Neutral Citation Number: [2023] EWCA Civ 1190

Case No: CA-2023-001710

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE COURT OF PROTECTION
The Hon Mr Justice Hayden
Case no.1410326T

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 October 2023

Before :

LORD JUSTICE BAKER
LORD JUSTICE LEWIS
and
LORD JUSTICE WILLIAM DAVIS

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VA (MEDICAL TREATMENT)

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The Appellant VK appeared in person
Parishil Patel KC (instructed by **Hill Dickinson**) for the **First Respondent Hospital Trust**
Claire Watson KC (instructed by **The Official Solicitor**) for the **Second Respondent, VA, by her litigation friend**

Hearing date : 5 October 2023

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Approved Judgment

This judgment was handed down by the judges remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be 2pm on 13 October 2023.

LORD JUSTICE BAKER :

1. This very sad case involves an application for permission to appeal against an order made on 25 August 2023 by Hayden J sitting in the Court of Protection in proceedings relating to a 78-year-old woman, hereafter referred to as VA. The order included a declaration that VA lacked capacity to conduct proceedings or consent to medical treatment including extubation and associated treatment and care. The order further provided that, pursuant to s.16 of the Mental Capacity Act 2005, it was in VA's best interests, and the court consented on her behalf, to undergo extubation and the provision of palliative care in accordance with a care and treatment plan prepared by the treating team at the hospital where she is being looked after.

Background

2. The background can be summarised as follows. On 17 February 2023, VA collapsed at home and was taken to St Thomas's Hospital. On the day after her admission, she suffered an acute drop in level of consciousness with a Glasgow Coma of 3 – the lowest level on the scale. She was unable to manage her swallow and therefore was intubated and transferred to the Intensive Care Unit ("ICU"). Her condition improved and four days later she was taken off the ventilator and transferred to the High Dependency Unit.

3. Unfortunately, VA then suffered further cardiac arrests and was readmitted to the ICU and reconnected to the ventilator. In the course of attempted resuscitation, the flow of cerebrovascular blood was restricted and subsequent MRI scanning revealed significant hypoxic brain injury. A review on 5 May 2023 concluded that there was no real prospect of neurological recovery. Further reviews, including those of Dr Robin Howard, a consultant neurologist instructed to provide a second opinion, confirmed that VA had suffered a profound injury to the brain as a result of an ischaemic event.

4. The treating clinicians concluded that, given VA's condition, remaining in the ICU on a ventilator was not a viable course. Two options were identified: (1) extubating VA and providing her with palliative care or (2) performing a tracheostomy and inserting a PEG tube with a view to moving VA to a ward and later discharging her into a community placement.

5. There is regrettably a deep conflict of evidence between the Trust and VA's family as to the steps that were subsequently taken. According to the Trust, many attempts were made over the following weeks to communicate with members of the family with a view to carrying out an analysis of which option was in VA's best interests. According to the family, the Trust failed to involve them in the process of making decisions and were not transparent about the options.

6. A series of best interests meetings were convened. The first took place on 6 April 2023. According to the Trust, members of the family were invited but did not attend. A second meeting took place on 9 May at which one of VA's daughters, AA, was present. The medical consensus at that meeting was to proceed to extubation given the neurological prognosis for VA. The clinicians said, however, that both options remained open depending on what were understood VA's wishes would have been in this situation. But if the team were unable to gain a clear understanding of VA's wishes, an application to the Court of Protection would be made to weigh up the two options and decide on

VA's behalf. According to the Trust, AA asked for further time for consideration to speak with the rest of her family.

7. A third best interests decision meeting was convened on 22 May with a view to consulting other members of VA's family about the best interests decision and in particular as to VA's wishes and feelings. On this occasion, three of VA's children – VK, VB and VA - were able to attend in person and her eldest daughter, MA, attended via telephone from her home abroad. According to the Trust, no clear picture emerged during the meeting about what VA would have wanted.

8. On 26 June 2023, the Trust therefore filed an application in the Court of Protection seeking a declaration as to whether it was in VA's best interests either (a) to extubate her from mechanical ventilation and implement palliative care or (b) to perform a tracheostomy to allow weaning from the ventilator. A hearing was fixed for 5 July. A statement was filed by two of the treating clinicians, Dr MT and Dr HC, both clinical consultants in critical care medicine, setting out the history of the case, recording that the clinical consensus was to proceed to extubation, summarising the benefits and disadvantages of the two options, and exhibiting minutes of the meetings on 6 April and 9 May and alternative care plans depending on which option was chosen.

9. On 3 July, however, a further meeting took place between the clinical team and members of VA's family. On this occasion, her elder daughter, MA, flew in from her home abroad to attend. At the conclusion of the meeting, an agreement was reached that VA should undergo a tracheostomy and the insertion of a PEG tube. According to papers filed in the proceedings, MA told the meeting that her mother would not want to be extubated but would rather wish to undergo a tracheostomy. A position statement was therefore filed in court by leading counsel on behalf of the Trust setting out the Trust's position at that time that, on balance, a tracheostomy and insertion of a PEG tube was in VA's best interests in that it provided the best chance of preserving her life and was in accordance with what her family said she would have wanted. Furthermore, such a course would allow further time for neurological assessments to inform future decision-making. A position statement from the Official Solicitor, who had been appointed as litigation friend, indicated that she would not oppose such an order.

10. At the hearing before Morgan J on 5 July, a transparency order was made in standard terms preventing the publication of information disclosing VA's identity. By the substantive order made at the hearing, Morgan J gave the trust permission to bring these proceedings. The order further included the following recitals:

> "A. MA, VA's daughter, has informed the Trust's solicitor and the Official Solicitor caseworker that she represents the views of the whole family, and they are all in agreement that a tracheostomy and percutaneous gastrostomy ("PEG") tube is what VA would have wanted and is in her best interests.
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> B. MA has also informed the Trust's solicitor that she will maintain communication with the Trust going forward to avoid future disagreements and that she would like the court to endorse the care and treatment plan (which included the insertion of a tracheostomy and PEG tube, and that VA will not be readmitted to the ICU for ventilation or other invasive organ support).

> C. MA has informed both the Trust's solicitor and the Official Solicitor caseworker that the family wish the proceedings to conclude.
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> D. VA's clinicians have agreed with the family that they will carry out an MRI scan before she is discharged from ICU.
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> E. A DNACPR has been put in place for VA on 6 April 2023."

The judge made a declaration that VA lacked capacity to conduct proceedings or to consent to medical treatment. On that basis, the judge ordered pursuant to section 16 of the Mental Capacity Act 2005 that it was in VA's best interests for a tracheostomy to be undertaken and a PEG tube inserted, adding that the court consented to that procedure on her behalf. By a further declaration, the judge also declared that, in the event that VA was discharged from the ICU following the procedure, it would be lawful for the Trust's clinicians not to re-admit her to the ICU for ventilation and other invasive organic support if in their clinical judgment this would be contrary to her best interests.

11. Following the hearing, however, another of VA's daughters, VK, arrived at court and in conversations with the Trust's representatives raised objections to the order. The following day she filed and served a COP9 application asking for it to be set aside, complaining that the family had not been allowed to seek legal advice and representation, nor a fair opportunity to speak on VA's behalf. As a result, a further hearing was listed before Poole J on 26 July.

12. Meanwhile, a further review by Dr Howard confirmed that there was no improvement in VA's condition. The conclusion of this review by Dr Howard was in the following terms:

> "The appearances on the MRI scan indicate devastating damage to the cortex, subcortical regions, deep grey matter, descending tracts and brainstem. There is also extensive vascular disease. In addition there is extensive loss of brain tissue due to necrosis and subsequent atrophy affecting the cortex and ventricles. The clinical findings and the MRI appearances are incompatible with this poor lady being able to make any form of neurological recovery from her present state. There is no doubt that her brainstem is still functioning. There is no immediate prospect of cardiac or respiratory arrest as a consequence of the brain injury but she remains profoundly vulnerable to the complications of being in a permanent profound vegetative state of wakeful unawareness (as defined in the RCP Prolonged Disorders of Consciousness guidelines)."

13. The hearing before Poole J was attended by MA, VK and also VA's son VB. One focus of attention from the family was on the "ceiling of care plan", that is to say the provisions, included in the recitals in the order and the declaration made by Morgan J on 5 July, relating to the DNR notice and the question of readmission to the ICU after the tracheostomy. The order made by Poole J included a recital to the effect that the Trust clarified that, in the event of a question arising as to the readmission of VA to the ICU after the tracheostomy, clinicians would discuss with the family whether that was

in her best interests and, in the absence of agreement, the matter will be restored to the Court of Protection for a decision. (I observe in passing that this was arguably inconsistent with the terms of the recital in Morgan J's order which appeared to give the Trust's clinicians the power to determine the treatment in those circumstances.) In further recitals to Poole J's order, it was recorded that MA agreed to the order of 5 July subject to that clarification relating to readmission to the ICU but that VK did not consider that she had sufficient information to make that decision and therefore asked to be joined to the proceedings. Poole J duly joined her as a party and gave further directions that, if she disagreed with the order, she should file an application to restore the proceedings by 31 July, identifying those parts of the order with which she disagreed.

14. On 31 July, VK filed a COP9 application stating that she disagreed with the recitals in A to E of the order of 5 July and with the care plan concerning readmission to the ICU. She raised a number of other complaints about the Trust's conduct. The matter was therefore restored before Roberts J on 2 August. At the conclusion of that hearing, the judge directed VK and any other family member by 9 August to file and serve a statement relating to their position concerning the order of 5 July The judge further directed the Trust to file a statement in response by 14 August, gave permission for the Official Solicitor to file a statement by 16 August, and listed the matter for a hearing before Hayden J on 24 August.

15. On 3 August, the Trust responded to a list of questions put forward by the family. In answer to the questions "Why do the doctors want to remove her from the ventilator? And why does she need a tracheostomy?", the Trust replied:

> "VA no longer needs the ventilator to support her breathing. She is breathing on her own but because she currently has an endotracheal tube that connects her to the ventilator, that also needs to be removed when the ventilator is removed.
>
> Unfortunately due to her devastating and irreversible brain injury it is likely that when the endotracheal is removed, she will have difficulty in clearing oral secretions which could subsequently block her airway (windpipe) and compromise her ability to breathe for herself. In people with no brain injury they are able to clear their oral secretions spontaneously when the endotracheal tube is removed due to normal physiological reflexes. Due to the severity of her brain injury, it is likely that VA no longer has these protective reflexes. Many would consider this as an unfortunate consequence of her severe brain injury and accept the risk that removing the endotracheal tube could result in her life being shortened but that this is the natural consequence of the irreversible brain injury and would allow comfort and palliative measures to be put in place.
>
> The placement of a tracheostomy overcomes the risk of her not being able to manage her own secretions when the ventilator is removed as it acts in a similar way to the endotracheal tube, having a cuff in the airway that reduces significantly the risk of unmanaged oral secretions obstructing the airway. It allows the

> disconnection of the ventilator as the patient can breathe unaided through the tracheostomy. It also avoids the risk of oral sores caused by the endotracheal tube and the ties used to secure it in the mouth. There are however small risks with placing a tracheostomy as it is a surgical procedure. The tracheostomy may well lengthen her life in terms of reducing the risk of airway compromise due to oral secretions and slightly reduce the risk of recurrent pneumonia but it does not treat or change the outcome from her devastating brain injury. The tracheostomy may lengthen her life but will not improve her quality of life or comfort. It would allow placement in a longer-term care facility that would meet her nursing needs.
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> As explained on numerous occasions … VA has remained in ICU far in excess of what would be considered as clinically appropriate. She is currently mechanically ventilated purely to overcome the resistance from the breathing tube in situ. VA can breathe herself and does not require mechanical ventilation. She requires no artificial organ support and consequently there is no therapeutic benefit to her remaining in ICU. To be stepped down from ICU she requires disconnection from the ventilator. This can either be by way of extubation or by the insertion of a tracheostomy which will leave her less susceptible to secretion retention and airway obstruction."

16. On 9 August, in accordance with Roberts J's order, VK, MA and VB sent emails setting out their respective positions. MA's email stated that their mother's wishes would be for a treatment plan with the availability of all options that seek to preserve life. For that reason, the family did not opt for palliative or end-of-life care and, of the options put forward, supported the tracheostomy plan. MA added that "it is very challenging and difficult for the family to fully understand the intended meaning of some of the medical terminology used in the treatment plans". She said that the family did not agree with the proposed non-admittance to the ICU for further ventilation and other invasive organ support, adding "we do not understand why critical care could be denied or withheld from our mother". She also said that the family did not believe that VA would ever consent to a DNACPR notice which was contrary to her wishes and the family's wishes. In his email, VB (VA's son) expressed "deep concern" about the clause denying resuscitation to VA in the event of a further deterioration or collapse. He complained about a lack of information provided by the hospital, stating that the family had been presented with an ultimatum to choose between a tracheostomy or extubation without understanding the procedures for any exploration of alternative options. VK's brief email stated that for personal reasons she was unable to give sufficient response by 9 August and asked for a meeting to give her an understanding of her mother's situation.

17. On 14 August, Dr MT and Dr HC filed a further statement setting out details of the treatment options. Concerning the ceiling of care, they said:

> "8. If VA's condition deteriorated on the ward to the point of requiring invasive organ support on intensive care again then it is the view of the intensive care team that this is not an appropriate escalation of therapy for this lady. She has a

> profound neurological injury that has left her in a persistent vegetative state; re-escalating organ support in the event of deterioration would only serve to potentially increase the length of her life for a period and not offer any benefit in terms of neurological recovery.
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> 9. There is a considerable burden to instituting organ support in any patient, requiring painful and invasive procedures. In a patient who cannot consent to these, and has no prospect of recovery beyond a vegetative state, then it is the view of the Intensive Care team that the burden of instituting invasive organ support outweighs the benefits gained from it.
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> …
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> 12. A repeat MRI scan of the brain performed at the request of the family on 10 July 2023 reconfirmed the severity of the profound neurological injury, with grossly abnormal appearances of the brain. Over the course of her stay she has been cared for by more than 10 different consultant intensivists and has been discussed at departmental complex case meetings, a professionals meeting and two best interest meetings. The combined opinion is that there is no role for readmission to intensive care for invasive organ support as the risks and burdens of instituting this outweigh the benefits. Treatments would be limited to those that can be delivered at ward level, e.g. nutrition, hydration, antibiotics when necessary and access to occupational therapy and physiotherapy where indicated."

They added that CPR would not be clinically appropriate as it would not be successful either in restarting her heart or restoring her breathing for a sustained period and would further worsen her neurological injury.

18. The two doctors then indicated a revised position on behalf the trust concerning VA's best interests. In part, this was influenced by comments made by another of VA's children, AA:

> "17. The treating team has wrestled with fine balance between the respective best interests associated with either of the available options for a long time. Our ability to reach a firm conclusion was frustrated by the lack of engagement from VA's family in the best interests decision-making process until 9 May 2023. Notwithstanding this engagement being then supplemented by the meeting on 3 July 2023, the Trust now understands that the input provided during those meetings as to VA's wishes, feelings and best interests must now be considered in line with the broader opinions of VA's family who have previously chosen not to engage.
>
> 18. The treating team would still be prepared to insert a tracheostomy but the Trust's position as to this being in VA's

> best interests was shaped by an analysis factoring in a holistic view based on what it previously considered to be an indication as to VA's wishes and feelings provided by certain family members on 3 July 2023. However, subsequent to this, another family member (AA) approached the bedside team on 30 July 2023 suggesting that some members of the family may not wish to proceed with tracheostomy.
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> 19. In light of the way this case has proceeded the Trust has reflected as to the input of the various members of VA's family and feel that the evidence as to VA's wishes has become confused and consequently unreliable. It now seems unclear as to what VA's wishes would be and consequently the Trust can now only revert to its initial position as to best interests shaped entirely on a clinical appraisal, favouring extubation.
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> 20. Whilst the placement of the tracheostomy and gastrostomy is likely to extend the length of VA's life, it is felt that the quality of her life would be so extremely poor with no cognitive awareness of surroundings, in a persistent vegetative state, dependent on all care and no realistic prospect of neurological recovery beyond this. It is therefore the view of the team that the burdens of this option outweigh the potential benefits. Accordingly, given the inability to reliably ascertain what VA's interests would be, due to the conflicting communication from immediate family members, we consider that, entirely on clinical appraisal, it is in VA's best interests to be removed from the endotracheal tube and placed on the palliative care pathway."

19. A further email from MA on 21 August reiterated her position opposing extubation but supporting a tracheostomy.

The judgment of 25 August

20. Thus the issue came before Hayden J on 24 August. At the hearing, the judge heard evidence from Dr TC and from three members of the family, namely MA (who attended via a video link from abroad), VB and VK. (According to the Official Solicitor's skeleton argument prepared for the present hearing before this Court, AA, who is another of VA's daughters, had been informed that she could file a statement but did not do so and did not attend the hearing.)

21. In his judgment, Hayden J set out the background. He summarised the evidence of Dr Howard as to VA's condition, and accepted his opinion that she was "at the lowest end of the spectrum of a profound disorder of consciousness". He observed that, at the time of the application, the Trust regarded both extubation and tracheostomy as "equally valid options", adding:

> "I have not found the logic which underpinned the basis for those apparently equal alternatives, easy to identify in either the written or oral evidence. The change in the Trust's position has,

> unfortunately, reinforced the family's general resistance to the hospital."

The judge summarised developments after the hearing on 5 July. He set out the position of the family members, observing:

> "The family's role, as they have come to understand in this hearing, is to help the Court understand, to the extent that it is possible, what Mrs VA would want in her present circumstances. This can now only be understood by endeavouring to understand Mrs VA's character and personality, what she may have said, if anything, in contemplation of her current situation. The code by which she has lived her life."

22. He then summarised the evidence of Dr TC in these terms:

> "21. …. Dr C clarified that Mrs VA's brain is in a process of atrophy. She is generally weaker and her muscle tone and function [are] also deteriorating. She does not require mechanical ventilation or treatment in ICU. She is receiving room level oxygen and can breathe independently. Her challenge is that she has a weak cough which could be managed effectively with deep suctioning via tracheostomy on the ward. Self-evidently, that is an intrusive procedure. Dr C, in common with all the other doctors, is clear, for reasons to which I have already alluded, that treatment of any kind is, and has been for some time, futile. It is also burdensome.
>
> 22. Extubation involves a risk that Mrs VA's cough might not be strong enough, effectively to regulate her own airways. The first 24 hours would be key. If Mrs VA managed, this would permit of the potential for her to be moved to a room, off the ward, for further care. If it were not successful, she would need medication to limit her secretions, less intrusive suctioning and this might not be successful. To confront the reality, it might lead to her death. As the doctors have made perfectly clear, Mrs VA is dying. Her children struggle to accept this and hope for reversal of their mother's medical fortunes.
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> 23. As everybody in this case is aware, ICU is an incredibly busy and extremely noisy environment. This is unavoidable, it is providing intensive care. It affords little privacy and no peace. The purpose of ventilatory support is, as Dr C put it "to support the patient whilst you identify and treat any reversible condition". When these are realistic objectives, the privations involved are proportionate and justifiable. When these objectives have disappeared, they are not. For Mrs VA, there is no reversible condition. Moreover, as I have already emphasised, she can breathe without ventilatory support. There can be no justification at all for continuing ventilation."

23. The judge then set out the relevant legal principles, citing passages from *Burke v GMC* [2005] EWCA Civ 1003, *A Local Authority v JB* [2021] UKSC 52, *Aintree v James* [2014] AC 591, and his own observations in *NW London CCG v GU* [2021] EWCOP 59. He identified the statutory principles in the 2005 Act relating to best interest in s.1(5), s.4 and ss.15-17, and passages from the MCA Code of Practice.

24. He then turned to the evidence of family members which he set out in a characteristically humane and insightful way. He recorded how VA had come to this country from Nigeria over 50 years ago, qualified as a midwife and raised a family of six children largely on her own. The judge described how the family had agreed that, of the children, MA was most like their mother and he described how her manner in court and her strength of character, eloquence and intelligence had brought a great deal of VA into the courtroom. MA had told the court that extubation and palliative care would be perceived in her culture as the family giving up on their mother. The judge observed, however (at paragraph 41):

> "This sense of responsibility and deep-seated belief in their duty to their mother has, in my judgement, paradoxically, diverted their focus onto what they think might be the right thing to do and not, as it should be, what is in their mother's best interests."

25. The judge then summarised his assessment of the family members' evidence about VA's wishes and feelings in these terms:

> "43. Because each of the children had different relationships with their mother, they have struggled to engage with the challenge of wondering what she would have wanted in her present parlous position. Some families never have the discussion about what they would want if they were to be in Mrs VA's circumstances. It could happen to anybody and the experience of this Court is that many do have such conversations. Increasingly, people make Advance Decisions setting out what their wishes would be. This family did not have these kind of discussions. MA said that it was not in their cultural tradition to do so. In any event, I am satisfied that Mrs VA never approached the subject.
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> 44. VA complied with some of her medication and not with others. I am told that she rather disliked hospitals and had an anxiety about professional negligence. Though I guard against the family's understandable strain to filter evidence into their own concluded view, I think this is most likely correct. It fits with the wider evidence of VA's intellectual independence.
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> 45. None of this provides secure ground to establish what Mrs VA would have wanted. That said, I am clear that privacy and independence were both important to this courageous woman."

26. He then expressed his conclusion in the following terms:

> "46. To justify continuing the invasive procedure of the tracheostomy, deep suctioning and PEG in circumstances where there can be no medical benefit and only physical burden, I would have to be satisfied that this is what Mrs VA would really have wanted. Even then, her wishes and feelings would not be determinative.
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> 47. Mrs VA is dying. She has a chance of doing so in the relative privacy and peace of the ward, perhaps even in a nursing home. With luck her children may share that privacy with her. Within the narrow ambit of what can be done, this is a not insignificant change for her. Extubation, palliative care focusing on giving Mrs VA the best quality of life, at the end of her life, is, I find, what is in her best interests. Accordingly, I grant the declaration sought by the Trust. It is important that I emphasise that the Official Solicitor who has attended personally throughout this hearing supported the Trust's application, having heard all the evidence."

The appeal

27. On 1 September, VK, acting in person, filed a notice of appeal against both the order of Morgan J dated 5 July and the order of Hayden J dated 25 August. On 5 September, I listed the application for permission to appeal for an oral hearing on 8 September, giving directions for the filing of skeleton arguments. On 7 September, VK sent an email to the Civil Appeals Office saying that she was unable to file a skeleton argument in time for the hearing because she was involved in other litigation and asking for an adjournment. On the morning of 8 September, before the start of the hearing before me, both MA and VB sent emails to the court in effect supporting the appeal by advocating for the carrying out of a tracheostomy as opposed to intubation. The hearing proceeded with VK present acting in person and the Trust and Official Solicitor represented to oppose the application. At the end of the hearing, I acceded to the adjournment application and made an order (1) listing the application for permission to appeal, with appeal to follow immediately if permission granted, on 5 October; (2) joining MA and VB as appellants (subject to (3) below); (3) directing the appellants by 18 September to either (a) file and serve grounds of appeal and skeleton arguments in support or (b) give notice to the court and the other parties that they do not wish to be joined or that they do not wish to remain as appellants; (4) directing the Trust and Official Solicitor to file skeleton arguments in response. I recorded as recitals that, although MA and VB had not applied to be joined as appellants, the Court would be assisted by their having an opportunity to make representations in relation to the appeal and further that the Court would be assisted if the appellants were able to obtain legal representation to help with the presentation of their appeal.

28. On 18 September, MA sent an email asking to be joined as an appellant, and setting out grounds of appeal and submissions in support. On the same day, VB sent an email to the Court saying that he did not wish to be joined as an appellant but saying that he wished to be "fully involved in the proceedings" and referring back to the detailed points raised in his earlier email dated 8 September. On 19 September, VK sent an email which she described as her statement, in effect her written submissions. The Trust and Official Solicitor duly filed skeleton arguments in accordance with my directions. In

his document, Mr Parishil Patel KC on behalf of the Trust indicated that, on dismissal of the application for permission to appeal or alternatively of the appeal itself, the Trust would seek an order that the appellants pay the Trust's costs. Perhaps in response to that indication, on 29 September, MA sent a further email indicating that she no longer wished to be joined as an appellant. She added, however, that in view of personal difficulties which her sister VK had experienced, she, MA, had considered it necessary to file statements and skeleton arguments and she remained eager to assist the court as needed.

29. As a result, VK is now, technically, the only person seeking permission to appeal against Hayden J's order. At the hearing before us, however, VB attended alongside VK and their sister MA attended via video link from her home abroad. We allowed all three siblings to address the court in support of the application. Unsurprisingly, there was considerable overlap between their addresses but for my part I found it extremely helpful to have the opportunity to hear from three members of VA's family.

30. In her grounds of appeal and in her written and oral submissions, VK focused on her criticisms of the fairness of the process. She contended that the Trust's actions had infringed her mother's rights under ECHR, in particular Articles 2, 6 and 8, and her own rights, in particular under Article 6. She said that the Trust had failed to follow the proper procedure when initiating the proceedings by failing to give family members sufficient notice. She asked the Court to discharge the orders dated 5 July and 25 August; to direct the discharge of the DNR notice, and to direct a fresh independent investigation of VA's care and treatment so that a new care plan could be created in her best interests. VK has also filed an application for the discharge of the Official Solicitor as litigation friend on the grounds that this function should be carried out by a family member. She has also applied to be appointed her mother's deputy. VK submitted that she and other members of her family had not been given an opportunity to ask questions of the treating team and had not been consulted properly about their mother's treatment. Like her brother and sister, she was opposed to the proposal that her mother be extubated.

31. In her written and oral submissions, MA stated that no clear reasons or valid arguments had been provided for varying the decision by Morgan J that her mother should undergo a tracheostomy. That decision had been taken after the family meeting on 3 July which MA had attended in person. MA said that prior to her arrival in this country to attend the meeting, the Trust had failed to engage with the family and that on arrival here she found her siblings "broken and exhausted". MA told this Court that at that stage all family members, including her other sister AA, had been in agreement with this course. She criticised the decision of the Trust to cast doubt as to the family's view about their mother's wishes on the basis of a subsequent conversation with AA on the ward which was never reconsidered at or endorsed by a family meeting. The agreement reached at the family meeting on 3 July had not included any agreement about the DNR notice or as to the question of whether VA should be readmitted to the ICU in the event of subsequent deterioration in her condition. But in MA's view, the most important point was that her mother should undergo the tracheostomy and not be extubated.

32. MA raises some specific points about the treatment proposed:

> "The process of extubation as described in court on 24 August 2023 does not align with the dignified, peaceful passing our

> Mother would wish for. Our Mother has a weak cough and heavy secretions. Extubation will not allow the deep suctioning our Mother requires. The removal of the endotracheal tube will result in a complete loss of airway support and the heavy secretions will block her airways. The suggestion by the medical team was medication to reduce secretions and if unsuccessful, attempts could be made to suction by placing a tube into the mouth and down the throat. This method sounds painful and invasive. It is possible our Mother could suffer for an unspecified amount of time struggling for oxygen. Our Mother will not be able to communicate her pain levels and whether or not comfort medications are providing sufficient relief. She could also suffer the indignity of repeated, invasive attempts to push instruments down her throat to remove secretions. It is respectfully argued that the order for extubation in our mother's case, with her specific condition and challenges has placed too much emphasis on expediting death (due to the perceived poor quality of life) and not enough focus on the actual mode by which death may occur. It is unlikely that the process of extubation will allow the dignified, peaceful passing our Mother would wish for."

33. MA expressed the hope that a resolution based on common ground between the parties could still be achieved, noting that the hospital team remained willing to carry out the tracheostomy if that course was authorised by the court.

34. In his submissions, VB reiterated the points made by MA about the disadvantages and risks of extubation, in particular the difficulties that would arise with the management of secretions. He added that the clinical team treating his mother had noted her tendency to bite down on the tube, risking damage to her teeth and hindering their ability to manage secretions efficiently. These difficulties would not arise if a tracheostomy was performed. VB also expressed concern about the consequences of removing the ventilator, fearing that this would lead to a rapid deterioration in his mother's condition. In his view, extubation would deprive his mother of peace and dignity in the final period of her life.

35. VB made a number of other criticisms relating to the earlier stages of VA's admission to hospital. He told this Court that there remained a number of unanswered questions as to how and why she had suffered a deterioration in her condition. He also corroborated the arguments put forward by his sister that the Trust had not provided the family a sufficient opportunity to discuss the various options.

Discission and conclusion

36. Three preliminary points must be made at the outset.

37. First, no one reading the written submissions filed by VA's three children, or hearing their highly articulate addresses to this Court, could doubt the sincerity of their views or the deep pain and distress they feel about what has happened to their mother. Equally, there is nothing in the documents filed with this Court to give rise to any concern about the professionalism and dedication of the hospital staff responsible for VA's treatment.

38. Secondly, although in her appeal notice VK seeks permission to appeal against the order dated 5 July as well as the order dated 25 August, in reality the former order was superseded by the latter order. Although the former order has not expressly been set aside, it has no legal force and there would therefore be no purpose in granting permission to appeal against it. The issue for this Court is whether to grant permission to appeal against the order of 25 August and, if we do, whether to allow the appeal. In the event of the appeal succeeding, the issues would have to be remitted for a re-hearing at which all issues would be considered, including the terms of the "ceiling of care" plan

39. Thirdly, the family's complaints and criticisms were in a number of respects directed at matters lying outside the scope of this application. The focus of the proposed appeal is on the judge's decision and whether it was wrong or unjust because of a procedural irregularity. Arguments raised by the appellant and her siblings relating to the causes of their mother's collapse, the subsequent deterioration in her condition after admission to hospital, the appointment of the Official Solicitor as litigation friend, and the question of whether VK should be appointed as her mother's deputy lie outside the ambit of any appeal against Hayden J's order and are not matters within this Court's jurisdiction.

40. Furthermore, complaints about the Trust's failure to engage with the family do not give rise to a ground of appeal against the order. The complexity of the issues involved and the grave consequences of the decision to be taken plainly required that every effort be made to engage with the family. The Trust strongly refutes the suggestion that it failed to engage with the family in an attempt to identify what course lay in VA's best interests. In the course of the hearing before us, Mr Parishil Patel KC drew attention to a chronology in the bundle which illustrated the efforts made by hospital staff to engage with the family. The family members reject these assertions and insist that the efforts made by the Trust were insufficient. As Mr Patel conceded, the deterioration in relations between the Trust and the family is deeply regrettable.

41. This Court is in no position to resolve this aspect of the dispute between the parties and it is unnecessary to do so for the purposes of this appeal. Whatever shortcomings there may or may not have been in the hospital's efforts to engage with the family, there can be no doubt about the opportunities afforded to the family by the courts. There is no merit in VK's assertion that the Trust failed to follow proper procedure in initiating the proceedings. Whatever may or may not have happened prior to the proceedings, the documents filed with the court and disclosed to the family in the course of the proceedings provided a comprehensive picture of VA's condition and full details of all matters relevant to the best interests decision. The reason why successive judges have agreed to reopen the decisions recorded in Morgan J's order was because of the family's assertions that its terms do not reflect what the family had agreed. It is clear from the transcript of his judgment delivered on 25 August that Hayden J gave the family members a fair opportunity to present their case and conducted a characteristically careful and sensitive analysis of the family's evidence. I therefore reject VK's assertion that there has been any breach of human rights so as to invalidate the court's decision.

42. There are three aspects of Hayden J's judgment which to my mind justified review by this Court. First, it is striking that, within seven weeks of a court order made by consent authorising the carrying out of a tracheostomy in preference to extubation, another judge reached the opposite conclusion. Secondly, it seemed to me at least arguable, on a preliminary reading of what is a relatively brief judgment, that the judge did not carry

out a sufficiently thorough analysis of the benefits and disadvantages of the two options. Thirdly, it also seemed to me at least arguable, on an initial reading of the judgment, that the judge's assessment of VA's wishes and feelings fell short of what was required. Admittedly, none of the family members who addressed the court articulated their criticism of the decision in precisely those terms, although they underlie points made by the family, in particular by MA.

43. Having now heard full argument, however, I have reached the clear conclusion that none of these concerns stands up to scrutiny so as to give rise to a meritorious ground of appeal.

44. The evidence before the judge clearly demonstrated that, prior to the family meeting on 3 July, the view of the medical team was that, on clinical grounds, extubation would be the better option in VA's best interests, having regard to her very profound disorders of consciousness. After that meeting, however, having been presented with an apparent consensus amongst the family members that VA would have wished to undergo a tracheostomy, the Trust accepted that the overall best interests analysis favoured that option and therefore agreed the terms of the order approved by the court on 5 July. Immediately after that hearing, however, VK challenged the order and, as clarified following subsequent case management decisions, her challenge was not confined to the "ceiling of care" elements in the care and treatment plan (i.e. the DNR notice and the provision relating to further admission to the ICU) but extended to all five of the recitals A to E in the order, including, in recital A, the assertion that all members of the family were agreed that tracheostomy and the insertion of a PEG tube was what VA would have wanted and was in her best interests.

45. In the light of the challenge to the order made by VK, and comments made by AA, the Trust reached the view that there was no clarity as to what VA's wishes and feelings would be. In those circumstances, the Trust concluded that the best interests analysis favoured extubation rather than tracheostomy. In short, that was a material difference between the case as presented at the uncontested hearing before Morgan J on 5 July and the case presented at the contested hearing before Hayden J on 24 August. Hayden J was not bound by the earlier decision and reached his conclusion on the totality of the evidence put before him.

46. On behalf of the Official Solicitor, Ms Claire Watson KC persuasively demonstrated that the judge's analysis of the comparative advantages and disadvantages of the two options in paragraphs 21 to 23 of the judgment, albeit succinct, was sufficient in the circumstances. The circumstances were that VA is "at the lowest end of the spectrum of a profound disorder of consciousness" and, as the judge observed on more than one point, is dying. He accepted the assessment of the treating doctors that a clinical analysis favoured extubation. The issue for the judge, as had been the case throughout the proceedings, was whether, in the ultimate best interests analysis, that clinical evaluation was outweighed by clear evidence of VA's wishes and feelings.

47. The judge addressed this final issue at paragraphs 41 to 45 of his judgment. Again, it is succinct but, in my view, sufficient. He reached the following conclusions:

    (1) All three siblings – VK, MA and VB – had struggled to engage with the challenge of wondering what their mother's wishes would be in this situation.

(2) VA never spoke about this matter.

(3) None of the evidence provided secure ground to establish what she would have wanted.

(4) There was not sufficiently clear evidence that VA would have preferred a tracheostomy to justify the invasive and burdensome consequences that treatment would entail.

(5) The evidence demonstrated that VA valued her independence and privacy. Extubation and a focus on palliative care would provide her with the opportunity of dying with relative privacy and peace.

48. In my view, this was a sensitive, insightful and fair analysis of the evidence about VA's wishes and feelings. Overall, the judge carried out a succinct but sufficient analysis of VA's best interests.

49. The matters set out at paragraph 42 above are sufficient, in my view, to justify granting permission to appeal. But, having considered the judgment carefully in the light of the submissions advanced by all parties, I find that there is no basis upon which this Court could properly say that the judge's decision was wrong. Accordingly, the appellant is granted permission to appeal but her appeal is dismissed.

50. Two consequential matters arise. First, as noted above, the Trust indicated in the skeleton argument filed on its behalf that, in the event of the application for permission to appeal being refused, or the appeal being dismissed, it would seek an order for costs against the appellant. At the hearing, Mr Patel confirmed that to be the Trust's position, although he pointed out that the fact that an order was made did not mean that it would be enforced, thereby hinting that, in the event that such an order was made here, the Trust might refrain from enforcing it against the appellant. On behalf of the Official Solicitor, Ms Watson indicated that she did not support the making of a costs order against the appellant. After discussion, the Court informed the parties that, whatever the outcome of the appeal, there would be no order as to costs (save for the usual provision that the Trust should pay 50% of the Official Solicitor's costs). My reasons for agreeing to this course were as follows.

51. Rule 19.3 of the Court of Protection Rules 2017 provide that, "where the proceedings concern P's personal welfare the general rule is that there will be no order as to the costs of the proceedings". Rule 19.4(1) permits the court to depart from the general rule if the circumstances so justify, adding that "in deciding whether departure is justified the court will have regard to all the circumstances including (a) the conduct of the parties; (b) whether a party has succeeded on part of that party's case, even if not wholly successful, and (c) the role of the public body involved in the proceedings". The Court of Protection Rules do not, however, apply to appeals to this Court from the Court of Protection. Such appeals are governed by Part 44 of the Civil Procedure Rules.

52. CPR rule 44.2, headed "Court's Discretion as to costs", provide, so far as relevant:

> "The court has discretion as to
>
> (a) whether costs are payable by one party to another;

(b) the amount of those costs; and

(c) when they are to be paid.

If the court decides to make an order about costs –

(a) the general rule is that an unsuccessful party will be ordered to pay the costs of the successful party; but

(b) the court may make a different order.

The general rule does not apply to the following proceedings –

(a) proceedings in the Court of Appeal on an application or appeal made in connection with proceedings in the Family Division;

(b) proceedings in the Court of Appeal from a judgment, direction, decision or order given or made in probate proceedings or family proceedings.

In deciding what order (if any) to make about costs, the court will have regard to all the circumstances, including –

(a) the conduct of all the parties;

(b) whether a party has succeeded on part of its case, even if that party has not been wholly successful; and

(c) any admissible offer to settle made by a party ….

The conduct of the parties includes

(a) conduct before, as well as during, the proceedings ….

(b) whether it was reasonable for a party to raise, pursue, or contest a particular allegation or issue;

(c) the manner in which a party has pursued or defended its case or a particular allegation or issue; and

(d) whether a claimant who has succeeded in the claim, in whole or in part, exaggerated its claim."

53. My reasons for concluding that there should be no order as to costs fall into two categories – general reasons applicable to such cases and specific reasons relating to this particular case.

54. For many years, the general practice in proceedings relating to children has been to make no order as to costs save in exceptional circumstances, for example, as identified by Wilson J (as he then was) in *Sutton London Borough Council v Davis (No 2*) [1994] 2 FLR 569 where "the conduct of a party has been reprehensible or the party's stance

has been beyond the band of what is reasonable". This applies to the costs of an appeal as well as to costs at first instance, although the application of the principle may be different. As Baroness Hale of Richmond observed in in *Re S* [2015] UKSC 20 at paragraph 29:

> "Nor in my view is it a good reason to depart from the general principle that this was an appeal rather than a first instance trial. Once again, the fact that it is an appeal rather than a trial may be relevant to whether or not a party has behaved reasonably in relation to the litigation. As Wall LJ pointed out in *EM v SW, In re M (A Child)* [2009] EWCA Civ 311, there are differences between trials and appeals. At first instance, 'nobody knows what the judge is going to find' (paragraph 23), whereas on appeal the factual findings are known. Not only that, the judge's reasons are known. Both parties have an opportunity to 'take stock' and consider whether they should proceed to advance or resist an appeal and to negotiate on the basis of what they now know. So it may well be that conduct which was reasonable at first instance is no longer reasonable on appeal. But in my view that does not alter the principles to be applied: it merely alters the application of those principles to the circumstances of the case."

55. This case is about an incapacitated adult, not a child. Accordingly, the express exclusion of the "general rule" that costs follow the event, which applies in family appeals to this Court under rule 44.2(3), does not apply. But the jurisdiction exercised by the Court of Protection in proceedings relating to P's welfare is akin to the jurisdiction relating to children in family proceedings. In children's proceedings, under s.1 of the Children Act 1989, the welfare of the child is the paramount consideration. In proceedings in the Court of Protection, under s.1(4) of the Mental Capacity Act 2005, any act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in her best interests Accordingly, for my part I would anticipate that, save in exceptional circumstances, there will usually be no order for costs of an appeal against a decision relating to P's personal welfare.

56. On the specific facts of this case, it was manifestly appropriate to make no order for costs against the appellant, because (1) the issue involved was of the utmost gravity and importance to VA and her family; (2) there was nothing in the conduct of the appellant or her siblings to warrant any such order; (3) it was not unreasonable of them to pursue their case that a tracheostomy was in their mother's best interests; (4) whatever difficulties may have arisen in their relations with the Trust, there was nothing inappropriate in the way in which they pursued their case – on the contrary, they presented their arguments in a helpful and articulate manner; (5) there was sufficient merit in their case to lead me to conclude that this Court should grant permission to appeal, although ultimately for the reasons set out above I reached the firm conclusion that the appeal should be dismissed.

57. For those general and specific reasons, I concluded that there should be no order for costs against the appellant.

58. The second consequential issue is the question of a further appeal.

59. The appellant may apply for permission to appeal to the Supreme Court. Under rule 10(2) of the Supreme Court Rules, any application for permission to appeal to the Supreme Court must first be made to "court below" which in this case means the Court of Appeal. If the court below refuses permission, the appellant may then apply for permission to the Supreme Court itself in accordance with rule 11 of the Supreme Court Rules.

60. As in all cases involving serious medical treatment, it is essential for the patient that any such application must be made very promptly. At the same time, I bear in mind that the appellant is a litigant in person. I would therefore direct that, if the appellant wishes to appeal to the Supreme Court, she should send to the Court of Appeal Office an email setting out in brief terms her grounds of appeal. That email should be sent within seven days i.e. by 4pm on 20 October 2023. Meanwhile, I propose that paragraph 2 of the order of 25 August 2023 authorising the extubation be stayed for the same period i.e. until 4pm on 20 October 2023.

61. If such an application is made, this Court will consider it immediately. If we refuse permission to appeal, the appellant would be entitled to apply to the Supreme Court. It is likely that we would then extend the stay for a further few days to allow her a fair opportunity to do so.

62. In my judgment, this timetable would strike a fair balance between VA's best interests and the rights of VK as a litigant in person.

LORD JUSTICE LEWIS

63. I agree.

LORD JUSTICE WILLIAM DAVIS

64. I also agree.