but the body who will be required to provide or fund that course of action refuses to do so? Specifically, what is the role of the Court of Protection where there is a dispute between the providers or funders of health or social care services for a person who lacks the capacity to make the decision for himself and members of his family about what should be provided for him?"

57. Lady Hale reiterated the well-established principle in a passage (cited by Mr Patel) in paragraph 35 of her judgment:

> "So how is the court's duty to decide what is in the best interests of P to be reconciled with the fact that the court only has power to take a decision that P himself could have taken? It has no greater power to oblige others to do what is best than P would have himself. This must mean that, just like P, the court can only choose between the "available options"."

The most pertinent aspect of her judgment, however, comes towards the end when, under the heading "Discussion", she gives guidance as to how the parties and the Court of Protection should deal with cases where the option proposed by one of the parties is not "available" because the body responsible refuses to fund it.

58. At paragraph 38-9, Lady Hale said:

> "38. … It is perhaps unfortunate that the issue was described in the Court of Protection as one of "jurisdiction" and that term was used in the statement of facts and issues before this Court. The issue is not one of jurisdiction in the usual sense of whether the court has jurisdiction to hear the case. After all, the Court of Protection made the orders which it was asked to make in this case and no-one has suggested that it had no jurisdiction to do so. It was seized of an application properly made by the authorities responsible for providing services for MN. The context was a care order giving the local authority parental responsibility for him which was about to come to an end. No doubt if there had been no dispute with the family about his care, there would have been no need to make an application. Section 5 of the 2005 Act gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court. But if there is a dispute …. the court clearly has jurisdiction to make any of the orders or declarations provided for in the Act. The question is not strictly one of jurisdiction but of how the case should be handled in the light of the limited powers of the court.
>
> 39. What may often follow such an application will be a process of independent investigation, as also happened in this case,

> coupled with negotiation and sometimes mediation, in which modifications are made to the care plan and areas of dispute are narrowed, again as happened in this case. But it does not follow that the court is obliged to hold a hearing to resolve every dispute where it will serve no useful purpose to do so."

59. At paragraph 40, Lady Hale referred to the Court's case management powers under the Court of Protection Rules which enable it to curtail the proceedings if the circumstances justify that course, having regard to the overriding objective. She continued:

> "41. The court is clearly entitled to take the view that no useful purpose will be served by holding a hearing to resolve a particular issue. In reaching such a decision, many factors might be relevant. In a case such as this, for example: the nature of the issues; their importance for MN; the cogency of the parents' demands; the reasons why the CCG opposed those demands and their cogency; any relevant and indisputable fact in the history; the views of MN's litigation friend; the consequence of further investigation in terms of costs and court time; the likelihood that it might bring about further modifications to the care plan or consensus between the parties; and generally whether further investigation would serve any useful purpose."

60. She emphasised, however, that the decision whether to curtail proceedings is a matter for the Court, not the care provider:

> "43. Case management along these lines does not mean that a care provider or funder can pre-empt the court's proceedings by refusing to contemplate changes to the care plan. The court can always ask itself what useful purpose continuing the proceedings, or taking a particular step in them, will serve but that is for the court, not the parties, to decide."

61. For twenty-five years after *Bland*, the practice was to apply to the Court in any case where the withdrawal of life-sustaining treatment was proposed, even where all parties agreed that withdrawal was in the patient's best interests. In *An NHS Trust & Ors v Y & Anor* [2018] UKSC 46, however, the Supreme Court concluded that it was no longer necessary for all cases involving the withdrawal of CANH from a patient in a PDOC to be referred to court. Lady Black, with whom the other members of the Court agreed, explained the reasons for this and the circumstances in which an application would continue to be required:

> "124. …. The survival of patients such as Anthony Bland, then so unprecedented, is now a well-established feature of medical practice. The documentation supplied to us shows that the difficulty that there is in assessing the patient and in evaluating his or her best interests is well recognised. The process is the subject of proper professional guidance, covering vitally important matters such as the involvement in the decision-making process of a doctor with specialist knowledge of prolonged disorders of consciousness, and the obtaining of a

> second opinion from a senior independent clinician with no prior involvement in the patient's care. The second opinion, as contemplated in the guidance (see paras 79 and 80 above, for example), is, in my view, a crucial part of the scrutiny that is essential for decisions of this sort, and the guidance sets parameters which should ensure that it is an effective check, in that the clinician who provides the second opinion must (so far as reasonably practical in the circumstances of the case) be external to the organisation caring for the patient, and is expected to carry out his or her own examination of the patient, consider and evaluate the medical records, review information about the patient's best interests, and make his or her own judgement as to whether the decision to withdraw (or not to start) CANH is in the best interests of the patient. Thus the interests of patients and their families are safeguarded, as far as possible, against errors in diagnosis and evaluation, premature decisions, and local variations in practice.
>
> 125. If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application can and should be made. As the decisions of the ECtHR underline, this possibility of approaching a court in the event of doubts as to the best interests of the patient is an essential part of the protection of human rights. The assessments, evaluations and opinions assembled as part of the medical process will then form the core of the material available to the judge, together with such further expert and other evidence as may need to be placed before the court at that stage."

62. Following the decision in *An NHS Trust v Y*, and pending the expected revision of the Code of Practice, Hayden J, then the Vice-President of the Court of Protection, issued Guidance on Applications Relating to Medical Treatment (17 January 2020). Under the heading "Situations where consideration should be given to bringing an application to court", the Guidance provides (paragraphs 8 and 9):

> "8. If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:
>
> (a) finely balanced, or
>
> (b) there is a difference of medical opinion, or
>
> (c) a **lack of agreement** as to a proposed course of action from those with an interest in the person's welfare, or
>
> (d) there is **a potential conflict of interest** on the part of those involved in the decision-making process
>
> (not an exhaustive list)

> then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration **must** always be given as to whether an application to the Court of Protection is required.
>
> 9. Where any of the matters at paragraph 8 above arise and the decision relates to the provision of life-sustaining treatment an application to the Court of Protection must be made. This is to be regarded as an inalienable facet of the individual's rights, guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms ("ECHR"). For the avoidance of any doubt, this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration."

63. It has been suggested that the Guidance is drafted to apply to situations where there is more than one option for medical treatment. In *GUP v EUP & Anor* [2024] EWCOP 3, however, Hayden J indicated that it applied more broadly. In that case, EUP, a patient in her late eighties, was supplied with artificial hydration but after several failed attempts the doctors concluded that it was not in her interests to be provided with artificial nutrition. Although the family disagreed with this conclusion, no application was made to the Court on behalf of the Trust and the patient's son, GUP, therefore sought leave to apply. Hayden J granted leave but concluded on the evidence that it was not in her best interests to be given life-sustaining medical treatment and gave consent on her behalf to the delivery of palliative and end-of-life care. At the end of his ex tempore judgment, Hayden J said (at paragraph 48):

> "In this case, the hospital had put in place a regime focused on palliative care. As I have identified above, this is undoubtedly in EUP's best interests, at least at the stage at which I am hearing the case. However, it was also clear that GUP and his family were never fully on board with that plan. It is certainly the case that there was a broadly co-operative relationship with GUP but I think it was equally clear that he had not accepted the medical consensus. The same applies to his sister, HUP. Who has expressed strenuous resistance to the hospital's plans at this hearing. GUP has told me that the hospital had indicated to him that they were to make an application to court to seek endorsement of their approach. I do not think this is in dispute. However, on 16th January 2024, the Trust confirmed to the family that they had been advised by their lawyers that it was not necessary for them to issue an application. The likely reasoning behind this is that the Trust considered that there was no ethical route to provide nutrition to EUP. The family disagreed and saw this as passivity, with profound consequences. They perceived an important decision having been taken, even though the decision was to take no action. They considered that the Court ought to be able to review that decision making process and identify its own evaluation of where EUP's best interests lay. I agree with the family. A decision not to provide nutrition is every

> bit as serious as a decision to withdraw nutrition. Where there is conflict, these cases must be resolved by the court."

64. In *Re AA (Withdrawal of Life-Sustaining Treatment: No Best Interests Decision)* [2024] EWCOP 39 (T3), however, Henke J took a different approach. The case concerned a 33-year-old man in a PDOC who was receiving CANH. The treating clinicians concluded that CANH should be discontinued and he should receive palliative care to minimise his pain and discomfort. Their conclusion was supported by a second opinion from an independent specialist but opposed by AA's family. The Trust applied for a declaration under s.15 of the MCA that the clinicians' plan was lawful and in his best interests but Henke J declined to make it, saying (paragraph 40):

> "This case is stark. There is only one available option before this court. The reality is that this court has no choice to make. Accordingly, I have concluded that there is no best interest decision to make here, and I do not do so."

In the alternative, the Trust sought a declaration to similar effect under the inherent jurisdiction. Whilst acknowledging that she had the power to make such a declaration, Henke J declined to do so, stating (at paragraph 41):

> "It appears to me that the declaration is really being sought to protect the clinicians and medical staff now and in the future from potential legal action given AA's parents fundamental disagreement with the PCP. I have considered whether I should grant the declaration sought in such circumstances. If I thought that on the ground that the declaration would make any difference to the outcome for AA then I may have been persuaded to make it. But the reality here is that the declaration will not alter anything. The clinicians will continue to treat in accordance with their clinical judgment whether or not I make the declaration. AA's parents' views, whether reasonable or not, are deeply held. In my view, granting the declaration sought will not change his parents' views nor actually how they are likely to behave to staff implementing the plan. It is purposeless."

The judge reiterated her view at paragraph 42:

> "The stark reality of his case is that AA is too fragile to be moved to another hospital and that those at the RHRU are clear that the only treatment plan clinically viable for AA and which they are prepared to implement is the PCP. The court has no choice and I have asked myself whether in circumstances such as these, when the court has no choice at all, it should rubber stamp the decision of others. I have decided that I should not. In coming to that decision, I should emphasize that I have the greatest respect for the clinicians in this case and the difficult decisions that they have had to take and will have to take until AAs death. They do so in accordance with their hypocritic oath and to the highest of professional standards. I do not criticise them or the judgment they have made. However, the reality of this case is that the

> treatment decision in this case is purely a clinical decision not the court's decision. The court's approval is not required to implement it. The court is not needed to sanction the plan and the court has no further role to play in what treatment AA does or does not receive."

Professional guidance

65. In addition, we were referred to professional guidance available for doctors. The guidance published in 2018 by the Royal College of Physicians and British Medical Association, "Clinically-assisted nutrition and hydration and adults who lack the capacity to consent", includes at page 32, under the heading "Who is the decision-maker and who should be consulted? – Key points", the following advice:

> "Where there is disagreement about whether a course of action is in the best interests of the patient, or the decision is 'finely balanced' (i.e., there is ongoing uncertainty), the Court of Protection remains the ultimate decision-maker, and can and should be asked to decide."

66. Finally, this approach is reflected in the national clinical guidelines published by the Royal College of Physicians "Prolonged disorders of consciousness following sudden onset brain injury" (2020) (reviewed in 2025). This was not included in the bundle of authorities included in our papers but as noted above was referred to in Professor Turner-Stokes' report. Section 4 of the guidelines is entitled "The Ethical and Legal Framework for Decision-Making". The "Summary of Recommendations" at the end of the section include the following passages:

(1) Recommendation 4.1, headed "Futile or clinically inappropriate medical treatments", includes the statement: "Clinicians should be aware that … if they decide that a given treatment would be clinically inappropriate within the particular context of a patient's presentation, they are under no obligation to offer it, and this is not a matter to be considered with reference to the Mental Capacity Act."

(2) Recommendation 4.4, headed "Decisions regarding treatment and care", includes: "Unless the decision is already covered by a valid and applicable advance decision to refuse treatment (ADRT), all decisions should be undertaken on the basis of best interests, under the terms of the Mental Capacity Act 2005."

(3) Recommendation 4.11, entitled "Applications to the court":

> "1. If the provisions of the MCA 2005, the Code of Practice and the relevant guidance have been observed, with respect to best interests decision-making, and if all parties (including family members, treating team and second opinion) are in agreement that it is not in the patient's best interests to continue CANH, then this can be withdrawn without application to the court.
>
> …

> 4. If, *at the end of the clinical decision-making process*, [emphasis added] there is disagreement between any of the parties that cannot be resolved by discussion and/or mediation, then the matter should be referred to the Court of Protection. Similarly, an application should be made if the decision is ultimately one that is finely balanced due to residual uncertainty about best interests.
>
> 5. Family members should not be in the position of having to make an application to the court in relation to serious medical treatment decisions.
>
> (a) If a court application is required, the NHS commissioning body with overall responsibility for the patient should bring an application to the court and should fund that application.
>
> (b) Every effort should be made to ensure that applications are made as soon as practicable and are processed in a timely and efficient manner."

67. Although the guidance is principally expressed by reference to CANH, it is plain from the document as a whole that it also applies to other life-sustaining treatment, including dialysis.

68. The following principles are therefore clearly and consistently established by the case law and professional guidance.

(1) All decisions about incapacitated adults, including clinical decisions, have to be made in the patient's best interests, taking into account all relevant circumstances and taking the steps identified in s.4 of the MCA.

(2) If all parties (including family members, treating team and, if obtained, second opinion) are in agreement that it is not in the patient's best interests to continue life-sustaining treatment, then this can be withdrawn without application to the court.

(3) If, at the end of the clinical decision-making process, there is disagreement between any of the parties that cannot be resolved by discussion and/or mediation, then the matter should be referred to the Court of Protection.

(4) If a court application is required, the NHS commissioning body with overall responsibility for the patient should bring and fund the application.

(5) In exercising its powers to make declarations and orders about the patient's best interests, the Court of Protection cannot compel the doctor to give a treatment that he or she considers clinically inappropriate.

Conclusion

69. Any decision about the care and treatment of a mentally incapacitated adult, including the withdrawal of life-sustaining treatment, must be taken in the patient's best interests. There is no carve out for "clinical decisions".

70. This is crystal clear from the cases cited above, in particular the judgments of Baroness Hale in *Aintree v James* and Lady Black in *A NHS Trust v Y*. Importantly, as Baroness Hale identified in *Aintree v James*¸ under s.5 of the MCA a doctor will not incur liability for an act done in relation to the patient if, when he did the act, he reasonably believed that it would be in the patient's best interests for the act to be done.

71. The course taken by the Trust in this case was contrary to established principle and practice articulated in the case law, the Code of Practice, and guidance. It is surprising that, in their letter to the appellant's solicitor dated 11 February 2026, the Trust's solicitors' exposition of the legal framework made no reference to the clear exposition of principle in Lady Black's judgment in *A NHS Trust v Y* or to the Vice-President's 2020 Guidance but instead included extensive citation from a first instance judgment which was plainly at odds with that Guidance, supported by a single sentence from a judgment of Holman J handed down in a child case nearly twenty years ago. That sentence – to the effect that he had no right or power to require doctors to carry out a positive medical intervention against their own judgment and will – is one observation in a lengthy judgment in which the judge based his decision on an exhaustive analysis of the child's best interests. With respect to Henke J, I do not consider the approach she adopted in *Re AA* was in line with the principles and practice identified in case law, the Code of Practice, and professional guidance.

72. If there is agreement between the family, clinicians and any experts asked to provide a second opinion that it is in the patient's best interests for life-sustaining treatment to be withdrawn, there is no requirement for the matter to be referred to the Court of Protection: *A NHS Trust v Y*. If there is disagreement, "a court application can and should be made" (*ibid* paragraph 135) The NHS commissioning body responsible for the patient must apply to the Court. The hospital cannot pre-empt court proceedings by unilaterally withholding or withdrawing treatment on "clinical" grounds. A decision whether or not to withdraw treatment has to be a best interests decision.

73. It follows that, notwithstanding her great experience in this jurisdiction, I concluded that the Vice-President erred in deciding that permission to bring the proceedings should be refused because "the medical decision-making process has concluded that dialysis will no longer be offered" and that there was "no option for the Court of Protection to consider". In argument, we were told that there are very few instances of permission being refused to bring an application under s.50. Counsel were unaware of any previous case in which permission to apply in respect of life-sustaining treatment had been refused. Although one can envisage circumstances in which repeated applications may amount to an abuse of process, it is difficult to think of any circumstances in which it would be appropriate to refuse an initial application for permission to bring such proceedings.

74. Once proceedings have been started, however, the judge will exercise their case management powers as the circumstances require. Many of these cases are very urgent and, as proposed by Lady Hale in *N v ACCG* in the context of a refusal to fund treatment, it is open to the Court to use its case management powers to adopt an abbreviated process. That again is a matter for the Court to determine, not the parties. In cases such as Mr Barnor's, where the view of the treating team and the second opinion experts is that continuing treatment is clinically inappropriate, the Court will scrutinise the evidence to determine whether withdrawal or withholding treatment is in P's best interests. In many, perhaps most, cases, the Court will conclude that it is not in

P's best interests for treatment to continue, and it may reach that conclusion swiftly. In no circumstances can the Court compel the doctors to provide treatment that they consider clinically inappropriate. But the decision is for the Court, not the clinicians.

75. It was for those reasons that I concluded that the appeal should be allowed and the order dismissing the application for permission to bring proceedings set aside.

76. Given the urgency, I further concluded that the right course would be for this Court to consider and determine the application for permission. As set out above, s.50(3) provides that, in considering an application for permission to bring proceedings in the Court of Protection, a court must have regard to (a) the applicant's connection with the person to whom the application relates, (b) the reasons for the application, (c) the benefit to the person to whom the application relates of a proposed order or directions, and (d) whether the benefit can be achieved in any other way. Mrs Townsend is Mr Barnor's daughter. In line with the principles set out above, her proposed application was designed to resolve the disagreement about whether dialysis and other treatment should be withheld from her father. It was plainly for his benefit that the disagreement be resolved, and the history of this case unfortunately demonstrated that this could not be achieved in any other way. For those reasons, I agreed that the appellant be granted permission to apply to the Court of Protection.

77. Given the urgency, there was some suggestion that this Court might determine the best interests issue. We decided, however, that the better course was to remit the proceedings for an urgent hearing in the Court of Protection for that issue to be determined.

78. There were two further issues on which we were addressed on behalf of the appellant through Mr Quintavalle. First, he urged us to grant interim relief in the form of declarations in the following terms:

(1) It is lawful, being in his best interests, for Mr Barnor to receive life-sustaining treatment, including (without limitation):

a. Regular dialysis;

b. Replacement of the tunnelled dialysis catheter and any other medical procedures reasonably necessary to facilitate dialysis;

c. All other treatment reasonably necessary to sustain his life pending the determination of his best interests by this Court.

(2) For the avoidance of doubt (there being an ongoing dispute between the First Respondent and members of Mr Barnor's family about whether continuation of life-sustaining treatment is in Mr Barnor's best interests) it is not lawful for the First Respondent, or for any person with clinical responsibility for the treatment of Mr Barnor, to withdraw (or withhold) life-sustaining treatment until and unless such withdrawal (or withholding) has been authorised by this Court in Mr Barnor's best interests.

79. We declined to make interim declarations to that effect. My reason for joining that decision was that (1) any order made by us would have only lasted for at most three days until the next hearing, (2) my assessment of the medical evidence of the treating

clinicians, supported by the written second opinions of Dr Prowle and Dr Elias, was that attempts in the few days before the next hearing to re-introduce a temporary line for dialysis would be invasive and expose Mr Barnor to significant risks, and, given his overall condition, could therefore not be declared to be in his best interests, and (3) the wording of the draft second declaration was tantamount to an order compelling the doctors to deliver a treatment which they consider clinically inappropriate.

80. The second issue raised by Mr Quintavalle was the transparency order. He invited this Court to discharge those parts of the order prohibiting the identification of Mr Barnor and members of the family. He informed the Court that there had already been publicity in the print media in which Mr Barnor and members of the family had been named, apparently before the transparency order was made. Mr Quintavalle conceded that, following the decision of the Supreme Court in *Abbasi v Newcastle upon Tyne Hospitals NHS Foundation Trust* [2025] UKSC 15, the prohibition of the identification of the treating clinicians could properly be continued during the currency of the proceedings and for a limited "cooling off" period thereafter. But the family wished to be released from the injunction preventing them from publishing their account.

81. Whilst being sympathetic to the family's wishes about this, in my view it was premature for this Court at that stage to relax the transparency order. Having granted permission for the application in the Court of Protection to be made, it was appropriate for Mr Barnor to be joined as a party and a litigation friend appointed. Ms Watson informed the court that, in that event, the Official Solicitor would accept the invitation to be appointed. The fact that, as Advocate to the Court, her counsel expressed support for the Trust's position on this appeal did not cause me concern that she would not carry out her duties professionally and with due regard to Mr Barnor's best interests as in other similar cases. I concluded that, as litigation friend, she would have been able to reach a quick conclusion as to whether it was in Mr Barnor's interests for the transparency order to be relaxed and that the question whether that should happen could therefore properly be considered by the judge to whom the proceedings were remitted.

82. As a result, this Court agreed an order in the following terms:

(1) The application for permission to appeal is refused on grounds 1 and 2 but allowed on grounds 3 and 4.

(2) The appeal is allowed on ground 3, for reasons to be given in a judgment to follow.

(3) The appellant is granted permission under s.50(2) of the Mental Capacity Act 2005 to apply to the Court of Protection for declarations and orders in respect of RB.

(4) The application will be listed before a Tier 3 judge of the Court of Protection on 26 or 27 February 2025, time estimate half a day.

(5) The Official Solicitor is appointed to act as litigation friend in the proceedings.

(6) The application for interim relief pending the next hearing is refused.

(7) The transparency order is extended in its current form until the next hearing.

83. I conclude with three final observations.

84. First, as I said at the outset of the hearing on 20 February, I have the deepest sympathy for the pain and anguish which the appellant and other members of Mr Barnor's family are going through. At this crucial point, I hope that they have not had to spend undue time in court proceedings and away from his bedside where I am sure they would have preferred to be.

85. Secondly, nothing I have said should be read as indicating any view as to the proper outcome of a best interests analysis in this case. That was a matter which we decided should be determined by the next judge, having regard to all relevant circumstances. In the event, as a result of Mr Barnor's death, no best interests evaluation will take place.

86. Finally, it is clear from the arguments advanced in this case, including those set out in Profesor Turner-Stokes' report quoted above, that there continue to be grave concerns amongst professionals about the procedure to be followed in these cases. I am aware that very substantial medical and legal resources are taken up by treating patients in PDOC. There are plainly arguments to be made for a different approach. But that can only come about after a proper process of careful assessment and consultation. It may be that this will be incorporated in the revised Code of Practice which is anticipated shortly. Until that happens, these cases must be conducted and managed in accordance with the MCA and procedure specified in case law and existing guidance.

LADY JUSTICE ASPLIN

87. I too have the deepest sympathy for Mr Barnor's family and Mr Barnor himself. I agree with the reasons which support our decision in this matter which Lord Justice Baker has set out above. It seems that the approach taken by the Trust arises from an erroneous view that clinical decisions lie wholly outside the scope of the MCA. As Lord Justice Baker has pointed out that approach is contrary to established principle and practice articulated in the case law, the Code of Practice, and guidance.

LORD JUSTICE NEWEY

88. I agree with both judgments.