Neutral citation number: [2022] EWHC 3682 (Fam)

Case No: COP 139338884

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 9th December 2022

Before :

MRS JUSTICE ARBUTHNOT

- -

Between :

MID YORKSHIRE HOSPITALS NHS TRUST	**Applicant**
- and -	
NB	**1st Respondent**
(BY HIS LITIGATION FRIEND, THE OFFICIAL SOLICITOR)	
- and -	
AB	**2nd Respondent**

- -

Hearing dates: 7th December 2022

- -

Ian Brownhill (instructed by **Hempsons**) for Mid Yorkshire Hospitals NHS Trust

Nageena Khalique KC (instructed by **the Official Solicitor**) for the **1st Respondent**

Ben McCormack (instructed by **Irwin Mitchell**) for the **2nd Respondent**

- -

Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

THE HONOURABLE MRS JUSTICE ARBUTHNOT

Mrs Justice Arbuthnot:

Introduction

1. These proceedings in the Court of Protection concern NB, who suffered a heart attack at home on 3rd September 2021. He was given cardiopulmonary resuscitation by his family and then by paramedics but for at least 18 minutes no oxygen was being carried to his brain. He suffered a severe hypoxic brain injury and has not recovered consciousness since. The medical professionals say he is in a persistent vegetative state.

2. For the last 15 months Mr B has been in hospital and has been given clinically assisted nutrition and hydration ("CANH") via a nasogastric tube. He also has a tracheostomy to help him breathe and is assisted by the respiratory physiotherapy team. He receives medication as he frequently suffers from infections. His family assist him greatly by gently massaging him and visit him daily.

3. In the months since he was admitted, his future prognosis and treatment has been discussed with his family. A second opinion from an independent Consultant in Neurological Rehabilitation was obtained in late January 2022, a meeting with the family took place and a best interests meeting was held on 2nd March 2022. Unfortunately, no agreement was reached between the clinicians and the family as to the way forward for Mr B.

4. An application was made to the Court of Protection on 31st May 2022. On 11th July 2022 an order for the instruction of a jointly instructed expert was made. The expert Dr Hanrahan reported on 21st July 2022. Discussions then took place between the parties, and it was agreed that mediation should be attempted. The mediation took place on 25th November 2022, but it did not result in agreement. It was unfortunate that the mediation delayed this Court's consideration of Mr B's best interests.

5. The Mid Yorkshire Hospitals NHS Trust ("the Trust") makes an application for a declaration that Mr B lacks capacity to conduct these proceedings and to make decisions about his medical treatment including the decision whether to accept continued life-sustaining treatment. This declaration is agreed between the parties.

6. The second declaration I am asked to make is in three parts, it is that it is lawful and in Mr B's best interests for the treating clinicians a. not to provide him with life-sustaining treatment including ventilation or clinically assisted nutrition and hydration, b. not to provide cardiopulmonary resuscitation in the event of a cardiopulmonary arrest and c. to provide palliative care according to a care plan which the court and the parties have been provided with. It is the first part of the second declaration (part a.) that is opposed by the second respondent I am concerned with.

7. The first respondent is Mr B who is the subject of these proceedings. He has a litigation friend, the Official Solicitor. Ms Khalique KC for the Official Solicitor supports the Trust's application.

8. Mr B is a family man with six children aged 13 to 30 and a wife, M, to whom has been married for 34 years after meeting when they were aged 19. The second respondent is his daughter AB who is representing the family in these proceedings.

9. The parties were all represented: the Trust by Mr Brownhill, Mr B and the Official Solicitor by Ms Khalique KC and Ms B by Mr McCormack. I would like to acknowledge the great help I have received from these very able and experienced counsel. They have approached this sad case with sensitivity and have done all they can to assist this court reach a difficult decision.

Mr B – Portrait

10. I must start this section of the judgment with a pen portrait of the man I am concerned with. I have been provided with statements from family members but also from friends. Mr B's wife and all three daughters attended the hearing remotely. I heard really moving evidence from his second oldest daughter, SB, and a close friend of her father's, AM. Neither found it easy to talk about this very special man. It made it clear how difficult Mr B's situation is for his family and friends.

11. The descriptions they gave in evidence overlapped. They speak of the same qualities which define the person he is. He is a family man but also a man who is at the heart of the local community. He is a very hard worker, his work spills over from his job building and doing car repairs into his support for his large family and anyone in the local community who needs his help. He takes their children to school, collects children from work, assists his wife with the shopping and until these awful events he had not spent more than one night away from his wife of 34 years.

12. He is described as a strong man, not particularly tall, a doer who could lift one end of a grand piano whilst four men were lifting the other end. He had a sense of humour, was fun to live with and told stories. He laughed a lot and I have seen some photographs of his family life with some of his wonderful children.

13. The tragedy is that he was middle-aged, very active and had a whole life in front of him with his family and now he will not be able to see his children as they grow older and perhaps have families of their own. He has 13-year-old twins and they will miss the guidance of this really rather extraordinary father, perhaps at the time they need it most. His considerable support for his wife M is now removed and she will have to make her way without him although I have no doubt, she will have the support of her daughters and sons.

14. His older children also miss the wise counsel of this Yorkshireman, jack of all trades, who had the sense to teach the girls and the boys the things that really matter - how to use a drill, wallpaper a room, lay bricks, plaster a wall and spray paint a car and most significantly of all the importance of hard work and family.

15. Above all, in the evidence I have read and heard he would have done anything for his family. He supported them fully, they all lived together in the same house and he was at the heart of the house along with M. They are extremely fortunate to have this wonderful man as their husband and father. Just in the way he has supported them throughout their lives, they now want to support him at his time of need.

16. I have read the family members' statements and I consider he would have been very proud of the support they have given him in the last 15 months. I suspect he was a modest man and would have been humbled to hear what has been said about him.

The events of 3rd September 2021 and treatment thereafter

17. On 3rd September 2021, Mr B had been having chest pains during the day. He collapsed with a heart attack in the evening and the daughters who were present gave him CPR. They were successful and when the paramedics arrived, they continued the work started by the family. Mr B was without spontaneous circulation for 18 minutes after the paramedics arrived.

18. He was taken to hospital first to Leeds General Infirmary where various tests were conducted including an electroencephalogram ("EEG") and a CT scan on about 7th September 2021, the latter showed that he had suffered severe hypoxic brain damage with a loss of differentiation between grey and white matter throughout the brain. It was relatively unusual to see a loss of differentiation in the basal ganglia. There was additional evidence of cerebral swelling. The EEG was grossly abnormal.

19. On 21st September 2021 he was transferred to Pinderfields Hospital in the Mid Yorkshire Hospitals NHS Trust. He has remained there since then being cared for in an acute respiratory unit because of a tracheostomy. He has been receiving good care which has been supplemented by daily visits from his family, once the Covid restrictions were relaxed.

20. Throughout his time in hospital, he has remained unconscious and early on he had myoclonic jerking and seizures which were controlled with medication. As well as the tracheostomy he has a nasogastric tube for feeding.

Professor Wade

21. The family did not require the specialists who had examined Mr B over the months to give evidence. To that extent they accepted their evidence. Their plea to the court, a very moving one, and one that any family member can empathise with, was for their husband and father to be given more time. As they put it "if there is a chance of recovery then dad would absolutely want that chance". They wanted more time to be given to him to see if recovery was possible.

22. Mr B has been examined by a number of specialists over the 15 months, but I am concentrating on the two independent experts. Professor Wade provided an independent opinion on 22nd January 2022 and having examined Mr B, met the family and the clinicians and read the notes, said that there was "no consistent and repeated evidence of any behaviour suggesting awareness". The treating team had assessed him occasionally using an observational tool which was designed to measure awareness and responsiveness. Mr B had three reflex responses only. All the behaviours Professor Wade observed such as eye movement and other sensory pathways were automatic and there were few of them. The clinical team had noted he often did not respond to pain. He still retained a startle response to sudden noise. His eyes were closed but if open he stared ahead. The only noise he made was coughing.

23. Professor Wade noted although he was breathing spontaneously there were no spontaneous movements. He did not appear unwell or in pain. He did not respond to either Professor Wade or the family who were present. He did respond to stimulation but the Professor concluded that he was unaware of himself and his environment.

24. Professor Wade helpfully explained the difference between somebody responding and somebody being aware. This was important in this case as Mr B breathes spontaneously, opens his eyes, blinks and coughs and occasionally moves his head. In Mr B, Professor Wade noted some responsiveness such as he will blink where a sudden noise occurs. The Professor said there were reflexes.

25. Awareness is judged through "behavioural observations". The Professor gave the example of the ringing telephone, if it rings and a person is startled they have heard it and had an automatic response. If the person reaches for the telephone and holds it to his ear then he has recognised the sound as indicating a telephone and knows what to do with it. Purposeful movement is something else that is considered. Unfortunately Mr B had shown no evidence of either discriminating between stimuli or of purposive behaviours. The behaviours described by the family were reflexes.

26. Professor Wade considered the brain damage that Mr B had suffered. The myoclonic jerking and possibly some more generalised epileptic convulsions in the first few days were "usually indicative of more severe brain damage". He remained unconscious even when he was no longer sedated. Although Mr B had intact vision and hearing and was sensitive to touch, these were automatic or reflex behaviours.

27. The Professor concluded there was "no prospect of any further recovery". Mr B was in a prolonged disorder of consciousness. He explained there were no medical treatments that could change that. The family raised with him their concerns that he was not receiving rehabilitation work but he pointed out this was to assess the level of awareness of a person and applies to someone with a much higher level of responsiveness and many more indication of awareness than Mr B has shown.

28. The Professor there was no doubt that for the remainder of his life Mr B would not be able to control any aspect of his care. He would not be able to function independently even at the level of scratching an itch. He would not be able to interact socially with family or friends at any level and would not recognise that a specific individual is with him. He will need 24 hour care and need to live in a residential or clinical setting. As time passes it is likely he will develop more spasticity.

29. He came to a provisional conclusion that it was not in Mr B's best interests to continue with clinically assisted nutrition and hydration through the nasogastric tube. He made it clear that a full discussion with the family needed to take place.

Dr Hanrahan

30. In the light of the inability to agree the future care for Mr B, Dr Hanrahan was instructed to provide an independent expert report in July 2022. His conclusions were based on his 11th July examination of Mr B over a period of six hours in the presence of his family and at time various staff. He also had access to his medication charts and other medical information. He spent time with the family explaining his diagnosis and justifying his prognosis.

31. Dr Hanrahan described the smoking habit of Mr B as a "substantial cardio-vascular risk". In addition to this risk was the family history of heart disease. Mr B's older sister and his father died of heart attacks. Dr Hanrahan said he was not really fit and well when he had a heart attack.

32. In his report Dr Hanrahan said Mr B was in a "prolonged disorder of consciousness" ("PDOC") and the time that had passed meant that this was chronic. There was a lack of behaviours indicating even minimal awareness and was "highly likely to be a permanent disorder of consciousness". He described Mr B as being in a vegetative state ("VS"), he said this with a high degree of clinical certainty. He was well below the high bar for full consciousness.

33. Dr Hanrahan considered the primary sensory pathways and came to similar conclusions to the ones reached by Professor Wade. He also saw some videos taken by the family including one of Mr B blinking rapidly ostensibly to a command but also one where the blinking continued despite there not being a command. Dr Hanrahan had to explain to the family that these movements were reflexive and not examples of awareness. These were not inconsistent with a vegetative state which he diagnosed and said it was "highly likely to be a permanent condition".

34. Dr Hanrahan said there were no future treatment options. The expert raised three clinical questions. The first related to decannulation of his tracheostomy, the second was that he agreed with Professor Wade that it would not be in Mr B's best interests to be prescribed clinically assisted nutrition and hydration. He went further to say that "his critical interests are not being served in the manner of his being kept alive with a potential loss of dignity". The third, was to withdraw other treatments to treat infections and other issues. In his opinion all active curative treatments should cease as they had no beneficial effect on the reversal of his severe brain injury.

35. Both experts suggested that Mr B in his current state had a life expectancy of seven years. At best Mr B might retain some awareness that would place him at the "very lowest end of the Minimally Conscious State" spectrum and this would relate to his reaction (my words not the expert's) to pain and discomfort but this was much less likely that him remaining in a vegetative state for the rest of his life or that he regains a little more arousal but "remains completely and permanently unaware".

The family and friends' evidence

36. I have read the statements provided from various family members and have set out above the portrait that is painted of this remarkable man. A friend to many, a family man and hard worker, who was at the centre of the local community. His friends and family miss him desperately. Dr Hanrahan said the the devotion and kindness he saw in the family was "truly moving".

Law

37. The principles the court must apply are agreed by the parties and are found in their position statements.

38. The first issue is whether Mr B has capacity to make decisions in relation to his medical care including whether hydration and nutrition is continued and whether he can conduct

litigation. It is agreed that he does not have capacity and I go no further into this issue, suffice it to say, there is evidence from two medical specialists in the papers that he does not have capacity. I find too that he will not regain it whatever my decision in relation to the second issue. I make therefore a section 15 Mental Capacity Act declaration that Mr B does not have capacity to make decisions as to his care and treatment.

39. The second issue for the Court and this is contested by the family is whether this court should declare that it is lawful and in Mr B's best interests for the treating clinicians not to provide him with life-sustaining treatment including ventilation or clinically assisted nutrition and hydration, not to provide cardiopulmonary resuscitation in the event of a cardiopulmonary arrest and to provide palliative care according to a care plan which the court and the parties have been provided with.

40. In a situation such as this one, where the clinicians and the family do not agree with the treatment to be provided to Mr B by the former, the Court of Protection has to make the decision on his behalf. The Court of Protection applies the Mental Capacity Act 2005.

41. Section 4 of the Mental Capacity Act 2005 sets out the criteria to be applied to determine what is in an incapacitated person's best interests:

"(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of (a) the person's age or appearance or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

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

(3) He must consider

(a) whether it is likely that the person will at some time have the capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

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

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

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

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

42. The leading case as to the application of the best interests' criteria is the decision of the Supreme Court in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, Baroness Hale highlighted the following:

> "[22] Hence the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."
>
> …
>
> "[39] The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be."

At paragraph 45 she added:

> "[45] The purpose of the best interests' test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are… But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which are important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being"

43. Mr B's rights are protected by the European Convention on Human Rights. In the present context, the relevant rights are established by:

a) Article 2 (the right to life). As MacDonald J noted in *Re Y (No 1)* [2015] EWHC 1920 (Fam) at paragraph 37, "the right to life under Art 2 of the ECHR imposes a positive obligation to provide life sustaining treatment, that obligation does not extend to providing such treatment if that treatment would be futile in nature and where responsible medical opinion is of the view that the treatment would not be in the best interests of the patient concerned (see *R (Burke) v The General Medical Council* [2005] EWCA 1003)".

b) Article 3 (protection from inhuman or degrading treatment)

c) Article 8 (the right to respect for a private and family life). As the ECtHR recognised in *Burke v UK* [2006] (App 19807/06) ECHR 1212:"the presumption of domestic law is strongly in favour of prolonging life where possible, which accords with the spirit of the Convention".

44. I also bear in mind the observations of the then Baker J in: *Re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2012] 1WLR 1653:

"235. Able-bodied people frequently feel (even if they do not say so) that disability invariably restricts the enjoyment of life. With the growth in understanding about disability in recent years, however, has come an awareness that people with disability often experience profound enjoyment of life, within the limitations that their disability may impose..."

45. In *PL (By her litigation friend, SL) v Sutton Clinical Commissioning Group and Anor* [2017] EWCOP 22 where PL had had a catastrophic stroke and it was the family's application that she no longer receive the life sustaining treatment of clinically assisted nutrition and hydration, Cobb J set out the list of factors a court might consider.

The factors are set out at his paragraph 9: I set it out in full below:

"The questions which require determination on this application are:

i) What is PL's current condition? What is her level of consciousness or cognisance? What is her awareness of the world around her?

ii) Does PL have the mental capacity to make a decision about the continuance of CANH? If she is assessed to lack capacity presently, is there a prospect that she could develop the capacity to make that decision?

iii) If she lacks capacity, is it in her best interests that I should confirm the continuing delivery of CANH? In answering this question, I should consider:

iv) Her previous stated views on life-support, and on sustaining life artificially, in the event that she is totally dependent on others, and incapable of functioning in many essential domains of her life;

a) The quality of her life at present; whether there is any or any significant enjoyment in her life; whether she experiences pain and/or distress, and if so how that is managed;

b) Her prognosis if CANH were to continue for the foreseeable future; whether there is any real prospect of recovery of any of her functions and improvement in the quality of her life;

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

d) The prognosis for PL if I were to authorise the discontinuance of nutrition but not hydration;

e) The views, wishes and feelings of the family and her carers;

f) PL's dignity;

g) The sanctity of life generally.

46. I apply this approach to the evidence in this case. I have been helped by the written and oral submissions I have received.

47. First, Mr B's current condition. It is clear from the uncontested conclusions of Professor Wade and Dr Hanrahan (let alone the treating clinician's views) that he is suffering from a prolonged disorder of consciousness and has severe brain damage. Dr Hanrahan described him as being in a vegetative state. Mr B has no awareness of the world around him and any movements he makes are reflexive and automatic. Very sadly, he is not aware that his family visit him every day.

48. Second, it is not in dispute that Mr B does not have the mental capacity to make a decision in relation to clinically assisted nutrition and hydration. According to the doctors, there is no prospect that he will develop the capacity in the future. Dr Hanrahan said his was "highly likely to be a permanent condition".

49. Third, the main issue for this Court is whether it is in Mr B's best interests that the court should confirm the continued delivery of clinically assisted nutrition and hydration. As to the matters that section 4 Mental Capacity Act 2005 requires me to consider:

a. First, I am to consider Mr B's previously stated views on life-support and sustaining life artificially. Unfortunately, the family have made it clear that Mr B had not stated his views about what he would like to happen in the circumstances in which he now finds himself to be in. At his fairly young age it is not surprising that he had not given it any thought.

b. Second, I am to consider Mr B's enjoyment of his life as it is now. There is no evidence that he enjoys his current life. All the evidence is that he has no awareness of where he is or who is with him or what has happened to him.

c. Third, another consideration is Mr B's prognosis if clinically assisted nutrition and hydration were to continue. The consensus is that he would live for approximately seven years. There would be no prospect of recovery of any of his functions. His quality of life would remain as it is currently. At best his

minimally conscious state may improve such that he would remain at the very lowest end of the minimally conscious state but that would mean he may feel pain and discomfort. There is no suggestion that even at best, he will ever recognise his family again. His physical presentation would get worse.

d. Fourth, I must consider the prognosis for Mr B if clinically assisted nutrition and hydration were discontinued. He would die within a few weeks. A palliative care package has been developed and was provided to Dr Hanrahan who had no suggestions to make which would have improved it. Understandably the family have not been able to consider it in any detail.

Having considered the plan with care, it seems thorough, well thought through and sensitive involving a hospice and a continuing high standard of care. Significantly it takes into account Mr B's cultural and religious needs. I asked whether the six children and their mother would be allowed to visit their father together. I am assured that this will be considered with sensitivity by the hospice.

e. Fifth, there is no suggestion here by the family that nutrition should be withdrawn but not hydration and the medical professionals are of the view that neither should continue.

f. Sixth, I must take into account the significant issue of the views of the family and of the medical professionals caring for Mr B. The views of the clinicians caring for Mr B are to be found in the bundle of evidence I have been provided with. Their views are supported by the independent evidence of Professor Wade and Dr Hanrahan which I have summarised above.

The family's views have been set out in a compelling way in their statements and in the evidence of SB. Their feelings of loss and bewilderment about what has befallen this close family are palpable. They say this strong man with a fighting spirit would fight to remain with his family as long as he is able to. They may wish for more time to be given to their father to see if recovery is possible, but the medical professionals are clear that he will never recover. The best that can be expected is a lesser minimally conscious state where he might feel pain. That is not the recovery the family wish for.

In terms of the time in which may have recovered, he has been in this vegetative state for just under 15 months. Sadly, there have been no first signs of recovery but there have been reflexive responses. These have had the effect of providing hope to a family watching and wishing for any sign of recovery but he will never return home and the greatest sadness is that he will never recognise his family again.

He will never be again the man he was. Their wishes and feelings are about bringing him back as he was. As Dr Hanrahan said it is hope that they have but it will not be fulfilled.

g. Seventh, dignity, it is hard to see how Mr B has any dignity in his current state. He has all his needs taken care of and is punctured by tubes which bring him nutrition, hydration and medication, they help his breathing and carry away any

waste products. He is prone to serious infections and has bed sores which are being managed. There is very little dignity in his circumstances.

h. Eighth, is the sanctity of life generally. Mr B is a practising Muslim, he celebrated the important festivals and went to the mosque regularly. I noted his values and beliefs are reflected in the way he has lived his life with its emphasis on family, hard wark and charity in the community. The family is concerned that taking away nutrition and hydration is speeding up the process of his death which his daughters say is "stopping what God has written for our dad". Another witness speaks about his concern that Mr B would suffer spiritually if clinically assisted nutrition and hydration was withdrawn.

In my judgment, it could be said that the life sustaining treatment delivered to Mr B thus far has already interfered with what God had written for their father. By refusing to permit the continuation of clinically assisted nutrition and hydration the Court will not be determining when Mr B will die, the time of death in those circumstances will depend on factors which have nothing to do with the Court's decision, nature will take its course.

Conclusion

50. It is not in dispute that Mr B lacks the capacity to make the decisions which need to be made for him. The family do not agree with the clinicians' prognosis and plans. The decisions have to be taken by the Court in his best interests. I have weighed in the balance the factors set out above in paragraphs 47 to 49 that are relevant to this decision.

51. The Court is not motivated to bring about his death. Mr B did not say what his views would be if he were placed in the situation he finds himself in. He never had to consider whether he would want to continue in a vegetative state being visited by his family on a daily basis. He was an active man who never sat still, who was the heart of his family and deeply involved in the local community and never had to think what it would be like to be utterly powerless with all his needs taken care of and with no awareness of his family let alone being able to communicate with them.

52. I noted too that what AB and SB made clear in their joint statement was that they would not want their father to "live in this condition for the rest of his life". Significantly they also said "he would not want that for himself" but according to the medical professionals if life-sustaining treatment continues he will remain in his current condition until he dies.

53. Considering the situation from Mr B's perspective, he was a practical, no nonsense Yorkshire family man, very kind and considerate, who had humility according to his wife and friends. I do not consider he would have wanted his family to suffer in this long drawn-out way, which could potentially continue for seven years when he has no hope of recovery.

54. This court is required to provide life sustaining treatment unless it would be futile to do so. The medical evidence is to that effect including that of an independent witness and from another who was brought in to provide a second opinion.

55. In my judgment, it is lawful and in Mr B's best interests that I make the declarations sought by the Trust supported by the Official Solicitor.

56. With sadness, I have to make the following declarations and orders: that Mr B lacks capacity in the ways I have set out above and it is lawful and in his best interests for the clinicians treating him not to provide treatment including ventilation or clinically assisted nutrition and hydration; not to provide cardiopulmonary resuscitation in the event of a cardiopulmonary arrest and to provide palliative care in accordance with his assessed needs administered by the Trust so that as far as is practicable, all reasonable steps are taken to minimise any distress to Mr B, maximize his comfort and to preserve his dignity until such time as his life shall come to an end.

57. That is my decision.