Neutral Citation Number: [2026] EWCOP 43 (T3)

Case No: 13698857

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26 August 2026

Before :

THE HONOURABLE MR JUSTICE MCKENDRICK

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Between :

NHS NORTH EAST LONDON ICB	**Applicant**
- and –	
(1) FHR (By his litigation friend the Official Solicitor**)** **(2) FN** (His Mother) **(3) FZR** (His father)	**Respondents**

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Mr Michael O'Brien KC and Dr Hina Pattani (instructed by **Capsticks)** for the **applicant**
Miss Katie Gollop KC and Mr Scott Storey (instructed by **Dovestone Law)** for the **first respondent**
Mr Pavel Stroilov of Andrew Storch Solicitors for the **second respondent**
Ms Aswini Weereratne KC and Mr Daniel Taylor (instructed by **GN Law)** for the **third respondent**

Hearing dates: 17-20 August 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 26 August 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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THE HONOURABLE MR JUSTICE MCKENDRICK

This judgment was delivered in public but a transparency order 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 P and members of his family 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.

McKendrick J :

Introduction

1. The issue before the court is whether or not clinically assisted nutrition and hydration (hereafter "CANH") is in the best interests of a 28 year old incapacitated young man, anonymised in this judgment as FHR. To resolve this profoundly important issue I have received a significant amount of professional, familial and expert evidence. I heard nine witnesses cross-examined over three days. I conclude that continued CANH is **not** in FHR's best interests and consent on his behalf, as he is unable to do so, to receive only palliative care. CANH is contrary to his best interests as it is futile and consigns FHR to an existence of distress with such limited consciousness and communication that his life is devoid of comfort or pleasure. There is little prospect of that ever changing. I endeavour to fully set out my reasons for arriving at this principle conclusion below.

2. The applicant is the relevant Integrated Care Board that funds FHR's care. The second respondent is his mother. The third respondent is his father.

3. There is no dispute whatsoever that FHR lacks capacity within the meaning of the Mental Capacity Act 2005 (hereafter "MCA") to make any of the relevant decisions in respect of conducting litigation or making decisions about life sustaining medical treatment, care or residence. He is profoundly incapacitated. The focus of the hearing has been confined to:

    a. is it in FHR's best interests to continue to receive CANH;
    b. if it is not in his best interests to receive CANH, where should he receive palliative care;
    c. should the transparency order made on 16 July 2026, remain in the same terms or be varied.

4. These proceedings have been highly charged and over-litigated. I attach as Annex 1, the agreed procedural chronology. The approach of some of the parties to this litigation has made resolution of the issues for FHR more difficult. At times he has been lost in the litigation.

FHR

5. At the heart of the proceedings is FHR, a young man who was born in December 1997. He is 28 years old. Whilst the evidence I have heard has often focused on FHR's disability, it is important to record the young man before his life changing injury.

6. FHR is British. He is a Muslim. He originally lived with both his mother and father who separated when he was young. He enjoys a very close relationship with his parents and particularly with his little sister. The siblings continue to be exceptionally close. FHR lived with his mother and sister in London. He went to school in London. He then spent some time living with his paternal grandparents and then with his father in Wales. He has a love of cars. He worked as a mechanic. He conspired, as young men do, with his grandparents to pressure his father into buying him a car. His father bought him an Audi Quattro. His father encouraged him to work in his restaurant business to repay the cost of the Audi. Clients and staff in the restaurants were very fond of FHR. FHR was then a people pleaser who made jokes and loved fun. FHR enjoyed watching Top Gear. Photos pre-injury show a young man who cared about his appearance and wore fashionable clothes. He had a girlfriend who was also Muslim and who was a few years younger. It appears they enjoyed a good if at times tempestuous relationship. FHR loves his family. Before his injury he was very close to his immediate and wider family.

7. On 29 January 2020 FHR sustained a severe hypoxic brain injury. He tried to hang himself. As a result FHR has complex medical needs: he is incontinent; he is very likely blind, he is mostly paralysed and requires a hoist to be moved out of bed, he requires PEG feeding, tracheostomy management and frequent suctioning. He has contractures that are getting worse. In 2020 he was diagnosed as in a vegetative state. He lived in his own adapted home between 2020 and 2025. Further PDOC reviews took place when he was moved to a residential home.

8. Movingly, FHR's sister, FRR, told me how she feels there are two brothers: FHR as he was before his injury and FHR as he is now some six years and seven months post injury.

The Background

9. FHR has been in a prolonged disorder of consciousness ("PDOC") since January 2020. He has experienced this every day for over six years and seven months. The exact nature of how he experiences this remains uncertain. There has been considerable dispute at this hearing amongst the professional witnesses as to whether FHR is in a persistent vegetative state (PVS) or whether he is in a Minimally Conscious State (MCS) and whether within that categorisation he is MCS- or MCS +. There was much debate about the three tools to assess consciousness in PDOC patients, namely the: CRS-R; the WHIM and SMART. I have found some of this debate doctrinaire. It has taken up much time, many resources and has led FHR to have been the subject of over 12 months of tests. Some of it has felt experimental. There is more than a hint of professionals following their own beliefs. Undoubtedly the extent of FHR's unconsciousness or awareness is an important evidential step in the best interests analysis. But ultimately whether FHR is PVS or MCS- is only part of the best interests picture and the court must not be distracted from the application of the humanity that is encapsulated in the section 4 MCA test to FHR's real circumstances in August 2026. That is to emphasise the need to focus on the individual, their circumstances, their background and what is currently in their best interests without a determined application of clinical formulations.

10. FHR was originally treated at the Royal Hospital for Neurodisability ("RHN") in Putney after his discharge from an acute hospital. In August 2020 he was discharged to an adapted private home. From that point professional nursing and care support was provided at home through agencies commissioned by the Integrated Care Board ("ICB"), and its predecessor, the Clinical Commissioning Group ("CCG"). FHR lived and received care at home from August 2020 to April 2025. In April 2025, following an application by the ICB, FHR moved to a care home, referred to as VCC. This enabled a PDOC assessment to be undertaken. Other than recurrent periods of hospital admission, FHR has resided at VCC since that time.

11. There have been three sets of Court of Protection proceedings since December 2020. On 23 December 2020, the CCG commenced the first proceedings concerning residence and care. I understand the welfare issues arose because of difficulties between the commissioned care team and FN. By order dated 27 June 2022, the Court made declarations under section 15 of the MCA that FHR lacked capacity in relation to litigation, residence, care and treatment, and that it was in his best interests to reside and receive care at home.

12. On 18 July 2023, the ICB commenced the second proceedings by a COP1 Application, again concerning residence and care. A final order dated 29 July 2024 recorded the parties' agreement that it remained in FHR's best interests to reside and receive care at home.

13. The ICB commenced the third and current proceedings by COP1 Application dated 29 October 2024. Initially the issue was residence and care. The ICB applied for FHR's transfer to a care home. By order dated 19 March 2025, DJ Mullins ordered FHR's transfer to VCC on an interim basis. The ICB confirmed that VCC was able to carry out a PDOC assessment. FHR moved to VCC on 14 April 2025. On 17 April 2025, during a visit by both FN and FRR, an ambulance was called by FRR. VCC staff considered this unnecessary. At hospital FHR was diagnosed with a chest infection and treated with antibiotics. He was discharged to VCC on 23 April 2025.

14. The background chronology is then not very clear but at some stage thereafter VCC restricted FN's and FRR's contact with FHR to daily video calls of up to 20 minutes only with no in person contact. Allegations were made of videos being placed on social media of FHR and others and unfair complaints being made against VCC staff. I note that no restrictions were placed on FZR or other family members. The restrictions on FRR were gradually relaxed and then lifted around August 2025. Video contact between FHR and FN has increased to 40 minutes daily. I have repeatedly emphasised since hearing these proceedings in April 2026 that however difficult relations may have been between FN and the VCC staff, given the momentous nature of the decision the court must make, in person contact between FHR and all his family members is very

likely to be overwhelmingly in his best interests. The applicant has appreciated that and has made effort to ensure greater contact.

15. In total, FHR had five emergency hospital admissions with infections during his residence at VCC:

    a. 17-23 April 2025 (increased secretions, drop in oxygen saturations, family call 999 and request admission to hospital against the wishes of VCC. Normal white cell count, C reactive protein and lactate level, which are markers that are normally raised in an infection were normal on 17/04/2025. Chest X-ray was clear. Indicating that there was no objective evidence of sepsis);
    b. 9-26 August 2025 (febrile, chest infection, right lung opacity. White cell count and CRP very high suggesting active infection);
    c. 8 December 2025 – 6 January 2026 (chest infection and abdominal distension. Very high inflammatory markers);
    d. 20 March – 29 April 2026 (chest infection and macroscopic haematuria);
    e. 15 May – 24 June 2026 (right sided pneumonia. Colistin nebuliser stopped).

16. VCC carried out a PDOC assessment of FHR between April and August 2025, using the WHIM and CRS-R methodologies. It is the family's respective position that they had little or no involvement in that assessment. The WHIM assessments were undertaken at VCC on 23 April 2025, 5 May 2025 and 9 May 2025 and CRS-R assessments were undertaken on 25 April 2025, 30 April 2025 and 2 May 2025. The WHIM assessment was further updated on 29 May 2025, 31 May 2025, 9 June 2025, 23 June 2025 and 7 July 2025 and the CRS-R assessment further updated on 14 May 2025. The report on the WHIM and CRS-R assessments by VCC concluded that FHR was in a vegetative state.

17. In June 2025, the ICB appointed Professor Wade as its clinical advisor. He produced a report, dated 26 July 2025, reviewing and endorsing the conclusions of the WHIM and CRS-R assessments conducted by VCC. This was done as a documentary exercise. On 17 October 2025 VCC held an informal meeting between the multidisciplinary team

("MDT") and the family to discuss FHR's best interests, in preparation for a formal best interests meeting. Many professionals and some family members attended.

18. By order of 22 October 2025, DJ Mullins ordered that the proceedings be transferred to a Tier 3 Judge. Within that order, DJ Mullins recorded that a serious medical treatment issue having arisen, the proceedings should be transferred to the Royal Courts of Justice. Case management decisions were made by the Vice President, Theis J. Peel J heard the matter in late 2025 and appointed a single joint expert, Helen Gill-Thwaites, an occupational therapist with considerable expertise in SMART assessments. She carried out a PDOC assessment using the SMART methodology in January 2026. Ms Gill-Thwaites filed her report on 11 February 2026. She made various recommendations, set out in summary at Appendix 6 of her report, about the steps she considered necessary to optimise FHR's condition and arousal levels and in respect of further assessments required after such optimisation was achieved.

19. On 6 March 2026, VCC held a formal Best Interests Meeting. The meeting was chaired by Dr Jonathan Martin, Consultant in Palliative Medicine, contracted by VCC to advise on, and support, best interests decision-making. He has had no direct clinical role in FHR's treatment. His role was to guide the best interests procedure. Many other professionals from various disciplines attended. Family members attended. A best interests decision was minuted on 25 March 2026, recording the conclusions that it is in FHR's best interests to continue receiving life sustaining treatment, including CANH and it is in FHR's best interests to be cared for at home.

20. On 9 April 2026, the ICB served a further witness statement from Ms Makwehe, setting out criticisms of both Ms Gill-Thwaites' report and the best interests minutes. Dr Martin responded to those criticisms in a further witness statement.

21. The proceedings then came before me on 23 April 2026 for case management. I admitted the evidence of Professor Wade as the ICB's clinical evidence but not as expert evidence. I appointed a single joint expert in the field of PDOC clinical expertise, Dr Nair to report on best interests. I also directed that the recommendations for optimisation and further testing should be attempted as recommended by the expert, Ms Gill-Thwaites, within the envelope of time available before the final hearing. The

matter was listed for a hearing to determine FHR's best interests in relation to the continuation of life-sustaining treatment.

22. On 14 May 2026, FN appealed the order of 23 April 2026, on the grounds that the Court had erred in admitting Professor Wade's evidence and further erred in listing a hearing to consider withdrawal of life-sustaining treatment. On 3 June 2026, the Court of Appeal refused permission to appeal on both grounds. King LJ observed: "*This case has been subject to egregious delay. It has throughout been a case in relation to serious medical treatment given that FHR was assessed as being in PDOC vegetative state in 2020*."

23. A further directions hearing took place before me on 17 June 2026 where it was necessary to re-timetable the final hearing from July into August for various practical reasons. There was a further hearing on 16 July 2026, when I heard FN's application to discharge or vary the Transparency Order. I refused that application but made some necessary amendments to the Transparency Order. The order of 16 July 2026 was made the subject of an application for permission to appeal by FN. Sir Stephen Cobb, P refused the application for permission to appeal on 18 August 2026.

24. At a Pre-Trial Review on 23 July 2026 I refused the application made by FN that the August hearing must also include the issue of FHR's residence in the light of FN's case that a care provider called Parador had agreed to care for FHR at home. It was said the destination of where he was cared for would be an integral part of the serious medical treatment issue. I rejected that submission noting that if CANH were to be in FHR's best interests, the court would make directions for a further hearing to deal with concrete competing options. I noted as of July 2026 there was only one residence option: VCC. I further noted that whilst FN's application for judicial review of the Applicant ICB's funding and/or commissioning of Parador has been allocated to me by order of MacDonald J, FN was not asking me to make any orders sitting as a judge of the Administrative Court and she did not yet have permission to pursue her application for judicial review. I was not prepared for the medical treatment issue to be yet further delayed by resolution of the funding issues with the commissioning of a home care package for FHR. I also noted that DJ Mullins and Peel J had both ordered that it was in FHR's best interests to reside at VCC and not at FN's home. I made clear the parties

would be required to deal with the location of palliative care, should CANH not be in FHR's best interests.

The Legal Background

25. Where an adult lacks mental capacity to make a specific decision for themself, in relation to that matter any act done, or decision made, on their behalf must be done, or made, in their best interests, see section 1(5) of the MCA. That adult is P.

26. In determining what is in P's best interests, the decision-maker must consider all relevant circumstances, whether P is likely to regain capacity, and, so far as reasonably ascertainable, P's past and present wishes and feelings, the beliefs and values that would be likely to influence P's decision if P had capacity, and the other factors P would be likely to consider if able to do so - see section 4(6) MCA; *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, Baroness Hale (Lord Neuberger, Lord Clarke, Lord Carnwarth and Lord Hughes agreeing), at paragraphs 23 to 26.

27. The decision-maker must take into account the views of anyone engaged in caring for P, or interested in P's welfare, as to what would be in P's best interests - s.4(7) MCA.

28. Where the determination concerns life-sustaining treatment, the decision-maker must not be motivated by a desire to bring about P's death – see section 4(5) MCA and *Aintree* per Baroness Hale at paragraph 25.

29. The views of P's family are relevant to a best interests determination, but family members are not themselves the decision-makers. Their views are relevant only in two respects: first, insofar as they help identify what P's own wishes and feelings were, or would have been; second, insofar as they otherwise inform the assessment of where P's best interests lie – see sections 4(6)–(7) MCA; and the Mental Capacity Act 2005 Code of Practice, Part 5, in particular paras 5.31–5.33 and 5.53.

30. Article 2(1) of the European Convention on Human Rights and Fundamental Freedoms (ECHR) provides: *Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law*. The right to life under Article 2 is an absolute right, not a qualified one.

31. In *Lambert and Others v France* [GC], application no. 46043/14, judgment of 5 June 2015, the Grand Chamber held that withdrawal of artificial nutrition and hydration from a patient in a vegetative state may be compatible with Article 2. In the absence of European consensus on whether life-sustaining treatment should be withdrawn, states have a margin of appreciation in end-of-life decision-making, however that margin is not unlimited and the Court retains power to review compliance with Article 2: *Lambert and Others v France* [GC], no. 46043/14, 5 June 2015, §§ 147–148; *A, B and C v Ireland* [GC], no. 25579/05, 16 December 2010, §§ 237–238.

32. There is, however, a European consensus as to the paramount importance of the patient's wishes. The patient is "the principal party in the decision-making process and whose consent must remain at its heart", even where the patient is unable to express his or her wishes. The patient's ascertainable wishes are therefore central to lawful end-of-life decision-making under Article 2: *Lambert and Others v France* [GC], no. 46043/14, 5 June 2015, §§ 74, 147, 178

33. Article 3 ECHR provides: "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment*." Suffering which flows from naturally occurring illness may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible: *Pretty v United Kingdom* [2002] ECHR 427, para 52.

34. The authoritative statement of how the court should undertake the best interests exercise under s.4 of the MCA is that given by Baroness Hale in *Aintree* (above), at paragraph 18 and paragraphs 39 to 45.

35. Treatment given to a person who lacks capacity is lawful only if it is in P's best interests. The question is therefore always whether it is in P's best interests to give the treatment, not whether it is in P's best interests to withhold or withdraw it. Where continuation of treatment is not in P's best interests, its withdrawal is lawful, see *Airedale NHS Trust v Bland* [1993] AC 789 (HL), Lord Browne-Wilkinson at 884, Lord Goff at 868 (Lord Keith and Lord Lowry agreeing with Lord Goff); applied in *Aintree* (above), Baroness Hale at paragraph 19 and paragraphs 21 to 22; *An NHS Trust v Y (and another)* [2018]

UKSC 46, Lady Black (Lord Neuberger, Lady Hale, Lord Wilson, Lord Mance and Lord Hodge agreeing), at paragraph 92.

36. Clinically assisted nutrition and hydration is medical treatment, not basic care, notwithstanding that its withdrawal may be perceived by lay observers as the withholding of basic care. Its withdrawal is subject to the same best interests analysis as any other medical treatment, see *Airedale NHS Trust v Bland* [1993] A.C. 789; and *An NHS Trust v Y* (above), Lady Black at paragraph 116.

37. In deciding whether life-sustaining treatment should continue, the emphasis is not on the likelihood of P regaining consciousness, but on whether P could ever recover a quality of life that P personally would value, see *Aintree* (above), Baroness Hale at paragraphs 39 to 45; and Briggs *v Briggs* [2016] EWCOP 53.

38. The starting point in every case is a strong presumption that it is in a person's best interests to stay alive. That presumption is not, however, absolute, see *Aintree* (above), Baroness Hale at paragraph 35, citing Sir Thomas Bingham MR in the Court of Appeal in *Bland* at 808.

39. Where a balancing exercise is required, the decision-maker must consider P's welfare in the widest sense — medical, social and psychological — must weigh the burdens of treatment against its benefits, and must try to put themselves in P's position in asking what P's attitude to the treatment would be, see *Aintree* (above), Baroness Hale at paragraph 39.

40. In a case concerning withdrawal of CANH from a patient with PDOC, the court may be assisted by addressing a structured list of considerations. A list of issues requiring determination in an application of this kind was set out by Cobb J (as he then was) in *PL (by her litigation friend, SL) v Sutton CCG & Anor* [2017] EWCOP 22 at paragraph 9; very recently endorsed by the Vice President, Theis J in *The Northern Care Alliance NHS Foundation Trust v (1) TB (By his litigation friend, the Official Solicitor), (2) MB, (3) RB* [2026] EWCOP 25 (T3) at paragraph 65 as follows:

> *"(i) What is [P's] current condition? What is [P's] level of consciousness or cognisance? What is [P's] awareness of the world around them?*

(ii) Does [P] have the mental capacity to make a decision about the continuance of CANH? If assessed to lack capacity presently, is there a prospect that they could develop the capacity to make that decision?

(iii) If they lack capacity, is it in their best interests that the court should confirm the continuing delivery of CANH? In answering this question, the court should consider:

(a) [P's] previous stated views on life-support, and on sustaining life artificially, in the event that they are totally dependent on others, and incapable of functioning in many essential domains of their life;

(b) The quality of [P's] life at present; whether there is any or any significant enjoyment in their life; whether they experience pain and/or distress, and if so how that is managed;

(c) [P's] prognosis if CANH were to continue for the foreseeable future; whether there is any real prospect of recovery of any of their functions and improvement in the quality of their life;

(d) The prognosis for [P] if CANH were to be discontinued: what would the palliative care package include, in the event that the CANH were to be discontinued, and where would her palliative treatment optimally be delivered (i.e. would P need to move from their current residential care home?);

(e) The prognosis for [P] if the court were to authorise the discontinuance of nutrition but not hydration;

(f) The views, wishes and feelings of the family and [P's] carers;

(g) [P]'s dignity;

(h) The sanctity of life generally."

41. In *NHS North Central London ICB v PC* [2024] EWCOP 31 Cusworth J held at paragraph 25:

> The courts now place less emphasis on establishing a specific diagnosis of Permanent Vegetative State ("PVS") or MCS but will nevertheless require evidence that it is not in the patient's best interests to continue life-sustaining treatment and that there is no prospect of meaningful recovery. Clinical evaluation and diagnostic testing (e.g. such as Wessex Head Injury Matrix ('WHIM'), the Coma Recovery Scale-Revised ('CRS-R') or Sensory Modality Assessment and Rehabilitation Technique assessment ('SMART')) remain an important evidential aspect in such cases.

42. Lieven J in *NHS West and North London ICB v MP* [2026] EWCOP 36 (a similar PDOC case to these proceedings) said the following about P's wishes and feelings at paragraph 73:

> It is therefore not possible to know with any confidence whether MP would have wished to have continued living in his massively diminished state. The Court of Appeal is clear that in those circumstances I should not speculate. In any event, there is in my view a limit to the weight that can be ascribed to wishes and feelings which could only have been given in totally different circumstances, and with no idea of the reality of the life that MP is now facing.

43. I have also had regard to the *Royal College of Physicians PDOC National Clinical Guidelines* dated April 2020. This document contains a helpful (if a little dated) summary of the law and it reminds me:

> "However, more recent case law (*Aintree v James [2013] UKSC 67, Briggs v Briggs [2016] EWCOP 53*) has brought a change in focus, the emphasis no longer being on the likelihood of regaining consciousness, but on whether a patient could ever recover a quality of life that they personally would value. *Best interests* discussions are therefore centred on a discussion of the patient's prior beliefs and values, and the predicted 'best' and 'worst case' scenario for recovery in terms of regaining ability to function independently, to communicate or interact at any level."
> And
> "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. From a legal perspective, the diagnosis of VS or MCS (permanent or otherwise) is no longer critical to decisions about life-sustaining treatment, as the only important question is whether the patient will recover a quality of life that they would value."

44. I have had regard to the entirety of the Guidelines and in particular Chapter 4 in respect of the ethical and legal framework for decision making.

The Evidence

45. The Royal College's PDOC National Clinical Guidelines is a helpful document. I was regularly taken to different parts of the Guidelines during the evidence. I have read the majority of the Guidelines after the hearing to remind myself of the core learning.

Professor Wade

46. Notwithstanding the fact I admitted Professor Wade's evidence and the application for permission to appeal this direction was rejected, there continued to appear to be some debate about his evidence. I made clear he is not an expert within the meaning of the Court of Protection Rules. However he is clearly a witness with expertise. It would be nonsensical if an ICB could not rely on a clinician to advise them in respect of a PDOC patient. I am entirely satisfied his evidence is properly admitted and I may attach weight to it: see sections 1 and 3 (2) Civil Evidence Act 1972 and *Phipson On Evidence 21st Edition Malel KC et al* at paragraph 33-112. Indeed most witnesses (including Dr Allanson) offered me their opinions on FHR's best interests.

47. Professor Wade is a professor and consultant in neurological rehabilitation. The background to his involvement in these proceedings is not entirely clear to me. There is a letter dated 26 July 2025 which suggests he was instructed by the parties jointly at the request of a judge who wished for a specialist in neurological rehabilitation to consider FHR's condition. But at the hearing I was told that Professor Wade was instructed by the applicant ICB to be an adviser in respect of FHR's condition. In any event, he is a clinician in this area of practice who has given evidence to the Court of Protection on many occasions, in respect of patients who are in a prolonged disorder of consciousness. He has provided a number of letters and two witness statements. There is a letter from him dated 26 July 2025 addressed to the ICB's solicitors. In that letter he reviews information from the VCC home and he sets out the background of the injury that had taken place. He effectively confirmed that FHR was in a prolonged disorder of consciousness and has been since 30 January 2020 and that VCC had conducted a thorough assessment of his care needs and his clinical state.

48. In a further letter dated 21 November 2025 again addressed to Capsticks, he said that he could not advise on changes in medication because he did not have a list of FHR's current medication. He set out that FHR was in a prolonged disorder of consciousness

and that he is at the lower end of the spectrum. He went on to say on a scale of 0 to 100 with 100 being wide awake and attentive and 80 would be sitting on a bus reading a book, FHR's score would be approximately two or three. He goes on to say that arranging another PDOC assessment will delay a decision that should have been made many months ago. He was opposed to there being a SMART assessment.

49. There is a further letter from Professor Wade dated 15 April 2026. Again Professor Wade sets out the essential background he goes on then to say he has read the minutes of a best interests meeting that took place on 6 March 2025. He then sets out several criticisms of that meeting, in particular he is critical that there is no consideration in the minutes of the meeting of the prognosis for FHR. He was also critical of the meeting and its assessment of FHR's level of consciousness. He goes on to consider in this letter the report from Ms Gill-Thwaites noting, she observed that FHR was in a vegetative state. Professor Wade critiques the 11 recommendations which were set out in appendix 6 of Ms Gill-Thwaites' report of 11 February 2026. Essentially he disagreed with her recommendations but I need not set out why. He goes on to discuss the different assessments used to assess the level of consciousness of PDOC patients. His report goes on to say the following:

> "The court should not concern itself with trying to establish the precise level of consciousness, for example, whether FHR is in a vegetative or a minimally conscious state, because these categories are invalid, with no evidential basis. He is self-evidently unconscious. No responses have suggested any evidently purposeful, consistent behaviours. No responses have suggested he extract significant meaning from complex environmental stimuli."

50. He goes on to say the recommendations made by Ms Gill-Thwaites will not benefit FHR and will not lead to any improvement in his state and will not add any useful information that will help the court in reaching a decision in this difficult case. He continues to say the recommendation made at the best interests meeting held on 6 March 2026 should be discounted, as it did not follow good practice and did not consider all the relevant information. He recommends the court should receive a comprehensive expert report considering all the relevant best interests factors for FHR, including his prognosis, the management options and whether active medical treatment remains in

his best interests or not. The contents of that letter appeared to have been repeated in a formal witness statement dated 20 April 2026.

51. Professor Wade filed a second witness statement dated 14 August 2026 as I made directions that all parties should be in a position to provide a short witness statement commenting on the expert evidence filed in the proceedings. Professor Wade noted the second report of Ms Gill-Thwaites and Dr Nair's report. He summarised their recommendations to the court. He also went through in some detail the underlying reports from professionals who reported to Ms Gill Thwaites. He went on in his witness statement to disagree with some of the recommendations made by Dr Allanson to optimise FHR's awareness. In particular he considered there would already have been a review of FHR's tracheostomy and he did not consider that there needed to be a reduction of medication nor did he consider that antidepressants were indicated.

52. His main conclusions then set out as follows:

> "The early brain imaging studies of FHR showed changes associated with severe cerebral hypoxaemia. The presence of early cerebral oedema suggests a more severe level of ischaemia. The bilateral absence of …. somatosensory evoked potentials, coupled with the imaging evidence of severe generalised hypoxic brain injury, indicated a very poor prognosis at the outset, as the treating team recognised. The occurrence of paroxysmal sympathetic hyperactivity is another marker of the severity of brain damage and indicates damage to the hypothalamic area, in addition to other areas.
>
> There has been no reported significant change over many years.
>
> One can be certain from the evidence that FHR's clinical state will continue to fluctuate within the envelope of responses and spontaneous actions that have been recorded over the last five years. Each observer will place their own interpretation on the observed behaviours, but nothing is going to change for the better until he dies; he may slowly decline as he ages."

53. Professor Wade was called to give evidence and was cross examined by the representatives. He confirmed he had never met FHR nor had he met the family members nor had he met the treating staff at VCC. His evidence was that the

categorisation of MCS -, MCS +, or PVS was a flawed concept because patients are not stable. He queried so many years after the injury the purpose of further testing. When asked about the tears seen by FHR's father, he said this was simply fluid that came out FHR's eyes. His evidence was that it was extremely unlikely that any further investigations will detect any change in FHR's consciousness. His opinion was that nothing that the therapists have reported shows any meaningful response to stimuli by FHR. When questioned by Miss Gollop about whether there was a real prospect of change, his view was there was not. He was asked about the likelihood of there being a positive change after a hypoxic brain injury and he answered that after three months any real change for the better was unlikely. I note the representatives asked him questions about the different ways of testing disorders of consciousness but I need not lengthen this judgement with that evidence.

Wadzanai Makwehe

54. Ms Makwehe is a Senior Complex Care Manager at the applicant ICB. Her witness statement addresses the palliative care options. She considered palliative care in the family home with their preferred care provider, Parador. She discounted this as Parador confirmed they have no experience of supporting palliative care at home. She did not identify another home based provider who can provide palliative care. A hospice responded to her enquiries and informed her whilst they could provide palliative care they could not manage FHR's tracheostomy. Her written evidence is that the Royal Hospital for Neuro-Disability has not responded to her enquiry.

55. A Specialist Unit ("the Specialist Unit") responded stating they could manage a palliative care package should the court rule that CANH was not in FHR's best interests. A Professor with considerable experience of PDOC issues at the Specialist Unit provided information about the palliative care arrangements. The witness statement explained that:

> "The [Specialist Unit] can safely manage FHR's tracheostomy alongside the palliative and end-of-life care he requires. Approximately one third of the unit's patients have a tracheostomy. During end-of-life care, the [Specialist Unit] operates a low-intervention tracheostomy management programme focused on

> symptomatic care only, and avoids routine deep suction, which is a source of discomfort. Excessive secretions are instead managed with glycopyrronium, in accordance with standard palliative care principles."

56. FHR's palliation would be managed in accordance with its four stage intravenous palliative care protocol "as set out in the national clinical guidelines for prolonged disorders of consciousness." A standard palliative care programme is exhibited to the witness statement. An individualised care plan would be developed for FHR and they could receive him into their care promptly following the court's decision. The experienced Professor said that FHR would be accommodated in a private side room. Family and friends would be free to visit and a reclining chair would be provided in his room to permit one family member to remain overnight. She was clear however that the Specialist Unit has a clear policy of respect from its staff and they would not tolerate abuse, which they have experienced from palliative care patients' families in the past. It was reported that she was not prejudging FHR's family, simply pointing out the standard policy.

57. Ms Makwehe was called to give evidence and was questioned by the parties' representatives. She accepted she had only looked at palliative care providers in the home over the last week. She was open to carrying out further investigations to ascertain whether a palliative care provider with experience of tracheostomy could be commissioned.

Dr Jonathan Martin

58. Dr Martin is a consultant in palliative care medicine at the National Hospital for Neurology and Neurosurgery. He was independently contracted to assist VCC to carry out a best interests decision process regarding FHR. He chaired the best interests meeting on 6 March 2026. He has experience of PDOC patients. He sets out the best interests process and his meeting with FHR's family members. He explains the main focus of his work for VCC was "to get the process right" noting that the collective decisions were taken collectively by the multi-disciplinary team. He notes that the ultimate decision is for the court and not the best interests meeting. He explains in his witness statement:

> "The national guidance on PDOC says that the person with overall responsibility for best interests decisions in the community is usually the GP (please see section 5.4.3 Practical arrangements for best interests decision-making involving life sustaining treatments, in Royal College of Physicians. *Prolonged disorders of consciousness following sudden onset brain injury: National clinical guidelines.* London: RCP, 2020)"

59. The main conclusion reached with reasons is set out as follows:

> "In the event, the MDT concluded that it was in FHR's best interests to continue CANH because the report of Helen Gill-Thwaites raised sufficient doubt about whether FHR's condition was adequately optimised for a reliable assessment, and therefore, whether the diagnosis of vegetative state (VS) was still correct - it was therefore necessary to continue CANH in order to be able to clarify that doubt. It seemed to the MDT that if we were going to believe the family (that FHR did respond to them sometimes while he was at home but then became much less responsive in VCC), then he should be moved to where, according to the family's unanimous account, he had previously been best optimised. Therefore, having made one best interests decision (to continue to provide CANH to enable optimisation as recommended by Helen Gill-Thwaites), the other (to return home) followed logically. We therefore felt it would be helpful for the Court if we reached a decision on this issue so that the Court can see our thinking."

60. In answers to questions when cross-examined by the representatives, Dr Martin said that the best interests decision made at the meeting he chaired was only a provisional one, given the role of the court. Dr Martin said that whether FHR was in a vegetative state or a minimally conscious state was a double edged sword because he could become more aware of the parlous state that he is in but on the other hand it may give him more awareness.

Dr Judith Allanson

61. The background to the involvement of Dr Allanson is somewhat complicated. Peel J granted the application for Ms Gill-Thwaites to be a single joint expert under the Court of Protection Rules. Ms Gill-Thwaites reported in early 2026. She reported to the court that FHR should be optimised and further tests should be carried out. In Annex six of her report she made a number of recommendations for optimisation and further testing. This was largely driven by the fact that during her SMART assessment of FHR, on 2 out of 4 occasions, he had appeared to follow the command "stick out your tongue." Recommendation 1 of Annex 6 recommended:

> "FHR to have regular reviews by an expert physician in PDOC to review his medication, specifically in respect to:
> - Medication to optimise arousal levels.
> - Exploration of causative factors of arousal levels
> - Tone/ physical management needs"

62. I acceded to the request for an addendum report from Ms Gill-Thwaites in line with her Annex 6 recommendations, in the context of doing what was possible to optimise FHR and carry out further tests of consciousness, before the final hearing. The parties, I am told therefore agreed that Dr Allanson was an appropriate clinician to carry out the Recommendation 1 clinical work. At no point did the court appoint her as an expert. He role was to report to the single joint expert, Ms Gill-Thwaites, who would then report to the court. I anticipated and my order made provision for those carrying out the Appendix 6 work to feedback to Ms Gill-Thwaites, precisely as Ms Endacott and Ms Cassim did (see below). FN's solicitors appeared to have misunderstood this and sent Dr Allanson a letter of instruction, which I am told the other parties agreed, with the exception of the Official Solicitor and later Mr O'Brien confirmed the ICB had not agreed to the letter of instruction. In these circumstances, I gave permission for FN to call Dr Allanson, noting she was FN's clinical witness and was not a court appointed expert.

63. Dr Allanson is a consultant in neuro rehabilitation at the Royal Hospital for Neuro-disability (RHN). In her report she sets out her letter of instruction. It is apparent from this letter her letter of instruction goes far beyond recommendation 1 of Ms Gill-Thwaites's Annex six. She sets out in her report that she visited FHR on 24 July and 5

August 2026. She examined FHR on both of those days with family members present and spoke to the VCC nursing team and others. She reviewed clinical notes and information. She set out a social and medical history. She set out the nature of the hypoxic brain injury sustained on 30 January 2020. She recorded that the team at VCC noted they had not seen any significant changes in FHR's presentation or level of awareness since his admission to VCC fifteen months ago. She recorded that none of the staff had observed any facial movements suggestive of a smile or a specific response to spoken requests to move. She further noted that FHR had been assessed by two speech therapists and that an occupational therapist visits every week or so. The occupational therapist had used standardised behavioural assessments including the WHIM and the JFK, recovery Scale. These professionals had not seen any responses from FHR, although it was noted they had not assessed FHR in the presence of family members. She set out further involvement by physiotherapist and a neuro physiotherapist who had been involved in FHR's care.

64. She sets out her clinical observations of FHR on her two visits. She says he was less responsive during the second visit. She says he did not demonstrate any signs of distress. She says there was no spontaneous movement of arms, fingers or legs. She states the following:

> "There was a variable startle movement to loud sounds such as clapping from behind from both left and right with no consistent head turning to the direction of sound or to voice, although on two occasions his head moved very slightly to his left in response to his father's voice. He had a partial right sided smile when I was discussing the world cup and Arsenal with his father. This was most prominent when I mentioned Liverpool football clubs recent difficulties. This facial movement was not seen during any of the rest of the visit with his father present. There were similar but less prominent right sided facial changes suggestive of smile when his sister was talking to him."

65. She goes on to explain that on asking him to 'stick out his tongue' his tongue was observed to move slowly inside his mouth and after five seconds or so he gradually moved his tongue to the edge of his lips. This was seen after separate requests, she

reports more than eight. She went on to explain the overall score ranging using CRS-R during her visit was 4 - 7/23. She opines that:

> "The intermittent responses to spoken instructions of tongue movements, the specific smile to mention of his favourite football team (Arsenal) and misfortunes of others, that were not seen at any other time are particularly suggestive of being aware. The response were not always sustained, possibly due to fatigue, over sedation, difficulty with initiation of movements, very restricted vision and likely reduced attention. If he had been able to sustain the most complex responses that he demonstrated, more consistently, his score would be indicative of him being in a higher level of the Minimally Conscious state (i.e. MCS+). For most of the time his responses were more consistent with a low level of Minimal Conscious State (MCS-)"

66. She explained that she does not believe FHR was in pain or distressed when assessed. She explained he was well cared for and relaxed at rest in his chair. She said that she thinks that FHR has a slightly better prognosis than many patients with hypoxic brain injuries. She goes on to conclude that she believes FHR is in a minimally conscious state. She states there are a number of potential factors likely to limit his level of arousal and awareness. She then gives the opinion that following her interpretation of the literature and her examination of FHR, she confirms her impression that there is some chance of change and regaining function, even after six years. She explains that because of the tracheostomy and his current level of secretions management, this is likely to make him drowsy. She states there could be a reduction in four of his medications to increase his level of awareness. She goes on to outline a number of other factors which relate to his reduced arousal levels. She makes some specific recommendations such as secretion management; further neurophysiological tests; further blood tests; a reduction in medication; a trial of antidepressant; and neuro stimulant medication.

67. She concludes her report stating that the above interventions will only be possible if all parties agree they are in FHR's best interests although she goes on to note that she was not instructed to offer an opinion on the continuation of CANH.

68. Dr Allanson was called by Mr Stroilov. She set out in her evidence that she had concerns about whether FHR had been optimised for the assessments of consciousness. She said there was uncertainty about the original hypoxic injury and she says the initial PDOC assessment was very soon after the injury. She was concerned that the original assessment took place during the COVID pandemic and therefore there were no family members present. She said FHR did not have the benefit of a senior consultant and some aspects of his care were sub optimal. She went on to say that she noted FHR had a strong cough and it may be the case he no longer needs the tracheostomy. She noted that if there were to be changes to the medication only one medication should be changed at a time. She questioned whether FHR had depression and whether he should be prescribed sodium valproate. She went on to say that in her clinical experience she had seen some people improve 6 ½ years after a hypoxic brain injury. When asked by me how many, she said there was only one or two. She said that one of these patients went on to do a psychology degree and another was able to resume driving.

69. She emphasised that she had seen FHR on two occasions and she had visited with family members present. She considered that FHR was able to open his mouth and move his tongue and she believed he was doing this on her command. She emphasised that if there were more clinical matters to explore to assess his consciousness therefore it makes sense to optimise him. She essentially concluded her evidence by saying to me were we absolutely sure FHR does not have a way to communicate with his family.

70. Dr Allanson returned to court the following day to observe the evidence of Ms Gill-Thwaites and Dr Nair. She was a little animated listening to the evidence of Dr Nair which was distracting and I had to ask for there to be less response to the evidence. Dr Allanson wrote a letter following Dr Nair's evidence, which was addressed to me directly. As unusual as I found this course, given the issues at stake I decided to admit her letter into evidence. I assume the purpose of her letter is to rebut aspects of Dr Nair's evidence. In that letter she disagreed with why FHR has had repeated infections whilst residing at VCC. She disputed the validity of assessments carried out in 2025. Yet again she took up the issue of the validity of CRS-R assessment tools. She also re-visited the issue of the need for adjustments to FHR's medication. She goes on to explain that she was puzzled that her findings on observation of FHR were so readily dismissed by Dr Nair. She emphasised that she is the only one who has had the fortune to meet FHR

with several members of his family on two separate occasions. The letter went on to remind me of parts of her CV and her research interests.

FN

71. FN has filed eleven witness statements in these proceedings. I have considered them all, but only propose to summarise her eleventh witness statement because it is one which most fully addresses the issues with which this judgment is concerned. FN begins by apologising that her witness statement was filed late. She explains this is because she is having severe panic attacks and anxiety and feels fatigued and is unable to concentrate. She explains that she considers the outcomes of the recent PDOC assessments and the diagnosis of vegetative state are unreliable. She emphasises that Ms Gill-Thwaites and Dr Allanson have both given a diagnosis of MCS and not VS.

72. She records that she has seen her son daily since his injury in 2020 until he went to what she calls 'captivity' at VCC in 2025. Before that she says she saw steady improvements over time when FHR was at home. She says that FHR's spasticity improved a great deal over the four years at home. She goes on to say that from careful and loving observations of FHR by her daughter and by her she knows that FHR has awareness. She gives the example of putting on a documentary and she could see him trying to concentrate. She says she could see this in FHR's face. She goes on to say that there were some nurses in respect of whom FHR was particularly comfortable. She states she could read in his face when he was particularly relaxed. She says that she believes it is very important for FHR to be surrounded by family and a permanent team of familiar nurses and carers. She says that from 2022 she instinctively feels that FHR was trying to merge into a higher state of awareness but that the sedative medication was holding him back. She goes on to make certain criticisms of the ICB and their refusal to fund further assessments.

73. She states that on moving to VCC there has been "an awful" deterioration in FHR. She points out the multiple hospital admissions and infections. She believes it is essential for FHR to return to receiving care at home and from there he will experience an upward trajectory.

74. Importantly she goes on to discuss FHR's wishes, feelings, values and beliefs. Her evidence is that FHR is a person who always identifies as a Muslim and was culturally shaped by family traditions. Her evidence is that FHR was very protective to his family members. She says that FHR was not strict about religious observances but he tried his best to be a good Muslim and he looked to Islam for guidance about serious things in his life. Her evidence is that he was a cheeky, mostly happy, free-spirited person who wanted people around him to be happy. She says that as FHR was growing up she always sensed how much he loved life. She gives the example of an uncle in Birmingham who was passing away from old age and who was bed bound. FHR visited him and she says what was important for FHR was family love and he was less concerned about illness, disability and the prospect of death. She believes this attitude to his own severe disability would be the same.

75. She goes on to exhibit in her witness statement a fatwa from the Islamic Council. She explains the Islamic Council is an NGO which specialises in helping Muslims living in western countries to resolve disputes according to the principles of Islam. She says the advice provided in the fatwa is from a "sheykh" who is a person learned in Islamic religious law. She believes FHR would want to resolve the present issue about his nutrition and hydration in accordance with Islamic ethical principles. The fatwa says it is an Islamic religious ruling and is dated 3 August 2026. It sets out the author's understanding of the background. It sets out some relevant Islamic principles quoting from the teachings of Allah.

76. The Fatwa states:

> "Having considered the information presented and applying the principles of Islamic teachings, the Islamic Council reaches the following Islamic ruling (fatwa):
>
> 1. On the circumstances described, it would not be permissible according to Islamic teachings to intentionally withdraw CANH from FHR where such withdrawal would directly result in his death.
>
> 2. It would not be religiously permissible for his family to consent to such withdrawal

> 3. The reason for this conclusion is that FHR is regarded, according to the information provided, as a living human being whose life retains its sanctity and dignity despite his condition.
> 4. Islamic teachings require that ordinary care, including nutrition and hydration where they remain beneficial and can be provided, continues to be offered to a living person."

77. Mr Stroilov asked some follow-up questions by email which were answered. I find the responses hard to follow. I assume given the sanctity of the sentiment the Fatwa can be read as a self-contained document rather than having to be read subject to Mr Stroilov's questions and the related answers.

78. FN also filed a number of witness statements from wider family and some friends. There is a witness statement from FHR's cousin. She says that she never had a conversation with FHR about artificial nutrition or hydration or life-sustaining treatment so she says she does not know what he would want to happen if he became unable to make decisions for himself. She goes on to say FHR is a kind, caring and thoughtful person who cared a lot about his family and she emphasised that the family wanted FHR to be treated with dignity and compassion and respect.

79. A witness statement was filed by FHR's paternal aunt. She emphasises that FHR has always been family orientated and she emphasises that it would be an important thing for FHR to take into account what his family thinks is best for him and how his decision might affect his family. She emphasises that FHR is a Muslim and when they grew up together he regularly attended Friday prayers at the mosque. She says he was not always very strict about religious observance but his moral beliefs and philosophy were those of a faithful Muslim. She discusses her own father's death from cancer in 2020 and notes that FHR never expressed any views about end-of-life treatment or palliative care.

80. A further witness statement was filed by a close friend of the family. She says she has known FHR since he was born. She emphasises two things: how much FHR loves his mother and the importance of his Islamic religion. She states following FHR's injury in 2020 FN put her entire life on hold and dedicated herself to looking after her son. She recounts an incident in the summer of 2025 when she visited VCC to visit FHR but the receptionist did not permit her to enter the care home. She says that when FHR was

admitted to hospital she was able to visit him several times. Her evidence concludes by saying the treatment of FHR and his family from the authorities and the care home has had a devastating effect on the family and on FHR's dignity.

81. FN gave oral evidence. She said that she does not agree to starving her child to death. She said if FHR was suffering and there was no way to stop the suffering she would agree to the withdrawal of CANH. She said that FHR does experience pain but she considers pain can be avoided if he lives at home. She accepted deep suctioning caused pain. She said she has been fighting for FHR's dignity and does not want dozens of people to be looking after him, when she as a mother is capable of doing everything for him. She accepted the spasticity and stiffness all over his body causes discomfort but she did consider it was painful. In answer to a series of questions from Miss Gollop she explained that FHR originally lived with her but then went to live with his paternal grandparents and then lived with his father in Wales and returned to live with her some months before the injury in January 2020. She went through the events of the day in which he suffered his injury in late January 2020. She explained the somewhat tempestuous relationship that FHR had with his then girlfriend.

FR – FHR's Sister

82. FHR's sister has filed four witness statements in these proceedings. I am principally concerned with her fourth witness statement. Her evidence is that she and FHR have always been incredibly close. She says she knows her brother's character, his values, his beliefs and what mattered to him before his injury. Her main concern is that she is worried an irreversible decision is now being considered when she does not believe that FHR has been optimised. She says that over the last year FHR has had a very difficult year because of repeated serious respiratory infections, pneumonia, sepsis, lengthy hospital admissions and a lung abscess. She says that he has spent a prolonged period away from familiar surroundings and his family and has had to recover from severe illness. She sets out that she wants Ms Gill-Thwaites' recommendations to be implemented in full. She describes Dr Allanson's evidence as extremely significant.

83. Her own observations are as follows:

> "I sit beside him. I play music for him. We watch television and documentaries. I talk to him about my day, my thoughts, our family and things that would have interested or amused him before his injury. There are occasions when I see his body relax, his face soften or his expression change. I have seen what I believe are smiles. I have seen changes in him when he hears something familiar or when somebody he loves is beside him."

84. She accepts in her evidence that FHR cannot reliably communicate yes or no. She sets out, understandably, she does not want FHR to be in pain and does not believe most of the time that he is suffering. She believes that any pain he does suffer can be treated. She considers that FHR experiences more discomfort now at VCC than when he was at his own home. She explained why she does not believe in the opinion of Dr Nair. She explains what mattered to FHR and says that family has always been the centre of FHR's life. She said that FHR was kind, compassionate and accepting. Importantly FHR is now an uncle and she gave birth to a daughter recently. She explains that whilst FHR is a Muslim and believed in Allah, he was not the most outwardly practising Muslim and did not live a perfectly religious life. She explains that she does not believe FHR intended to kill himself in January 2020 and believes this was an impulsive act. She goes on to explain that she does not believe FHR would want the decision the court has to make to be made before knowing what more could be done for him. Her evidence is FHR would want the reversible problems stabilised; his pain treated; his medication properly reviewed and for the tracheostomy to be removed if possible. She made an impassioned written plea to the court to give FHR more time and not to make the best interests decision now.

85. FR gave very moving oral evidence to the court. She said she accepts there will be a time when her brother departs but she does not agree with the withdrawal of CANH. She said her brother would not want to die in that way. She considers that FHR does find pleasure throughout the day. She emphasised how family oriented FHR was and is. She considers his life has elements of joy. She described her knowledge of the injury in late January 2020. She notes that he had come home to live with his mother and she knew his then girlfriend. She was not aware that her brother was reported by his GP to have suicidal ideation. She was asked about whether FHR was homeless because this was noted in contemporaneous records. She noted FHR wanted his own home. She was

then asked about her own observations of conscious and intentional responses by FHR. She says that when she visits and puts a hand on his cheek she has observed him sigh. She said when she has asked him to open an eye, he has done so. She said he did show signs of awareness. She emphasised that the last year has been a horrible one for him. She then very movingly addressed me directly making an impassioned plea to delay the ultimate best interests decision and to give her brother more time to be optimised and to go home to consider further his level of awareness before any best interests decision is made to remove CANH.

FZR

86. FZR, FHR's father, has produced several witness statements. His most recent deals more fully with the issues the court must confront at this hearing. His evidence is that before the injury, FHR was a vibrant, social and much loved member of the family. He cared about how he looked; he took pride in his appearance and was a stylish young man. He was part of a large and close family with many aunties, uncles, and grandparents alongside his sister, mother and father. He explains that he has always been very close to FHR. He does not believe his son intended to end his life in January 2020 and describes the incident as an impulsive one. He emphasises that FHR was and remains Muslim. He explained that FHR appeared more settled in his own home and he considers he seemed more relaxed, with his eyes open more often and more responsive. He states that on an occasion when he spoke to him about football, FHR smiled and pushed back on his hand. FZR says this is important to him because it suggests there are moments when he is aware of familiar voices, subjects and people. He says he knows his son's face and his reactions and the difference between him being settled and unsettled. His evidence is that the care provided at home was not only practical but it was emotional and personal and his family knew how to speak to him; how to reassure him and how to notice changes in him. He then goes on to set out his concerns about VCC.

87. He states that it is very hard for him to say with certainty what FHR would want in his current circumstances. His evidence is that he cannot categorically say that FHR would want to continue living in his current conditions. He goes on to say given FHR cared about his appearance, his independence and his life, he considers FHR would find his

current condition extremely difficult. He says "*FHR valued being able to present himself in the way he wanted. He liked looking good and being himself. I believe he would have found a life in which he was dependent on others for every aspect of care, unable to communicate clearly and unable to control his own body, very hard to accept*." He goes on to counterbalance this view, emphasising the importance of FHR's Muslim faith. He says he has seen FHR respond positively to family presence including smiling and appearing comforted by familiar voices. He believes those moments of comfort are real and should be taken seriously.

88. In his oral evidence he said to Mr O'Brien he would not consent to the withdrawal of CANH in any circumstances. He explained in answer to a question from Miss Gollop that FHR had a personal issue around the time of his injury but would not explain what that was. He explains that FHR came to live with him in Wales after his GCSEs and that he dropped out of college, but worked in one of the family restaurants and was very popular with staff and customers. He explains he was persuaded to buy his son an Audi Quattro. He goes to explain that he has seen his son smile and that he can move his tongue on command. He says that the care staff have seen this and have commented on it.

89. I add that I have watched a video of FHR with Ms Cassim (the occupational therapist) and FZR. Ms Cassim recorded several of her sessions to ask FHR to 'stick out his tongue'. In one of these FHR was sitting with considerable support in a chair. His father was beside him speaking lovingly to him. FHR was not able to follow any instructions. I noted he moved his tongue around reflexively. FZR states that when he spoke to FHR about Allah, FHR produced two tears. I could not see that and I do not think Ms Cassim saw the tears, as she does not appear in front of FHR at the time. FZR wiped them away and FHR noticeably flinched when the tissue touched under his eye causing FZR to apologise to him. My own untrained assessment, having watched the video twice, does not lead me to conclude it is more likely than not FHR became emotional because he understood what his father was telling him. I however accept I should consider the evidence of those experienced to do so rather than make my own conclusions from the video. I add that I was very struck by the tender loving care with which FZR cared for his son. It was very moving.

Helen Gill-Thwaites

90. Ms Gill-Thwaites is the single joint expert in the assessment of FHR's level of consciousness, as directed by Peel J in late 2025. Her first report is dated 11 February 2026 and it follows a SMART assessment into FHR's level of consciousness. The report explains that a sensory modality assessment and rehabilitation technique is an investigative tool designed to identify all aspects of the patient's responses from formal assessment, their team and their family and includes a review of external factors. She says FHR's assessment began on 20 January 2026 and was conducted on five different days over a 10 day period and involved 16 hours and 40 minutes of formal assessment of FHR. With further interviews, the entire process took some 25 hours and 40 minutes. Her report notes that FHR is well cared for by the team at VCC. Her report notes that FHR's GP confirmed FHR's medical stability and optimal arousal, prior to the commencement of the SMART assessment. Her report notes that previous PDOC assessments did not provide any details of the assessments, such as the scores range and reproducibility of the responses observed. She noted there was no reference to the involvement of the family in the earlier assessment process. Her executive summary notes that her assessment demonstrated responses indicative of those at the vegetative state with the highest motor response at SMART level 2C.

91. Despite the description of a vegetative state, her report goes on to say the following:

> However, unverified responses were observed at the equivalent of **[SMART 5 Mid HI]** to "stick out your tongue" in 2 out of the 4 sessions in which he was optimally aroused and this needs to be fully explored. Video evidence is provided in Video 1 in this report. The exploration of this response can be conducted initially in structured video sessions with a PDOC Expert assessor or highly proficient PDOC specialist SLT. Should the unverified responses be confirmed as verified and reproducible, his diagnosis would change **to MCS+.**

92. Section 5 of her report sets out the need for FHR's optimisation prior to the assessment. She received an email from FHR's GP on 19 January 2026 stating the GP was happy for the assessment to begin. The report further notes a doctor at VCC stated FHR was optimally aroused and all sedative medication had been minimised at an in-person

meeting on 20 January 2026. The report goes on to deal with a number of further issues such as seating, wheelchair positioning, sitting tolerance etc.

93. Section 6 sets out details of behavioural observations. She sets out the family's observations as follows:

> "The highest functional communicative response seen by the family is at the equivalent of [**SMART 5 Mid HI]** where his sister reports that if she asks him a question, he can sometimes answer "yes" by sticking out his tongue, but she has not reported to have seen a No response. At the equivalent of **[SMART Level 4]** various meaningful communicative responses have been reported by his mother, father and sister who feel that they can identify these subtle facial expressions as they are more familiar with him than others and they include:
>
> □ Moving his tongue sometimes as if he is trying to speak.
> □ Shedding a tear sometimes when his father is praying with him.
> □ A sigh when family are speaking or leaving and they feel he is trying to communicate.
> □ Looks such as relaxed, concentrating, feeling calm, and disdain.
> □ Grimace when in pain.
> □ A pout when he doesn't like something.
> □ A smile in response to gossip."

94. The report goes on to state: "*Based on these current findings, [FHR] is unable to actively engage in external activities, make choices or control his environment and does not demonstrate any clear signs of enjoyment in his life*."

95. Given the issue of whether or not FHR was able to stick out his tongue on command, Ms Gill-Thwaites set out in her appendix 6 eleven recommendations for further work. I accepted her opinion to the court at the April 2026 hearing and directed her to produce an addendum report prior to the final hearing, attempting as much of the Appendix 6 recommendations as possible prior to the final hearing. As a result Ms Gill-Thwaites filed an addendum report dated 31 July 2026 in which she summaries the outcome of the further assessments of FHR's awareness:

> "The summary of the motor responses seen in the sessions to address recommendation 7, 8 and 10 reveal that there was no evidence of an ability to follow any verbal instructions including "stick out your tongue", "move head back", or "close eyes" and no meaningful facial expressions observed when the sessions were more formal and only with the SLT and OT. However, although the family members could attend only 4/10 sessions, Anisa Cassim stated that "*there is currently insufficient evidence to confirm that [FHR] demonstrates purposeful and reproducible responses to the verbal commands, "Stick out your tongue," "Stick out your tongue for 'yes'," or "Move your head."* Anisa Cassim concluded that the behaviours observed *"cannot be verified as purposeful responses or evidence of intentional command following at this time.""*

96. Table 1 of her report then notes how many of her Appendix 6 recommendations were met, not met or partially met. Her assessment is that only one of her recommendations was met; three were partially met and seven were not met.

97. Ms Gill-Thwaites then compares the further work to her own 2026 SMART assessment which described FHR's vegetative state and concludes as follows:

> During SMART 2026 an unverified response to "stick out your tongue" was seen 2/10 at **SMART 5 Mid HI** but could not be verified or confirmed but needed to be further explored to ascertain if it is reproducible and confirmed. Amy Endacott (SLT) did not see this responses and Anisa Cassim (OT) could not verify this response; she did observe it twice in one session when he was with his father but could not verify it. It is possible that his suboptimal medical status at the time and limited opportunity to explore with his family may contribute to limitation to these responses.
>
> In the functional communicative modality, he did not demonstrate any communicative responses during SMART 2026 at **SMART Level 1C** indicative of a diagnosis of VS. However, a shedding of a tear has been observed twice with Anisa Cassim OT when working with his father and sister and this has been reproduced and verified by Anisa Cassim. Dr Allanson also saw a smile which was reproduced during her visit with the family, and this was also

provided as evidence in a photograph in the SMART report (but offered by the family). This would be indicative of **MCS-** for functional communication.

Therefore, given these findings his diagnosis has changed from **VS to MCS-,** due to the observations of meaningful emotional responses. His motor responses to verbal command following still remain unverified so these cannot at this stage be confirmed either way.

98. She concludes as follows: "*In conclusion, at present, based on the information gathered, he has some ability to show emotions such as a smile and shedding tears, indicating a diagnosis of MCS-. However, he has no ability to engage in activities and his responses to verbal instructions still cannot be confirmed as being potentially meaningful, since they have proven to be difficult to verify and reproduce. This could be attributed to the paucity of a stimulating environment and limited direct time with his family to promote such responses. Any future exploration of his responses would require all recommendations in Dr Allanson's report and the SMART report to be addressed in full*."

99. Ms Endacott, the speech and language therapist who carried out ten sessions with FHR, noted the following in her report to Ms Gill-Thwaites:

> "As per legal instruction, 10 communication assessment sessions were completed from 7 July 2026 until 21July 2026. These varied in length from 20-40 minutes. FHR was seated in the wheelchair comfortably, suitably awake and environment was optimal for every session. His daily seating tolerance was reported to be 4 hours and there was no evidence of a bespoke daily programme across all sessions.
>
> An oral desensitisation programme was delivered at the beginning of each session. This did not appear to have any impact on functional ability. It was not observed to reduce or increase the spontaneous oral and facial movements.
>
> A range of verbal commands were trialled across the sessions. No verified and reproducible auditory command following was observed on any occasion.
>
> The only consistent pattern observed was the increased amplitude of the stereotyped spontaneous facial movements (eye blinking, mouth closure/lip pursing, tongue thrust) that occurred on episodes of auditory input. This

> appeared to be part of a generalised auditory startle response. This was observed in response to speech and environmental sounds.
>
> Facial expressions observed (frowning) were spontaneous or reflexive in nature as part of physical posturing pattern or in response to physiological trigger such as secretion accumulation.
>
> In summary, FHR did not demonstrate any evidence of auditory comprehension (and subsequent instruction following) or any communicative intent. All behaviours observed were reflexive in nature, in line with a diagnosis of vegetative state."

100. Ms Cassim, the occupational therapist, reported to Ms Gill-Thwaites as follows:

> "Overall, the findings from this assessment provide no evidence of purposeful or reproducible responses to verbal commands presented by either the family members or me. The commands assessed included "Stick out your tongue," "Move your head," and "Stick out your tongue for yes questions" presented during the assessment.
>
> During Session 2, a possible meaningful response was queried during interaction with FHR's father. FHR's father presented the verbal commands, "Stick out your tongue if you love me" and "Stick out your tongue if you would like me to visit more." Following these commands, tongue movement was observed. This could not be verified in other sessions.
>
> In this session when FHR's father spoke to him talking about God and praying FHR stuck out his tongue to which FHR's father reported he felt that this tongue protrusion is a behaviour he has seen previously and believes it may represent a form of "signal" used by FHR (video recording of session at 9:00mins). During this interaction, FHR was also observed to become tearful while his father was speaking which is verified as his father wiped away the tears (video recording of second session at 9:18mins). In session 8 this was also verified where FHR shed a few tears when his sister, niece and brother in law was present. This occurred just prior to the session. FHR was also observed to give a big sigh when a command was asked "Stick out your tongue if you want to

> go home "by his sister in session 4 (video recording 9:21 mins). This behaviour was previously reported to be a response observed by his sister as mentioned in the SMART assessment (2026). This was not verified as it was not observed in other sessions of this assessment.
>
> The reported response of tongue protrusion to indicate "yes" for questions asked could not be reproduced in subsequent assessment sessions, either in the presence or absence of family members. It is acknowledged that most assessment sessions (Sessions 3, 5, 6, 7, 9 and 10) were completed without family members present, which may have limited opportunities to observe responses during familiar interactions.
>
> Based on the available assessment findings, there is insufficient evidence to conclude that tongue protrusion represents a purposeful response or reliable evidence command following of "stick your tongue out for a yes response".
>
> Furthermore, no verified, or reproducible responses to the commands "Stick out your tongue" or "Move your head" were observed across any of the completed assessment sessions, irrespective of whether these commands were presented by the me or by family members.
>
> In summary, based on the assessment and available observations, emotional expression in the form of crying was verified on two occasions. However, there is currently insufficient evidence to confirm that [FHR] demonstrates purposeful and reproducible responses to the verbal commands, "Stick out your tongue," "Stick out your tongue for 'yes'," or "Move your head." The behaviours observed were not reliably linked with the presentation of these specific verbal commands and therefore cannot be verified as purposeful responses or evidence of intentional command following at this time."

101. Ms Gill-Thwaites gave oral evidence and was cross examined. She spent some time setting out the background of the SMART assessment. She emphasised that her role was simply to lay out information regarding what the patient can or cannot do. She said clearly that FHR has not yet 'emerged'. She accepted in response to a question from Mr O'Brien that her January 2026 SMART assessment remained reliable. When asked whether she had been able to verify if FHR can follow commands she said that they

have not got any further to verify that. When taken to Miss Endacott's report, she accepted that FHR could not follow any instructions. In respect of Ms Cassim's report, she said that tears had been seen and this was verified and therefore she thought that FHR had some awareness but at the low level. She went to say "*I think there is some degree of need to explore more with the family*". In answer to a question from Mr Stroilov she said "*you might see a different picture with Dr Allanson's recommendations, you might not. I wonder if we have gone as far as we can, it's up to the expert*."

Dr Nair

102. Dr Nair is the single joint expert appointed to report to the court on FHR's best interests. He is a consultant in rehabilitation medicine. His report is dated 7 August 2026.

103. His report sets out the background, FHR was admitted to hospital at 12:50 am on 30 January 2020. It reports that FHR was found hanging and received seven minutes of CPR from a paramedic neighbour and a further 10 minutes of advanced life support from the London Ambulance Service. The report notes he had 17 minutes of either no flow or low flow to his brain, but there is not a precise timeline. Arterial blood gas analysis done on 30 January 2020 indicated a PH of 6.88 which he states is very low and a lactate of 19.2 M and OL/L which is very high. This suggests severe metabolic acidosis and an indication that the period when FHR had no circulation was significant enough to cause metabolic arrangement which included damage to the liver. FHR was sedated, intubated and ventilated and transferred to ITU. He was in intensive care for over a month and then transferred to HDU. A tracheostomy was inserted on 20 February 2020 and a percutaneous endoscopic gastronomy feeding tube was inserted on 26 March 2020.

104. Dr Nair records the following from the intensive care team "*for FHR there is no prospect. Given his young age and healthy constitution he is likely to survive if supported but the consequences of the hyperbolic scenic event will be devastating. I personally feel extremely uncomfortable in offering a tracheostomy knowing that it will not benefit him I also understand extreme pain of the family.*" On the 14 February 2020

a neurologist stated "*the likely outcome is a cerebrally performance category of four or five, i.e. persistent vegetative state or death. At best a CPC of three i.e. severe neurological disability could be expected.*" A CT scan was done which showed diffuse brain swelling with low density changes seen in the basal ganglia in both cerebrally hemispheres suggestive of hypoxic ischaemic injury. A CT scan was repeated in February 2020 which showed extensive low density change in both cerebral hemispheres with effacement of cerebral sulci. There was also lots of grey white matter differentiation in the basal ganglia and the notes recorded the appearances of global hypoxic ischaemic changes affecting both cerebral hemispheres with extensive ischaemic change. Radiological appearances suggest a bleak outlook the notes recorded

105. A best interests meeting was then convened and FHR was transferred to RHND Putney. Dr Nair recounts some of the issues that were dealt with at the RHND such as spasticity, assessment of awareness with the Wessex Head Injury Matrix (WHIM) and the Coma Recovery Scale - Revised (CRS-R) and also a SMART assessment. Management of tracheostomy and continence and also posture seating and nutrition were all dealt with. A 'do not attempt CPR' was added to FHR's medical notes on 25 August 2020.

106. On 27 August 2020 FHR was discharged to his home in London with a care package funded by NHS continuing care. He remained at home until April 2025 when he was transferred to VCC on an interim basis pursuant to the order of District Judge Mullins. Dr Nair notes five admissions to an acute hospital in central London from 17 April 2025 to 24 June 2026, most of these admissions related to various lung infections. On 25 July 2025 FHR was seen by Dr Ashford a consultant physiotherapist at the regional hyper- acute rehabilitation unit outreach service. It was noted that there had been a deterioration in contractures especially in the lower limbs.

107. Dr Nair then sets out a social history recounting FHR's childhood and his life as a young man, his religious beliefs and some background about his mental health. The report notes GP records from 2019 in which FHR reports suicidal ideation and self-harming behaviours. It was noted he suffered from anxiety and had panic attacks and was prescribed sertraline.

108. Dr Nair then sets out the range of medications that FHR takes. He goes on to set out his findings on examination of FHR. Dr Nair saw and assessed FHR on 8 July 2026 at VCC and in the light of Dr Allanson's report he returned to see him on 31 July 2026. He sets out his summary of those observations. Dr Nair's report then sets out a discussion with the family and he has also provided a video recording of his detailed discussion with them.

109. Dr Nair then sets out a prognosis and life expectancy for FHR. He acknowledges the analysis is making certain assumptions but he concludes there is a 52% probability that FHR may live another 20 years to the age of 48. But he records it may be significantly less than 20 years because of the severity of his hypoxic brain injury, tracheostomy and the frequency of his infections. He states FHR remains at risk for developing worsening contractures and pressure sores. He says there is a strong possibility of FHR remaining totally dependent for well over a decade. He then considers the prognosis without CANH and he applies the RCP guidelines and notes that the dying process typically takes between one to three weeks after CANH has been stopped. He notes that when this takes place patients develop dehydration and multiorgan failure which includes renal failure, acidosis, uraemia, and other metabolic and electrolyte disturbances that ultimately end in cardio respiratory arrest. He notes that as FHR has a tracheostomy the process of withdrawal of CANH must take place at a facility that has access to palliative care and care of the tracheostomy.

110. He then reviews the various PDOC assessments that have taken place. He sets them out from February 2022 at the acute hospital, the assessments at Putney in June 2020, the further assessments at VCC in April 2025. He further summarises the most recent findings of Ms Gill-Thwaites, Ms Endacott, and Miss Cassim.

111. Dr Nair then considers the severity of the hypoxic brain injury, he concludes that by way of the duration and severity of the hypoxia, the metabolic arrangements, the radiographic and neurophysiological findings and also by way of the myoclonus and paroxysmal sympathetic hyperactivity that this was a very severe injury. He notes there is a much worse prognosis for patients with a hypoxic injury as opposed to a traumatic brain injury. He then considers the trajectory of change in awareness and the PDOC assessments over time. He concludes that the assessments have met the recommended

standards set out in the national PDOC guidelines and opines there is no evidence that there is a trajectory towards emergence from PDOC and that FHR effectively remains in a permanent vegetative state.

112. Dr Nair sets out wider best interests factors such as FHR's personality and his religious beliefs and wider background features - these are very much in keeping with the evidence of the family I have set out above. He then summarises the conclusions of the best interests meeting held on 16 March 2026, he notes that unlike at that meeting there is now no clinical uncertainty.

113. On pain he says this:

> The truth is that one can never be certain if FHR feels pain or not. Given that FHR has a tracheostomy with an inflated cuff, he is not able to vocalise and therefore we may be underscoring him for that component. Pain is certainly a very important factor in making best interest decision for FHR. This has been addressed Prof Wade and Hanrahan at times, rather philosophically. Given some of the responses to stretching and splinting, it is very likely that FHR does feel pain, though we can never be certain, given the MRI evidence of damage to the thalamus, a major relay station before pain is perceived in the cerebral cortex. The conclusion of the pain review is probably correct for FHR- *"The unconscious person with a prolonged disorder of consciousness exhibiting pain behaviours in response to nociceptive stimuli likely experiences pain without analysing its significance; they are unlikely to anticipate or remember it*
>
> ……
>
> We can never be certain that he feels pain, but he has many reasons to feel pain and therefore we must assume that he does."

114. Dr Nair then sets out his opinions on Dr Allanson's recommendations in her report. He notes there are a number of important scans and documents Dr Allanson has not seen. He comments on the observations made by Dr Allanson. He does not believe that reducing Gabapentin and the very small doses of Levetiracetam would result in FHR

emerging from PDOC. He observes that Dr Allanson's central recommendation for more testing is what he calls a "safe conclusion".

115. Dr Nair summarises FHR's current experience :

> FHR remains in a permanent vegetative state, over 6 years after attempting to take his own life and suffering a catastrophic hypoxic brain injury. He requires 24/7 care with at least 1 carer with him at all times. He has a tracheostomy with and inflated cuff to protect his airway. At present he needs deep tracheal suctioning every half hour. The tracheostomy tube needs changing every month. This involved a visit to the ENT department of a hospital when he was at home. He is fed through a feeding tube. He has an indwelling catheter, and he needs daily rectal digital evacuation of his bowels. He is hoisted out into a tilt in space wheelchair for a few hours a day. His father admits that his circumstances have not improved over the past 6years while his mother, when asked about the improvements to date, mentioned that he is able to hold his head up.

116. He then turns to give his opinion on CANH.

> "The benefit of CANH is that it keeps FHR alive and in doing so we are respecting the sanctity of life and probably the beliefs, religious or otherwise, of FHR and his family.
>
> The burdens are significant and, in my opinion, far outweigh the benefits. The tracheostomy needs suctioning every half hourly. A cuff inflated tracheostomy in situ for so many years risks causing tracheomalacia and tracheal stenosis. The contractures in limbs, trunk and pelvis have and will continue to worsen. High resolution CT scans of his chest show that he is having permanent changes in his lungs from recurrent infections. All of these complications and burdens will continue to increase. The toll on his family and FN in particular must be acknowledged and trauma of not being allowed access to her child can

> be devastating to any parent. The family are consumed by their sense of duty and responsibility to continue to look after their child at the expense of everything else. Therefore, there is a need for decision makers to look at FHR's welfare in the widest sense, beyond that of the medical and nursing interventions and medications, but also of the impact of continuing CANH on the FHR's family, the carers and staff in the community and even the commissioning ICB."

117. Dr Nair opines:

> "Despite hours of assessments at significant cost and effort. FHR does not reliably and consistently have the ability to indicate 'yes' and more importantly to indicate 'no'. After 6 years and 6 months, there can be no dispute, that this status will never change. It is the giving of daily digital rectal evacuation, half hourly-to-hourly deep tracheal suctioning, frequent hospital admissions and ongoing CANH that must be justified and not the withdrawal."

118. He notes: "*even if FHR survives 10 years, given that he is for antibiotics and hospital admissions, which will mean FHR will endure this suffering and total loss of autonomy for far too long*." He concludes that CANH is no longer in FHR's best interests. He concludes his medication has been optimised. He concludes there is no need for further assessments and there should be no further delay. He recommends transfer to the Specialist Unit for palliative care. Alternatively, he opines that if, CANH is in FHR's best interests he should be discharged home.

119. Dr Nair was cross examined. He emphasised the severity of the hypoxic brain injury. When asked about review of the tracheostomy, he observed that FHR goes to a London hospital where his tracheostomy is reviewed by the ENT team every month. He noted that CT scans show changes in the lungs brought about by aspiration. In answer to a question from Mr O'Brien he said that the trajectory of FHR's awareness was more important than whether he is in MCS or PVS. His evidence was that there was nothing to indicate a positive trajectory, rather his opinion was that FHR's condition will deteriorate. Furthermore he said that if FHR was in MCS he would have

some understanding that he is in pain and distress but would be unable to do anything about it, causing yet further distress. He was clear when challenged that the review of medication will not change FHR's level of awareness. He noted that FHR opens his eyes and moves his tongue around a lot. He was not persuaded by Dr Allanson's reporting of FHR communicating by smile or tongue movement and did not view that as purposeful communication and did not consider it was either verifiable or properly repeated. In answer to a question from Mr Stroilov, Dr Nair agreed that if possible the removal of CANH should take place at the home. He said he strongly agreed with this. He did not disagree that there should be a review of the tracheostomy but noted that this could not currently take place, given FHR requires suctioning every 30 minutes. He accepted that if the tracheostomy were removed it would reduce the burdens on FHR. He also said "FHR has had a catastrophic brain injury at the worst end of the spectrum." He was asked about an earlier assessment which noted FHR produced facial grimacing. He observed that this test was likely to demonstrate FHR was grimacing in pain. Dr Nair said he had not seen any evidence of positive life experiences. He repeated that on the balance of probabilities he assumes that FHR feels pain.

Outline of the Parties' Positions

120. The applicant supports the withdrawal of CANH. Mr O'Brien submitted there was more than sufficient evidence before the court to determine FHR's level of consciousness and proceed to carry out the best interests analysis. He pointed out FHR has been the subject of 12 CRS-R assessments, 23 WHIM assessments and 2 SMART assessments. These have spanned over six years and there was no upward trajectory. He highlighted the severity of the January 2020 injury and the very bleak prognosis then. He noted Professor Wade's evidence that there was no trajectory of improvement and cautioned against interpreting "tears" as any form of communication. He informed me that Ms Makwehe was in touch with a care provider who had said they could provide palliative care in the home for a PDOC patient with a tracheostomy. He emphasised that Ms Gill-Thwaites' only SMART assessment concluded FHR was in a vegetative state. I was invited to accept Dr Nair's evidence and find in particular FHR lived a life of pain and distress with no prospect of improvement.

121. FN and FZR, with the passionate support of their daughter, supported the continuation of CANH. Ms Weereratne submitted I should follow Dr Allanson's recommendations and order further testing of awareness after further optimisation. She was not able to say how long this would take, but that the proceedings should be further adjourned and further evidence should be filed. Mr Stroilov submitted it was clear CANH was in FHR's best interests and he should be discharged home and the proceedings brought to an end and he should then be subject of twelve monthly reviews as per the RCP National Clinical Guidelines.

122. Mr Stroilov submitted FHR is "diagnosed" as MCS and there is a real prospect of improvement, in particular given: i. a return home; ii. the prospect of the removal of the tracheostomy; and iii. a medication review. There was a real possibility of a recovery of function based on Dr Allanson's evidence. The court should support the conclusion of Dr Martin's March 2026 best interests meeting. The SMART assessment approach and evidence of Ms Gill-Thwaites and Dr Allanson were much more focused on FHR than the evidence of Professor Wade who was unduly critical of SMART and had never even met FHR. Dr Nair's best interests assessment is flawed. The case for CANH based on wishes, feelings, beliefs and values was powerful and fully evidenced by the familial evidence. Much of the family evidence was not challenged and therefore must be accepted. The sanctity of life must be respected.

123. Ms Weereratne made the following headline submissions which she developed:

a. There has not been six years of reliable assessment of FHR's consciousness. The February 2020 test could not show any trajectory. The RHND Putney assessments were flawed as they took place during COVID and therefore there was no family present. There was a critical gap between 2021 and 2025. The VCC 2025 assessments are flawed for a variety of reasons.
b. The CRS-R and WHIM tools have significant limitations.
c. The family have reported functional responses which are significant.
d. Dr Nair's evidence is problematic.
e. Very little weight can be attached to Professor Wade's evidence.
f. FHR's medications can be reduced.
g. Dr Nair's benefits and burdens analysis is flawed.
h. FHR has potential for improvement.

i. Properly considered CANH remains in FHR's best interests given his wishes and feelings and beliefs and values.

124. The Official Solicitor on behalf of FHR submitted the continuation of CANH was no longer in his best interests and he should be palliated. Miss Gollop's written closing submitted the following:

> "Her [the Official Solicitor] reasons for taking the position she does in relation to the treatment decision will be explained in oral submissions. However, to assist family members, in brief summary she has reminded herself that the standard of proof is the balance of probabilities but also noted that as Art 2 is engaged, the Court will wish to apply anxious scrutiny. In that context, she notes in particular:
>
> a) The clear evidence that FHR probably experiences pain/discomfort when a stimulus capable of causing pain/discomfort is applied;
> b) The evidence that his contractures have worsened over time;
> c) The nature of his current care regime which includes care which is likely to give rise to stimuli causing pain/discomfort;
> d) The lack of clear and compelling evidence that he is aware of the presence of family members and intentionally responsive to or communicative with them;
> e) The lack of clear and compelling evidence that he derives any pleasure from his current existence;
> f) The lack of evidence that there is a real prospect of significant neurological improvement in awareness."

125. Ms Gollop submitted that the Official Solicitor found aspects of Dr Allanson's evidence difficult to follow. She described Dr Nair's report as "clear, well structured, thoughtful and balanced."

Analysis

126. I must apply the section 4 MCA best interests test to FHR's circumstances in August 2026 and consider this against all the evidence received to evaluate whether it

is in FHR's best interest to receive CANH or not. I have reached the clear conclusion that CANH is no longer in FHR's best interests, for these summary reasons, on the balance of probabilities:

a. in January 2020 FHR suffered a very severe hypoxic injury which has severely disabled his brain function leaving him blind and mostly paralysed (*severity of the injury*)
b. FHR is, and has been in, most likely, a permanent vegetative state for 6 years and seven months and is unable to communicate or respond to stimuli operating at a very low level of awareness; *(Consciousness*)
c. FHR will not emerge and will not recover any reasonable level of function; (*prognosis*)
d. he experiences pain; *(pain*)
e. he is subjected to an arduous care regime; *(discomfort*)
f. he does not, and most probably cannot, experience pleasure, certainly not joy and most probably cannot even be comforted; (*benefits?)*
g. whilst I am clear about his beliefs and values (Islam and family) I have no reliable evidence as to his past or present wishes and feelings in respect of being maintained alive in his current condition by CANH; *(Past and present wishes, feelings, beliefs and values*)
h. his family love FHR dearly and their love has led them to interpret responses that the clinical evidence plainly demonstrate is beyond FHR's cognition/awareness as a result of his brain injury; (*the family's evidence*)
i. to continue CANH would be futile and burdensome and whilst life is of great value, this is not absolute and this is one of the cases where to continue CANH even for six to twelve months to carry out further testing is wrong in principle and wholly unfair on FHR (*conclusion*).

127. There was a dispute in respect of the clinical evidence between the single joint expert Dr Nair, supported by Professor Wade on one side and Dr Allanson on the other. Ms Gill-Thwaites appropriately limited her evidence to presenting information on FHR's awareness and did not offer an opinion on best interests. Whilst she suggested further investigation of awareness this was equivocal and she appropriately deferred to the expert, Dr Nair, in her oral evidence.

128. After careful consideration where there is a clinical disagreement between Dr Nair and Professor Wade and Dr Allanson, I prefer the written and oral evidence of Dr Nair for the following reasons:

a. Dr Nair is the sole single joint expert on the issue of FHR's best interests and was appropriately instructed and has carried out his role and reported to the court with conspicuous professionalism;
b. Dr Nair's evidence is supported by Professor Wade, who is not an expert witness but who is a clinician with considerable pedigree in the area of PDOC patients;
c. Dr Nair took great care to consider and respond to Dr Allanson's observations and purposefully returned to observe FHR and re-consider matters after receipt of her draft report;
d. Dr Nair was far less pulled into the doctrinaire disputes about the three different types of PDOC assessments and was more focused on FHR;
e. Dr Allanson was not instructed as an expert witness and was properly speaking only supposed to report on Recommendation 1 of Ms Gill-Thwaites' Appendix 6 of her first report, at the end of the day, Dr Allanson's evidence went much further;
f. Dr Allanson did not see the same material as Dr Nair and was instructed by FN's solicitors;
g. Dr Allanson appeared a little animated sitting in court during Dr Nair's oral evidence and she took the unusual step of writing to me directly after the hearing, which has led me to ponder whether she may have inadvertently transitioned from clinician to advocate for the family. I do not mean that to be critical and it is entirely understandable, given the desperately sad background to these proceedings, why someone may wish to support the family.

Severity of Injury

129. I accept Dr Nair's evidence in respect of the January 2020 incident and the severity of that. Dr Nair has reviewed the medical records and carefully set out this background in his report. His views are triangulated with Professor Wade's paper assessment and

with what is reported by the treating clinicians at the time of the injury and immediately after. I particularly note the ethical issues which arose in fitting the tracheostomy in 2020. FHR sustained a very serious hypoxic brain injury which has left him with permanent life altering disabilities as set out in Dr Nair's report. This is very important context.

Consciousness

130. FHR's level of consciousness has been tested from 2020 to 2026. I do not accept the criticism of the 2020 or 2025 tests. The fact the COVID pandemic resulted in tests being carried out without family present does not render those results unreliable. Those were the tests carried out at the time. Some patients will have no family that does not mean their awareness tests are unreliable. Other patients will have family but it is not inevitable they will respond better simply because their family are present. Without being flippant, some patients may respond because their pet is present. PDOC assessors must evaluate the patient as a whole and their circumstances and carry out tests (standardised and recorded if possible) which are appropriate. Holding fixed views to a particular test is not helpful. In any event, for FHR, the presence of family members being present did not make any difference to his responses to the 'stick out your tongue' test. Each test of FHR – and there have been many – evaluates him as being in a persistent vegetative state, whether this was SMART or CRS-R or WHIM. The tests have been done over time. The trajectory is the same. It is not material for the purposes of assessing his consciousness now, that there were no PDOC assessments from 2020 to 2025 when he was living at home. There has been extensive testing in 2025 and 2026 and this correlates to the results observed in 2020.

131. On balance, I consider it more likely than not that FHR is in a persistent vegetative state. That is the result of each formal CRS-R, WHIM and SMART carried out from 2020 to 2026. The limited evidence that FHR may be MCS- came about following the further work undertaken in July 2026 as per Appendix six of Ms Gill-Thwaites' report. FHR did not demonstrate awareness or consciousness through the 'stick out your tongue' test. The basis for a shift to MCS- was the purported responses by way of tears and a smile. This is quite different from the objective, verified and reliable 'stick out your tongue' assessment. It is much more subjective. From watching the video of the

assessment by Ms Cassim it appears she was not observing FHR when his father spoke to him and when the tears were produced. The RCP National Clinical Guidelines require "clearly discernible behavioural evidence of self or environmental awareness." Looking at the evidence from Ms Cassim, Dr Allanson and the family I do not think FHR demonstrates *clear* discernible behavioural evidence.

132. The RCP National Clinical Guidelines at section 1.5 clearly anticipate there may be reflexive tears and smiles, but this must be clearly linked to stimuli. At section 1.4.1 smiles and tears are also consistent with PVS if they are 'spontaneous'. The evidence is patchy at best and has not been observed by professionals over many assessments and more generally by carers who are with FHR much of the time.

133. Again, I prefer the evidence of Dr Nair and Professor Wade that it is more likely looking at all factors that FHR is in a permanent vegetative state than MCS-.

134. However, should I be wrong and FHR is MCS- I accept the evidence of Dr Nair and Professor Wade that it makes no difference to the best interests outcome. Indeed, MCS- may even make for a stronger best interests case for CANH to no longer be in FHR's best interests because it likely increases his awareness of pain, discomfort and the futility of his existence. I have considered it may be the case that MCS- may mean emergence is more likely but seen overall I think this is less likely than likely, especially at 6 years and 7 months and, like the Official Solicitor, I do not find Dr Allanson's evidence of 2 people emerging from PDOC after six years to go on and study/drive helpful. That is so far removed from FHR's condition and prognosis and I accept Dr Nair's evidence.

135. Dr Nair, Professor Wade and Dr Martin all acknowledge the 'double edged sword' nature of MCS- and the RCP National Clinical Guidelines also acknowledge the possibility of greater pain and discomfort in MCS- patients.

Prognosis

136. I note the RCP National Clinical Guidelines state:

> "For both VS and MCS, the likelihood of significant functional improvement diminishes over time, although the prognosis for recovery is more heterogeneous for MCS than for VS. In both VS and MCS there are isolated reports of recovery of consistent consciousness even after many years, but these are a rarity, and inevitably those who recover remain profoundly disabled."

137. RCP National Clinical Guidelines further states:

> "If the patient remains in chronic VS/MCS for more than 6 months without any evidence of a trajectory towards improvement, they may be diagnosed as being in permanent VS/MCS. This diagnosis should be confirmed by an Expert PDOC Physician who completes the form in Annex 2f, and this information entered in the national registry.
> At this stage, the reasonable hope of recovery is no longer applicable and the balance of benefits and harms swings further away from active treatment."

138. I accept Dr Nair's evidence that FHR may live for another twenty years although given his injury he may pass sooner. I also accept Dr Nair's evidence that the prognosis is incredibly bleak and it is more likely than not that FHR will not recover. I accept all of the opinions offered by Dr Nair as set out below:

> "The BMA guidance further states *"The longer a patient remains in VS or MCS following sudden-onset brain injury, the less likely they are to emerge and the shorter their life expectancy. In time, therefore, patients will stabilise, and the situation becomes clear. At this point, outcome may be predicted with a greater level of certainty, so a shorter and less detailed assessment is warranted"*. 6.5 years after a catastrophic hypoxic brain injury, there can simply be no justification for further testing, and CANH decisions must be based solely on best interest discussions and balance of benefits over burdens of ongoing treatment. Further testing will cause delay, of which there has been plenty already.

> Despite hours of assessments at significant cost and effort. FHR does not reliably and consistently have the ability to indicate 'yes' and more importantly to indicate 'no'. After 6 years and 6 months, there can be no dispute, that this status will never change. It is the giving of daily digital rectal evacuation, half hourly-to-hourly deep tracheal suctioning, frequent hospital admissions and ongoing CANH that must be justified and not the withdrawal."

139. Furthermore, I do not accept Dr Allanson's views that there may be hope for recovery if: (i) there is a medication review; (ii) trial of neuro-stimulants (iii) removal of the tracheostomy; (iv) a trial of amantadine or any of the other suggestions. For reasons set out above, I prefer the evidence of Dr Nair and Professor Wade and I specifically agree with Dr Nair's opinion that: "*Spending more time, effort and resources, and tinkering with his medications when he has a catastrophic brain injury are meaningless. Just as carrying out further SMART assessments, which when inconclusive, will be blamed on a certain precondition or preconditions not being met."* I accept Dr Nair's evidence in his letter which carefully reviewed the impressive efforts of FHR's GP to manage his medications. Reducing certain medications will in any event likely cause FHR more pain and discomfort.

140. I have looked at the two academic papers exhibited to FN's witness statement. They do not take matters further for FHR's prognosis.

Pain and Discomfort

141. I accept Dr Nair's evidence that FHR experiences pain and discomfort. This is not in dispute: his family accept he is in pain and experiences discomfort. I accept FHR's contractures are getting worse. The fact that during her observations Dr Allanson did not observe pain and discomfort does not detract from this.

142. Furthermore, I cannot conclude that the proposed review of the tracheostomy will lead to it being removed. I do not know. Dr Nair accepted in cross-examination that there should be a review but he did not accept it was more likely than not the tracheostomy would be removed. Furthermore, it was his evidence that it could not be

removed just now given the need for suctioning every thirty minutes. I find that suctioning is painful and causes discomfort to FHR. Furthermore, I agree with Dr Nair that it is not plausible that the ENT team have treated the tracheostomy for six years and seven months and yet have not considered, on a regular basis, whether FHR does or does not need a tracheostomy. The fact there is no formal evidence of a review in these proceedings only goes so far. Even if the tracheostomy were removed, there are many different ways in which pain and discomfort are caused to FHR as Dr Nair describes in his report.

Benefits?

143. FHR is cortically blind. He is mostly paralysed. He is fed by a PEG tube. He needs the tracheostomy to breathe. He is at a very low level of consciousness. On balance I consider it more likely than not he obtains no benefit to his current life. I have not overlooked the family's evidence that they consider he can follow a documentary; that he has smiled in their presence; that at times his face looks more relaxed and settled. Their deep love for him and their prolonged optimism likely leads them to infer pleasure where they believe they can. FHR's devoted parents and sister – and the wider family – yearn for responses and reaction and of course, naturally, they must hope and pray for awareness and some form of pleasure. Love has the power to impair our objectivity. There is no reliable evidence before the court of awareness leading to joy, comfort or pleasure. No witness has explained how it is that FHR cannot stick his tongue out when asked, but he has the awareness and cognition to be able to produce the emotions necessary to cry when his father speaks to him of Allah or to smile when his football team is mentioned. I am satisfied these are not meaningful responses but are reflexive.

144. I have also factored in the hypothetical possibility of FHR being discharged from VCC to his adapted home and thereby spending more time with his family and a smaller group of experienced carers. Given my findings on awareness, pain, discomfort and benefits this does not alter my best interests analysis.

Past and present wishes, feelings, beliefs and values

145. I accept the evidence that FHR is a Muslim and would want his life and his death to take place within the religious teaching of Islam. Whether he was particularly devoted or observant does not matter. I also accept that family is something that has mattered a lot to FHR throughout his life.

146. I am clear, however, that it is necessary to adopt the same approach as Lieven J in *MP supra* namely: "*It is therefore not possible to know with any confidence whether MP would have wished to have continued living in his massively diminished state. The Court of Appeal is clear that in those circumstances I should not speculate.*"

147. *Aintree* requires me to approach the best interest decision from the perspective of FHR and I have tried hard to do that. I have done so in the past by way of a granular assessment of past and present wishes, feelings, beliefs and values, see in a similar context *UCL Hospitals NHS Foundation Trust v PK*[2025] EWCOP 17 (T3) see paragraphs 62 and 66 in particular. However, so profoundly bleak and difficult is FHR's current condition it is hard to assess the family's evidence and arrive at the conclusion that FHR could have envisaged his current circumstances and either by way of his family values or his faith or a combination of both, envisaged what he endures and wanted it to continue.

The Family's Evidence

148. Mr Stroilov made much of the fact in closing that aspects of the family's witnesses' evidence had not been challenged by the applicant or the Official Solicitor. That is not surprising and does not lead to all their evidence being accepted and as such the best interests analysis altering to continue CANH. Much of their evidence cannot be disputed as it is their perception of FHR's awareness and their perception of his responses to their devotion to him. Their love largely dictates their evaluation of what they see and hear.

149. I pay tribute to their determination to keep FHR with them.

Conclusion

150. I have considered the clear conclusion from the March 2026 best interests meeting. Dr Martin's evidence was that the ultimate decision was for the court. The serious medical treatment issue has been carefully case managed by DJ Mullins and other judges since late 2025 (see Appendix One). The evidence has been carefully gathered and was the subject of appropriate challenge at the final hearing. The applicant, the single joint expert in best interests and the Official Solicitor, as litigation friend to FHR, all agree CANH is no longer in his best interests.

151. There is little doubt applying section 4 MCA and carrying out the anxious scrutiny required of a decision of this nature, that CANH is no longer in FHR's best interests. He is consigned to a life of pain and discomfort with no realistic prospect of recovery of awareness or function. Whilst the various tests of awareness are carried out there is no way to end the pain and discomfort and there is no means to try to add pleasure or comfort to his life. Looking at the decision from the perspective of FHR and applying *Aintree,* FHR, on the balance of probabilities, can never recover a quality of life that he personally would value.

152. I have not overlooked Mr Stroilov's various submissions in respect Articles 2 and 3 ECHR, *Lambert supra* and his reference to various unincorporated international human rights treaties. My task is to apply the MCA within the context of human rights law. The section 4 evaluation takes into account these powerful factors.

153. FHR must now receive palliative care. There can be no further delay. Dr Nair's evidence was that this should take place at home if possible. I agree. For many, the manner of our passing is incredibly important. The location of where we die holds much significance to many people. On the basis of the evidence currently before me and with cooperation from everyone I am in favour of FHR going to his rest at home, surrounded by his family. I hope that can be achieved but it will require cooperation between the family and professionals and it will require compliance with the transparency order.

154. That being said, there is no choate care package option for FHR to receive palliative care at home. The RCP National Clinical Guidelines are sceptical about the possibility of palliation at home. The applicant has identified through Ms Makwehe's evidence a placement at the Specialist Unit. Ms Makwehe was open to looking at other palliative

care options and had only looked into issues for a short period of time. The issue is important and must be properly addressed. I am satisfied on the evidence before me, however, that the Specialist Unit has considerable experience of palliation in PDOC patients and they could meet FHR's needs at the end of life. I shall therefore make a section 16 MCA order that it is in FHR's best interests to be palliated at the Specialist Unit. There is no need for any expert evidence on palliation. The Specialist Unit is experienced in this difficult end of life clinical management. The RCP National Clinical Guidelines set out how palliation in PDOC patients can take place.

155. However, I hope the palliative treatment plan can be delivered at home with a safe and appropriate care provider. Therefore the parties have permission to apply to: (i) file an agreed order providing for the section 16 MCA order to be varied to permit palliation at home; or (ii) in the light of disagreement between the parties, they have permission to apply back on Form COP 9 with a witness statement limited to eight pages setting out their proposed circumstances for the location and care arrangement for FHR's palliation and the matter will be put promptly before the vacation duty judge.

156. I have made clear since April 2026 that it is in FHR's best interests to have in person contact with all his family, including his mother. Contact between FN and FHR has been arranged albeit VCC require FN to sign a contract of expectations to ensure there is no unpleasant behaviour. I am satisfied the applicant understands the importance of ensuring this in person contact between mother and son takes place without any undue difficulty or barriers. At this sad time, conflict must be avoided.

157. These long running proceedings must now come to an end. Apart from what is set out above, the proceedings are now concluded. Therefore, it follows that the transparency order made in July 2026 to protect FHR's dignity and private life and to ensure the integrity of these proceedings, will not be required after he passes. It shall cease to have effect twenty one days after his death to permit a 'cooling off' period.

158. I conclude these difficult proceedings by hoping FHR finds peace and that his family are capable of finding fortitude and endurance in the difficult weeks ahead.

Appendix One – Relevant Procedural Background

DISTRICT JUDGE MULLINS

23/12/2020 CCG commences COP proceedings regarding residence and care.
27/06/2022 The proceedings conclude with declaration that it is in FHR's best interest to reside and receive care at FN's home.
23/06/2023 ICB commences second set of COP proceedings regarding review of residence and care.
29/07/2024 The proceedings conclude with declaration that it is in FHR's best interests to reside and receive care at home.
29/10/2024 ICB commenced the present COP proceedings with an application seeking an urgent transfer to a care home and injunctions to restrain FN from interfering with FHR's care. On the same day, without a hearing, the Court granted interim injunctions, made a Transparency Order in the standard terms, and gave directions for a contested hearing.
14/11/2024 FZR was joined as a respondent.
29/11/2024 The Court noted a confirmation from the ICB that, following face to face assessments the proposed care home (ACCH) notified it was unable to meet FHR's complex care needs; the placement was currently stable in the community and there were no alternative placements options. The Court adjourned the contested hearing and gave further directions.
30/01/2025: At a contested hearing, the ICB sought an order for FHR to be moved to another nursing home, VCC. The court was not satisfied on the available evidence at that time, that it was in FHR's best interests to move to VCC. A contested best interests hearing was listed for 24/02/2025, with directions for filing of evidence.
19/02/2025 The Court refused FN's application for an adjournment. The court recorded that it appeared that part of the rationale of the ICB for moving FHR to VCC was that this would facilitate completion of a PDOC assessment. The court did not consider it had the evidence necessary to consider this issue properly, referring to the Royal College of Physicians PDOC Guidance 2020. The court recorded that it would require evidence from an expert PDOC physician on the practicability of assessments being undertaken in the family home.
24/02/2025 The Court, with the agreement of all parties, considers that FHR requires a timely PDOC assessment. The court recorded that FHR was not under the care of a neurology consultant or a neurology team and that it appeared to the court that this should urgently be considered by the appropriate bodies. The court gave directions on evidence, including as to whether a consultant neurologist or neurological team would take responsibility for FHR and complete the PDOC assessment.
19/03/25 The ICB sought a placement at VCC on an interim basis after the agency delivering care at home had given notice on 12/03/25. At the hearing, the court noted that a bed was due to become available at VCC on 21 March 2025 but that VCC was unwilling to hold that bed beyond this date for FHR. The court noted no other options for home care had crystallised as realistic options at the time of the hearing. The court was concerned that if the two remaining providers of last resort were unable to offer a home package due to capacity issues or because they could not meet his needs, then FHR would be left without suitable care and risked acute admissions or placement in a nursing home which was not suited to his complex needs. The ICB confirmed that VCC could facilitate the necessary PDOC assessment and any best interests assessment which might follow such an assessment. The court found it to be in FHRs best interests to move to VCC on an interim basis. The Court authorised limitations on FN's visits to VCC to 5 hours per day, and made injunctions to regulate FN's conduct before and after the

move. The Court directed the ICB to look at alternatives for FHR's care including home care providers for the family home in London or FZR's home in Wales.
08/04/2025 FN applies for permission to appeal the decision authorising interim placement at VCC. Permission was refused by HHJ Hilder.
09/04/2025 At a hearing: FHR ordered to be moved to VCC on 14 April 2025 with injunctions amended in relation to FN.
30/04/2025 Following COP9 by FN raising concerns about the care at VCC and the ban on FN's and FRR's in-person visits to VCC since 23 April 2025, the Court gives directions for an urgent hearing.
02/05/2025: At the hearing, ICB submits that VCC is on the brink of serving notice and insists on continuation of contact restrictions. The court determined that it is imperative that the placement at VCC is protected. The Court authorised the continuation of contact restrictions for FN and FRR until 5/06/2025 (contact limited to video calls of no more than 20 min per day), unless agreed otherwise with VCC and subject to the ICB's obligation to conduct a formal review by 16/05/2025.
05/06/2025 At the hearing, FN and FZR sought a direction that the ongoing PDOC assessments at VCC should be halted on the basis that FHR is unlikely to have a fair PDOC assessment due to his family not being involved in the assessment and FHR not being in the best clinical state because of the care he is receiving at VCC. The Court determined that the PDOC assessment should continue and gave further directions.
20/06/2025 FN's solicitors cease to act.
29/08/2025 FZR, supported by OS, filed an application for an urgent case management hearing to address escalating concerns about FHR's health and welfare, non-compliance with the Court's previous order (in particular, expert evidence, ICB's witness evidence and directions to review contact arrangements).
25/09/2025 Order records family concern that FHR's health and welfare are deteriorating as evidenced by hospital admissions.
09/10/2025 At the hearing, the Court:

- identified a dispute over Serious Medical Treatment, given the outcome of VCC's PDOC assessment and the dispute about its reliability;
- transferred the proceedings to a Tier 3 Judge
- discharged the previous directions for expert evidence;
- ordered a Best Interests Meeting to be held on 17/10/2026.

MRS JUSTICE THEIS
29-31/10/2025 The Court identified the issues in the case as (i) Serious Medical Treatment, (ii) Contact, (iii) Residence and Care and (iv) FN's Compliance with the Transparency Order. The Court listed a directions hearing before Mr Justice Peel and gave directions for evidence from the ICB and FN.
MR. JUSTICE PEEL 03/12/2025
Residence: the ICB relied on its public law decision to refuse funding for any home care package and only to fund care at VCC, and submitted that VCC was accordingly the only available residence option. The Court ordered residence at VCC.
Serious medical treatment: the Court

- determined that, in view of the issues raised, a further PDOC assessment was required
- (As suggested by OS) Appointed Helen Gill-Thwaites as a single joint expert to carry out the further PDOC assessment
- Postponed the Best Interests Meeting until the further PDOC assessment has been completed.

- If the lead clinician following the initial PDOC reports recommends withdrawal of CANH, the ICB has permission to instruct Professor Wade to provide an independent second opinion, including in respect of the PDOC assessment.
- Listed a further directions hearing for 23/04/2026.

11/02/2026: Expert report of Helen Gill-Thwaites
16/02/2026 FN filed judicial review proceedings challenging ICB's residence decision. The ICB responds on 9/03/2026.

MR. JUSTICE MCKENDRICK
23/04/2026
Residence: ICB confirmed it would fund care at home if it is found by CoP to be in FHR's best interests. FN made a COP9 application for an urgent declaration that it was in FHR's best interests to reside and receive care at home. The Court ordered the ICB to file a witness statement providing an update regarding its progress in identifying a care package for FHR to return home.
Serious Medical Treatment: The Court delivered an ex tempore judgment. The Court ordered:

- To list the Final Hearing on the issue of Serious Medical Treatment for 15-17 and 23 July 2026
- Permission for ICB to adduce the witness statement of Professor Wade.
- Permission to FN to adduce the witness statement of Dr Jonathan Martin, the 2nd witness statement of Jonathan Harris, the 2nd witness statement of FHR's sister FRR, and the first witness statement of Pavel Stroilov.
- Directions for further observations and other work recommended in Appendix 6 of the expert report of Helen Gill-Thwaites:
    - "Suitable professionals and arrangements to conduct the observations, shall be put by the applicant to the other parties, within 14 days of this hearing with agreement within 48 hours. If there is no agreement, HGT shall be asked to provide her view and the parties are to be bound by that, subject only to making a COP9 application to the court." (paragraph 5(a));
    - For the professionals instructed to carry out the observations to file their own report (paragraph 5(b)(iv)
    - For Ms Gill-Thwaites then to complete a supplemental report.
- Directions for a PDOC clinical expert to be jointly instructed to prepare a comprehensive report addressing (i) an overview of FHR's clinical features; (ii) an overview of the evidence relating to his level of consciousness, taking into account the assessments already available; (iii) his current clinical state, care and treatment needs, any evidence of pain, and any other relevant factors; (iv) his prognosis and life expectancy if treatment continues; (v) management options, including medical treatment, care, and placement; and (vi) his opinion as to FHR's best interests in relation to continuing active medical treatment and, if appropriate, his place of care.

The parties were unable to agree the identity of the single joint clinical expert. The issue was restored to the Court, who appointed Dr Nair as the single joint expert.
20/05/2026: ICB made a COP9 application for a 'clarification' of the Order of 23 April so that HGT's Recommendations 1-6 do not need to be followed.
22/05/2026: The Court ruled (without a hearing) that all HGT recommendations should be implemented, if possible before the trial.
17/06/2026: Urgent case management hearing following a COP9 application by the ICB. The Court ordered an adjournment of the Final Hearing to 17-21 August (a) to give the parties more time to implement HGT recommendations, particularly in relation to optimisation and (b) to accommodate Dr Nair's availability to complete his expert report. The Court directed an urgent meeting between HGT and all parties' solicitors to determine (a) which of the

recommendations in Appendix 6 of her report can practically be implemented to enable the observations to be completed by midnight on 24 July 2026 and (b) suitable professionals and arrangements to implement the recommendations to the extent they can be accommodated within the deadline of 24 July 2026.

23/06/2026: Meeting between the parties' solicitors and HGT. HGT advised instructing a 'PDOC Expert Physician" pursuant to her Recommendation 1 and provided a shortlist of experts. Parties agreed that FN's solicitors will take the lead in enquiries to PDOC Expert Physicians and joint instruction. Other professionals instructed to implement HGT recommendations are Anissa Cassim (expert PDOC assessor) and Amy Endacott (SLT).

29/6/2026: FN solicitors circulated a draft letter to HGT seeking to clarify her comments which appeared to question the impartiality of Dr Nair. The other parties refused to agree to make that enquiry.

7/07/2026: FN filed a COP9 application for permission to send the letter to HGT re Dr Nair's impartiality.

16/07/2026 At the hearing, the Court refused FN's application to discharge the Transparency Order and made no order in relation to enquiries to HGT about Dr Nair, but encouraged the parties to agree the terms of a letter to HGT.

23/07/2026 Pre-Trial Review:

- The Court refused FN's COP9 application to expedite the Final Hearing on the issue of residence. Evidence for the Final Hearing on 17-21 August confined to Serious Medical Treatment.
- Permission for FN to file up to five statements from FHR's extended family,
- Permission to ICB to file a witness statement from VCC and a witness statement re palliative care
- The letter to Ms Gill-Thwaites be sent today,
- Directions on trial timetable and agreeing witness template

28/07/2026: Dr Allanson files a Summary Report; seeks an extension of time to prepare her full report because of a serious illness in the family and late availability of relevant evidence.

29/07/2026 ICB files COP9 seeking directions further to the summary report of Dr Allanson. Following FN's response, ICB withdraws the application.

30/07/2026: Anissa Cassim and Amy Endacott file their respective reports. FN filed and served the witness statements of SB, SS and FB. The ICB objects to the evidence of FB on the grounds that she is a family friend, not a member of the extended family.

31/07/2026: Supplemental Report of Helen Gill-Thwaites

5/08/2026 FN's solicitor files COP9 seeking permission for oral evidence from Dr Allanson and permission to rely on the witness statement of FB.

8/08/2026 OS COP9 seeking further directions.

07/08/2026 Dr Nair submits report.

10/08/2026 Dr Allanson submits updated report.

18/8/2026 – Sir Stephen Cobb, P refuses permission to appeal the order of 16 July 2026.