This judgment was delivered in private. 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 the family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Neutral Citation Number: [2024] EWHC 1288 (Fam)

Case No: FD24F00033

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27 May 2024

Before :

MR JUSTICE PEEL

- -

Between :

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	**Applicant**
- and -	
The Mother of G	**Respondent**

- -
- -

Oliver Lewis for the **Applicant**
The Respondent in person

Hearing date: 24 May 2024

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 27 May 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE PEEL

Mr Justice Peel :

Introduction

1. The application before me, dated 17 May 2024, is brought by the Hospital Trust ("the Trust") for a declaration pursuant to the inherent jurisdiction that an adult woman to whom I shall refer as G died on 15 May 2024 at 13.30, and for authorisation to cease provision of all current medical support.

2. This is a tragic case. The sudden and wholly unexpected death of G has been the most appalling shock for the family. The grief and bewilderment of G's mother (the Respondent to the application) is obvious. These events are very recent and very raw. I have nothing but the profoundest sympathy for them.

3. On 14 April 2024, G, aged 36, was transferred by ambulance to the Trust's Emergency department after ingesting 1.5 to 2 litres of engine coolant containing a lethal dose of ethylene glycol at home some 14 hours earlier. She presented with a Glasgow Coma Score of 4 (3 being the lowest and 15 the highest). She had low oxygen levels, an unstable cardiac rhythm and was experiencing multiple seizures. She was treated with anticonvulsants, intubated and taken to the ICU where she received multi-organ support. She is fully dependent on a mechanical ventilator. Her organs continue to be mechanically supported, but this is treatment which maintains them rather than sustaining life.

4. On 15 April 2024, it was noted that G's pupils were fixed and unresponsive. A CT head scan revealed brain swelling and compression. The neurosurgical opinion was that there was no possibility of viable surgical intervention.

5. On 16 April 2024, G's pupils remained fixed and dilated. Sedation was stopped. She had no cough, gag or corneal reflex. Her family were informed that all tests suggested she had died, but at that time it was not possible to carry out brain stem testing due to high oxygen requirements precluding the apnoea part of the testing procedure.

6. On 18 April 2024, an electroencephalogram showed no electrical activity in the brain. A further CT head scan showed complete loss of grey-white matter differentiation. All neurological criteria continued to point to diagnosis of death.

7. On 19 April 2024, some of the tests set out in the Code of Practice for the Diagnosis and Confirmation of Death produced by the Academy of Medical Royal Colleges (2008) ("the Code of Practice") were carried out, but not all; hypoxia continued to prevent completion of the apnoea test. The absence of brain stem reflexes was noted in all the tests which were carried out.

8. On 23 April 2024, a clinical discussion took place which indicated that it would not be possible to declare death without an apnoea test.

9. On 30 April 2024, a second opinion was sought from an Intensive Care Medicine and Anaesthesia Consultant at another Hospital Trust, who said that in his view, if apnoea

testing were possible, it was extremely likely that G would meet the neurological criteria for death.

10. Throughout this time, the Trust had repeated conversations with family members, setting out the clinical opinion that G had suffered a devastating brain injury and probably already fulfilled the criteria for diagnosing death, but the absence of an apnoea test meant it could not be confirmed. G continued to be fully mechanically supported and cared for.

11. At a best interests meeting on 7 May 2024, the future care of G was discussed with the family, including the options of continuing or withdrawing the mechanical support. In the event of dispute, the matter would be referred to court.

12. On 15 May 2024, formal brain stem testing, including the apnoea test which by then could be carried out because her hypoxia had sufficiently stabilised, was performed by two qualified consultants in accordance with the Code of Practice. The testing was observed by G's brother and 2 sisters, and by G's mother for part thereof. The first set of tests began at 13.00 and fulfilled all the criteria for declaration of death by neurological criteria. There was clear evidence of irreversible brain damage, no red flags identified as potential confounders and no potentially reversible causes. G's time of death was recorded as being 13.30, which is when the first set of tests concluded. At 14.00 the second set of tests was carried out which confirmed the findings. That day, the Clinical Ethics Advisory Group reviewed the case and confirmed their agreement that G had been certified dead by appropriate methods.

13. On 15 and 16 May 2024, the clinical team discussed the outcome of the brain stem testing with the family, including G's mother. Her view was, and remains, that G needs more time and might recover.

14. The unanimous view of the ICU consultant body is that G is dead by neurological criteria in accordance with the Code of Practice. She has an irreversible cessation of brain stem function, a permanent absence of consciousness and an irreversible loss of capacity to breathe independently. The Trust proposes that mechanical support should be withdrawn within 24 to 48 hours, allowing the family time to prepare, visit and, if they wish, be present for the withdrawal of support.

Application for an adjournment

15. The application was listed before me at 2pm on Thursday 23 May 2024. G's mother, and three of G's siblings, attended remotely. G's mother applied for an adjournment of 3 to 4 weeks. Having heard submissions, I decided to adjourn until 10.30am the following morning (i.e. 24 May 2024) for the following reasons:

    i) G's mother has known since 16 April 2024 that the clinical view is that G is dead, as confirmed by a number of tests and assessments leading up to the brain stem testing on 15 May 2024. She, and the family, have been aware since at least the best interests meeting on 7 May 2024 that in the event of a dispute between the Trust and the parents, an application would be made to court. She has been kept informed of the clinical assessments throughout. She was served with the application on 17 May 2024. As was apparent during the hearing, she is well informed about the medical circumstances, and fully understands the Trust's

case about the conclusions of the brain stem testing. In general terms she has been aware of the Trust's case for some time, and has had the opportunity to consider it, take medical advice of her own, secure legal representation and formulate her response.

ii) On the face of it, she was unable to advance anything to challenge or undermine the Trust's case that G is brain stem dead, or the process by which that conclusion was reached.

iii) In short, there was no obvious lacuna in the evidence, or any need for further specific inquiry. A lengthy delay would have served no purpose.

iv) However, although she was fully aware of the application, it became apparent that she had not seen the position statement prepared on behalf of the Trust, and did not have the relatively small bundle. In the circumstances, I considered it appropriate to grant a short adjournment to enable her to better prepare for the hearing.

16. As I said to the parties when I granted the short adjournment, it seemed to me that the proper course was to hear the evidence and submissions the next day, and to decide at the conclusion of the hearing whether to adjourn for further inquiries.

17. In the event, having now heard the case, I do not consider there is any need for a further adjournment. The evidence is clear. Nothing suggests that (i) the brain stem tests were not carried out in accordance with proper procedure, or (ii) the conclusions of the brain stem tests are wrong or (iii) there is the slightest doubt that she is, in neurological terms and by reference to the brain stem testing criteria, dead. Tragic though this is for the family, it is the inevitable conclusion.

The evidence and submissions before me

18. I read the bundle. I had a witness statement from a Consultant in Intensive Care and Acute Medicine, who is a member of the clinical team and one of the doctors who undertook the brain stem testing. He gave oral evidence. He was convincing in what he told me, and I unreservedly accept his testimony.

19. G's mother was understandably anxious and distressed. However, she was able to ask detailed, well-informed questions of the doctor. Other family members, although not parties to the proceedings, also joined the hearing, which was conducted by MS Teams, and were able to ask questions and make points. There is no doubt that this has been extremely painful for them all.

20. I am satisfied that I have more than enough material to adjudicate fairly upon the case.

This judgment

21. At the conclusion of the hearing on Friday 24 May 2024, I reserved judgment and indicated my intention to send out a draft the following day. That draft, sent during the morning of Saturday 25 May 2024, set out my decision and reasons before finalisation and formal hand down on Monday 27 May 2024.

The Law

22. I have had regard to, inter alia, **Barts Health NHS Trust v Dance & Ors (Re Archie Battersbee) [2022] EWCA Civ 935**, **St George's University Hospitals NHS Foundation Trust v Casey [2023] EWHC 2244 (Fam)** and **St George's Hospital NHS Foundation Trust v Andy Casey and others [2023] EWCA Civ 1092**.

23. From these authorities I derive the following principles:

i) There is no statutory definition of death.

ii) In **Airedale NHS v Bland [1993] AC 789** the House of Lords accepted the validity of a medical diagnosis of death arising from an irreversible absence of brain stem function. As Lord Keith stated at p.856:

"In the eyes of the medical world and of the law a person is not clinically dead so long as the brain stem retains its function".

iii) The rationale for the absence of brain stem reflexes being the criteria for death is explained in Appendix 5 of the Code of Practice:

"The brain stem controls all the essential functions that keep us alive, most importantly our consciousness/awareness, our ability to breathe and the regulation of our heart and blood pressure. Once the brain stem has died it cannot recover and no treatment can reverse this. Inevitably the heart will stop beating; even if breathing is supported by a machine (ventilator)".

iv) The clinical definition of death in s2 of the Code of Practice is as follows:

"Death entails the irreversible loss of those essential characteristics which are necessary to the existence of a living human person and, thus, the definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe. This may be secondary to a wide range of underlying problems in the body, for example, cardiac arrest"; and

"The irreversible cessation of brain stem function whether induced by intra-cranial events or the result of extra-cranial phenomena, such as hypoxia, will produce this clinical state and therefore irreversible cessation of the integrative function of the brain stem equates with the death of the individual and allows the medical practitioner to diagnose death."

v) Once brain stem testing has been administered, and where that test has indicated that a person has died by reference to the criteria set out in the 2008 Code of Practice, if that outcome is the subject of a dispute the case becomes one to be decided in the Family Division under the inherent jurisdiction of the High Court.

vi) In those circumstances, if there is a dispute about death, the narrow (but vital) issue for the court is whether the person has died.

vii) If the court determines that the subject of the application is not brain stem dead, then it will proceed to a best interests decision either in the Court of Protection (for an adult who lacks capacity) or in the Family Division (for a child).

viii) If, by contrast, the court determines and declares that the subject is dead, the question of best interests is not relevant (**Re M (Declaration of Death of Child) [2020] EWCA Civ 164** at para 24). The court can proceed to make a declaration of death, and that withdrawal of medical intervention is lawful.

ix) The standard of proof in determining whether the subject of the application is dead is on the ordinary civil basis: para 30 of **St George's Hospital NHS Foundation Trust v Andy Casey and others [2023] EWCA Civ 1092**.

Procedure

24. At para 61 of **St George's University Hospitals NHS Foundation Trust v Casey [2023] EWHC 2244 (Fam)**, MacDonald J made some comments about the procedure to be adopted in applications for declaration of death pursuant to brain stem testing. To those I offer the following additional observations:

i) The application (or claim) is brought under the Part 8 procedure set out in the Civil Procedure Rules where the claimant (usually the Hospital Trust) seeks the court's decision "on a question which is unlikely to involve a substantial dispute of fact" (CPR 8.1(2).

ii) Usually, where brain stem testing has been carried out, there will be no substantial dispute of fact. Hence, the Part 8 procedure is appropriate for cases of this nature.

iii) Under the rules, the claimant must file witness evidence with the claim form (CPR 8.5(1). In cases of this nature, that will ordinarily be one or more statements from clinicians. It is hard to conceive of any good reason why witness evidence should not be filed in accordance with this rule to set out the procedure and conclusions of the brain stem testing; after all, the case must be proved by the claimant.

iv) The rules also provide for an acknowledgment of service by the defendant within 14 days of service of the claim form (CPR 8.3(1)(a)), which should be accompanied by any written evidence upon which the defendant seeks to rely (CPR 8.5(3). There are then provisions for the claimant to file evidence in reply (CPR 8.5(6)).

v) In my judgment, the strict application of these rules is unlikely to be appropriate, save, as I have suggested at iii) above, in respect of the obligation on the Hospital Trust to file evidence with the claim form. Applications for declarations of death by reason of brain stem testing are usually urgent in the sense that it is unreasonable to wait any length of time for determination of such sensitive matters. Absent legitimate reasons for questioning the validity of the tests and their conclusions, the court is likely to feel able to proceed to an expedited hearing, with a foreshortened timetable, requiring the defendant's evidence to be produced in very short order, or perhaps dispensing with the need for formal

evidence from the defendant altogether. This seems to me to be legitimate, and consistent with the overriding objective in Part 1 of the CPR, in circumstances where the evidence in respect of brain stem testing is, or appears to be, incontrovertible. It will, however, all depend on the facts of the case. I do not for one moment suggest that an expedited hearing will always be appropriate, but in my view it is likely to be so where there is no realistic basis advanced for challenging the testing procedures or conclusions.

Conclusion

25. There is nothing before me to suggest that the brain stem tests were not conducted rigorously in accordance with the Code of Practice. The conclusions of both tests were identical, and the medical practitioners were entitled to make a diagnosis of death. No other clinical tests have given any cause to think that the results of the brain stem tests are wrong, or that there is a reversible cause, or that clinical intervention will achieve a different outcome. The Trust has sought second opinions, and the unanimity of the clinical evidence is clear. G is, very sadly, dead; there are no reversible causes and there are no neurosurgical treatment options.

26. The position of the family, in particular G's mother, is understandable but sadly futile. Many of the points raised, including complaints about aspects of treatment, had little or nothing to do with the brain stem testing. The family referred to a terrible incident in 2010 when G was critically ill in a coma, from which thankfully she recovered, but she was not pronounced dead in accordance with the brain stem test criteria and that recovery is not, to my mind, a justification for disputing the present diagnosis. Had she in fact been brain stem dead, as the clinician told me, she would not have recovered. G's mother put forward an article to support a submission that the Code of Practice is not valid in that it is not a proper indicator of death. Essentially, she challenged the medical and legal definitions of death, but given the established authorities to which I have referred, and the contents of the Code of Practice, which govern both the medical and legal approach, that is not a sustainable argument. G's mother also mentioned that when she massaged G's feet, there were reflexes in the legs and feet, but the clinician explained that is not unusual even when a person is declared dead by reference to brain stem testing because separate spinal reflexes, travelling down to the feet, can continue; they are not a marker of life in neurological terms.

27. G's mother opposes the application. None of the five siblings of G who joined the hearing indicated they opposed a legal finding of death by reference to the brain stem testing.

28. As I have already indicated, I am satisfied that there would be no purpose in further adjourning the case, and it is appropriate to proceed to a conclusion, dispensing, so far as necessary, with the provisions of Part 8. There is no relevant gap in the evidence which needs filling. The brain stem tests were carried out in accordance with the Code of Practice and there is nothing to suggest that any further inquiry would reach a different conclusion. To allow more time in the hope of a miracle has no clinical justification. The family's wish to retain a vestige of hope is beyond reproach, but it has no clinical or other foundation.

29. In my judgment, the evidence is overwhelming. I am satisfied that the Trust has established its case that G died at 13.30 on 15 May 2024. I shall so declare, and I shall

further authorise withdrawal of mechanical ventilation and medical support. However, in my judgment such withdrawal shall not take place before 4pm on Monday 27 May 2024, which give the family a little more time to process this tragic event.