



Neutral Citation Number: [2025] EWCOP 36 (T3)

Case No: COP20023006

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21 October 2025

Before:

MRS JUSTICE THEIS DBE
VICE PRESIDENT OF THE COURT OF PROTECTION

Between:

A London NHS Trust

Applicant

- and -

**(1) DT (By her litigation friend, the Official
Solicitor)**

Respondents

(2) YT

Katie Gollop KC (instructed by **Kennedys Law LLP**) for the **Applicant**
Claire Watson KC (instructed by the **Official Solicitor**) for the **First Respondent**
Victoria Butler-Cole KC (instructed by **Bindmans LLP**) for the **Second Respondent**

Hearing date: 17th October 2025
Judgment date: 21st October 2025

Approved Judgment

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This judgment was delivered in public but a transparency order dated **17 October 2025** is in force. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of DT must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

Introduction

1. The court is concerned with decisions relating to DT, age 42 years, that have arisen in tragic circumstances. Prior to 23 August 2025 DT was a healthy, vivacious, dynamic and much loved member of the X family and her wide circle of friends. She arrived at Y airport in Country Z, where she had travelled for a trip she was very much looking forward to. DT collapsed at the airport on arrival after reporting feeling unwell during the flight. DT never recovered consciousness, she was admitted to hospital there and was then transferred by her family to a hospital here in September 2025. Following tests and observations the clinical team looking after DT in London believe she is brain stem dead. The clinical team consider it necessary to establish diagnosis and confirmation of death by brain stem testing performed according to the *Academy of Medical Royal Colleges 2025 Code of Practice for the Diagnosis and Confirmation of Death* (“the 2025 Code”).
2. DT’s family are profoundly and deeply shocked by everything that has happened. They do not agree to the brain stem tests being undertaken here, they wish to fly DT to a hospital in Country W that can undertake such tests and withdraw treatment. The family have provided evidence from a hospital that can receive DT and has confirmed they can undertake the necessary tests. DT’s family stress the strong connection DT has with Country W. She was born and brought up there, has been based back there for the last 10 years, all her family live there and, in accordance with her religious and cultural beliefs, the rituals following death require burial within a very short period following death. There is detailed evidence from DT’s older sister, YT, that sets this out. The family position is supported by DT’s litigation friend, the Official Solicitor
3. These proceedings were issued on 8 October 2025, The President of the Family Division, Sir Andrew McFarlane, made directions at a hearing on 9 October 2025 listing the matter today. The court has heard oral evidence from Dr B, one of the clinical intensivists caring for DT and YT, DT’s older sister.
4. I announced my decision at the conclusion of the hearing on 17 October 2025 that it was in DT’s best interests to be transferred to Country W for brain stem testing to be undertaken. This judgment sets out the reasons why I reached that conclusion.

Background

5. The essential background is not in dispute.
6. Prior to DT’s collapse at the airport in August 2025 she was well and healthy. She had felt unwell during the long haul flight to Country Z. On arrival she was seen by the medical team and found to have a depressed level of consciousness. Whilst being taken to hospital she had a cardiac arrest and was resuscitated after a prolonged period. She had another arrest and was started on mechanical ventilation and placed on Extracorporeal Membrane Oxygenation (ECMO). There followed further arrests and she was further resuscitated. DT experienced no flow and no flow states during which there was no, or critically reduced, blood flow to vital organs including the brain.
7. On assessment at the hospital DT was found to be unresponsive and her pupils were non-reactive to light. She had a CT pulmonary angiogram which detected multiple acute pulmonary emboli. The working assumption since is that pulmonary emboli were the cause of the arrests and all the damage that flowed from that. A CT scan of the brain showed hypoxic-ischaemic brain injury. During her hospital admission in

Country Z, DT did not receive long acting sedative drugs. Her neurological state remained unchanged; she had a Glasgow Coma Score (GCS) of 3, with pupils fixed and non-responsive to light, together with loss of corneal and gag reflexes.

8. DT was flown to the Trust hospital in London at the request of the family in mid-September 2025. Her condition since admission here has remained static and she has not received any sedatives. An EEG showed no convincing cerebral activity. An MRI of the head showed changes consistent with late stage hypoxic ischaemic injury, including brainstem coning. An MRI of the whole spine on 26 September 2025 showed severe brainstem and spinal cord hypoxic-ischaemic insult. A CT angiogram as ancillary testing for diagnosis of death was undertaken on 30 September 2025. DT has remained unresponsive to all stimuli, made no spontaneous movements, no effort at spontaneous breathing, her pupils remain unresponsive to light, she had not coughed on deep suction and gag and corneal responses are absent.
9. On 23 September 2025 Dr D, ICU Consultant, met with the family to discuss the opinion of the treating clinicians that DT is probably brain stem dead and brainstem testing was needed to diagnose and confirm death. In discussions between the clinical team and the family the family proposed a specialist to undertake a second opinion, but neither the hospital nor the family had any success in contacting the person put forward.
10. The Trust sought an internal second opinion on 25 September 2025 from Dr C, Clinical Director for Neuroanaesthesia and Critical Care, who confirmed the conclusions reached by the clinicians.
11. Dr B, ICU Consultant, met with the family for the first time on 29 September 2025. At this meeting he reiterated the clinicians' opinion that there was overwhelming evidence to suggest a diagnosis of death by neurological criteria and raised the need to make an application to the Court of Protection in the event of ongoing disagreement.
12. Dr B met with the family again on 2 October 2025 when he informed them that the clinical conclusion regarding DT remained the same, they had been unable to contact the doctor the family had put forward for a second opinion and they considered the next stage was to make an application to the Court of Protection. The family raised the possibility of DT being transferred to Country W for that testing to be undertaken there. That request was repeated at a further meeting with the family on 6 October 2025.
13. These proceedings were commenced the following day, 7 October 2025.

Legal framework

14. The application made by A London NHS Trust ("the Trust") is to the Court of Protection by way of a COP1 application.
15. As a matter of law DT is not dead. In *St George's University Hospitals NHS Foundation Trust v Casey & Ors* [2023] EWHC 2244 MacDonald J stated at [42] "*where there is a dispute about whether a person has died, until brain stem testing has been administered in accordance with the 2008 Guidelines and indicated a cessation of brain stem function, it is not possible to say, in law, that the person is dead.*" This confirms the position set out by the President of the Family Division, Sir Andrew McFarlane in *M (Declaration of Death of Child)* [2020] EWCA Civ 164 at [24].

16. There is no issue in this case that DT lacks capacity to make any decisions regarding her medical treatment. Consequently, any decision made by this court is governed by what is in her best interests, in accordance with s 4 Mental Capacity Act 2005 (“MCA 2005”):

“1 The principles

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

4 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 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 to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

...

(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

...

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

...

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

(11) “Relevant circumstances” are those—

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

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

17. The question for the court, as articulated by Ms Butler-Cole KC for DT’s family, is whether it is in DT’s best interests to be repatriated to Country W in circumstances where the purpose of her transfer is for brain stem death testing to be carried out and treatment withdrawn or for the tests to be undertaken here.

18. That question needs to be considered in the statutory framework of the MCA 2005 and the MCA 2005 Code of Practice.
19. The relevant caselaw on best interests can be summarised as follows:
- (1) In assessing best interests, the court is not limited to consideration of best medical interests: it encompasses medical, emotional, psychological and social issues. Baroness Hale in *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67 at [39] and [45]. Decision makers must look at welfare [39] ‘...in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question...they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be’. [45] ‘...The purpose of the best interests test is to consider matters from the patient’s point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient’s wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament.’ The court’s task is summarised as follows; it should ‘stand in the shoes of the person who is unable to make the decision’ (N v A CCG [2017] UKSC 22 at [1]).
 - (2) Where it is possible to ascertain with sufficient certainty what P’s views would be, they should generally prevail (*Briggs v Briggs and ors* [2016] EWCOP 53 per Charles J, recently applied in *University College London Hospitals NHS Foundation Trust v PK & Anor* [2025] EWCOP 17 per McKendrick J).
20. The 2025 Code is an important consideration but it is not the law. The 2025 Code has been approved by the Academy of Medical Royal Colleges (the Academy) and makes clear in the Academy statement at the start of the 2025 Code that “*The Code does not [and could not] seek to be a comprehensive statement of clinical and/or legal obligations leading up to and following the death of a person.*”
21. Part 6 of the Code is relevant to the circumstances in this case following a devastating brain injury, but where the circulation is maintained by ongoing mechanical ventilation and other intensive care interventions.
22. At paragraph 6.9 the Code sets out that families should receive an explanation of the tests, the implications of the result and the certainty provided.
23. Paragraph 6.69 addresses “*Managing requests to prevent the application of neurological criteria...*”. The Trust rely on the various meetings with the clinical team and the family that have taken place to date. Paragraph 6.69 continues ‘*We recommend approaching the patient’s family in the usual way that treatment disagreements are managed in intensive care. That is, with respect and compassion, honesty and transparency, listening and seeking to understand, with patience and allowing more time for explanation within the areas of disagreement, and by providing cultural and religious support and second opinions if acceptable to the family...Legal advice should be sought urgently if agreement cannot be reached in a reasonable amount of time and at most within a few days.*”

The evidence

24. The two statements from the consultant intensivists caring for DT set out the clinical evidence since DT's collapse in August. In their first statement dated 7 October 2025 they state that *"In light of all the clinical evidence and investigations to date it is our opinion that [DT] is probably brain stem dead."* In their second statement, dated 15 October 2025, they set out their collective view as follows *"It is our collective professional opinion that unfortunately DT is dead. We do not suspect that; we are certain of it"*. They continue in that statement *"We are deeply sorry to have to say that mechanical ventilation, invasive blood pressure support and the hormonal and other injections and interventions we have continued to provide are supporting her organs but not sustaining DT's life. Those measures do not become life-sustaining simply because the confirmatory tests according to the Code have not been performed and they do not change the fact that she is brain stem dead"*.
25. What they consider is their dilemma by reference to the 2025 Code is set out as follows *"the primary purpose of the Code is to outline the criteria by which death can be diagnosed in an accurate, standardised and timely manner, whatever the circumstances in which death has occurred."* Continuing later *"The Code recommends that the diagnostic criteria are regarded as the authoritative guidance in the UK and says that "This will ensure that all deaths are diagnosed and confirmed in an accurate, standardised and timely manner."* (paragraph 3.7)
26. They go on to state *"The Code does not discuss circumstances where a patient arrives in the UK from overseas with a devastating brain injury with subsequent investigation strongly suggesting that brain stem death has occurred. However, our understanding of the Code is that the fact that the patient is in the UK, and not in their home country, is not a reason not to diagnose and confirm death in an accurate, standardised and timely manner... Our reading of the Code is that it does not give doctors a discretion to bypass the fundamental principles of diagnosing death in an accurate, standardised, timely way by not undertaking the tests to diagnose death and instead facilitate transfer to another country."* Later observing *"It is unclear whether we require consent before we are permitted to diagnose our patients as dead due to neurological criteria."*
27. Although the second statement refers to wider consequences following any decision in this case, in oral evidence Dr B confirmed that this was the first case he was aware of that raised the issue about lack of agreement with the family about brain stem testing being undertaken in the context of the location of such testing. He was vaguely aware of another case, but could give no details. His concern is that there could be an increase in similar requests to that made in this case. His oral evidence expanded on what he considered to be the ethical dilemma the clinicians felt they were in where they held a strong clinical view that DT was dead but were unable to undertake the brain stem testing in a timely way that accorded with the 2025 Code. However, in response to Ms Butler-Cole he accepted that whilst his clinical view was that DT had died that was not the position in law. He agreed the letter from the hospital that will receive DT in Country W had answered all the relevant questions. He confirmed it set out a similar process as would be undertaken here regarding brain stem testing and withdrawal of treatment, although he was not aware of a similar code regarding brain stem testing as there is here in Country W. He said he had no concerns about the hospital in Country W. He also confirmed he did not take any issue with what YT had set out about DT's circumstances, and wishes and feelings.
28. Ms Butler-Cole asked Dr B about what would weigh in the balance against DT going to Country W. It had been directed that the reasons for withholding agreement, which should include the opinion of DT's clinicians about her fitness to fly, should be detailed in the second written statement but it was not. Dr B set out his concerns that

the treatment that DT was currently receiving was not life sustaining and futile due to the clinical view. He confirmed that arrangements could be put in place for her to be handed over to a specialist medical transfer company and they would provide a fitness to fly note to enable that to happen, if that was the court's decision. Dr B outlined the risks involved in such a specialist transfer, including matters such as equipment malfunction. He considered the risks to be higher than when DT was transferred to London because of her deterioration but recognised she remained static. Dr B accepted that there had been no best interest process undertaken at the hospital in respect of the question where brain stem testing should take place, and said the clinical team were unaware of any request about transfer to Country W until 2 October 2025.

29. YT, DT's older sister, has been with DT over the last eight weeks since soon after her initial collapse. In her statement she sets out DT's background and what she considered would inform her wishes and feelings. These included details of her deep connection to Country W through being born and educated there, the untimely death of her father there, her strong religious and cultural connections there, the fact that she had been based back there for the last 10 years and the majority of her family and friends are there. Whilst YT recognised they had not had specific conversations about matters such as are involved in this case, they have discussed where they would want to be if something happened to them and DT would always say she would wish to be in Country W. As YT describes, that reflected DT's strong sense of belonging to Country W. YT sets out that DT is a devoted and active member of a church in Country W and has a designated pastor. She outlines that this particular church practises very specific rites of passage, including at death involving specific timeframes when the burial should take place, within a very limited time following death. This reflects what their mother did for her parents, as well as for their mother's eldest sister who lived in another country and was brought home before she passed away. YT states the reason why they made the decision to bring DT here from Country Z, rather than fly directly to Country W, was due to the length of flights. In the event there was any treatment possible DT would have wished for it to take place in Country W. This was DT's wishes when she had been ill in 2016. YT reports that *"...we are clear as a family what her wishes and values would be – she would want to be flown back to [Country W]. It would be unthinkable to us to go against what she would want, and we have no doubt at all about what that is."* They recognise the risks inherent in such transfer including that she could die during the transfer. In her oral evidence YT stressed the importance for DT to get her to the place she calls home, and be with her family and loved ones. YT anticipates the brain stem testing taking place within 48 hours of DT's arrival in Country W and understood that the specialist medical transfer could take place within a matter of days.
30. YT makes clear in her statement the family do not oppose brain stem testing, recognises and acknowledges the result is a likely diagnosis of brain stem death and all the implications of that.

Submissions

31. The Trust recognise the very difficult and tragic position the family are in. Ms Gollop KC states the clinical team are driven by the situation they find themselves in, where they consider they have a '*parallel truth*' of their clinical assessment of DT's death and being unable to diagnose this in accordance with the 2025 Code, due to the lack of agreement with the family.
32. Ms Gollop submits the legal position is not as clear as submitted by the other parties and is more nuanced, referring to the reality gap between the clinicians' clinical

assessment of death and the diagnosis of death in accordance with the 2025 Code. She referred to this position as '*clinically disempowering*'.

33. Ms Butler Cole emphasised that the legal position is settled. In the absence of agreement being reached regarding brain stem testing under the 2025 Code, the Trust needed undertake a best interest decision. In the absence of agreement regarding best interests the MCA 2005 governed the position. Proceedings in the Court of Protection should be issued for the court to make a decision between the available options that are in the person's best interests.
34. She submits this legal framework aligns itself with the 2025 Code that has been produced by the medical profession so there is consistency regarding diagnosis of death. That is why the Court of Appeal in *Barts Health NHS Trust v Dance* [2022] 4 WLR 83 urged caution to judges being asked to make any declarations outside the 2025 Code.
35. She relies on the fact that Dr B took no issue with the evidence put forward by the family as to DT's wishes and feelings, nor made any challenge to the evidence from the hospital in Country W as to the steps they would take if DT was transferred to their care. As regards other factors to weigh in the balance the issue about continuing treatment that is futile, she submits it is only for a relatively short period of time, a matter of days. On the Trust's own case if brain testing was to be undertaken here they remain willing to transfer DT to Country W, still in receipt of that treatment, which significantly undermines their position about the weight to be attached to the futility of the treatment. Whilst there are inherent risks in the transfer Dr B accepted DT could be transferred safely.
36. Ms Watson KC was equally forthright in her submissions about the clarity of the legal framework for what the court is being asked to decide, it is under the MCA 2005. Whilst she acknowledges the facts are unusual the legal framework, she submits, is not. She submitted the best interest analysis includes DT's current and past wishes, together with her beliefs and values. The Official Solicitor's view is that the evidence points all one way, it is cogent and compelling in establishing the many strong connections DT has with Country W. Whilst she accepts wishes are not determinative in this case, they carry considerable weight in the balancing exercise that the court is required to undertake. She recognises the court needs to weigh in the balance the futility of ongoing treatment but submits it is only a matter of days and DT's position remains static.

Discussion

37. This is a truly tragic set of circumstances for DT's family. The need and circumstances of these proceedings will have added to that. However, as YT stated in evidence, she feels the proceedings have, through her family, given DT a voice.
38. I understand and recognise the very difficult position intensivists can be put in by the very nature of their work, and the many difficult and emotionally challenging conversations each of the clinicians will have had with families during their respective professional careers. However, it is important to remain focussed as to what the applicable legal framework is in what can often be a fast moving, dynamic and demanding situation.
39. In my judgment, the legal framework is clear. As Ms Butler-Cole submitted, the 2025 Code was drawn up by the medical profession to provide a framework for when and how death can be diagnosed in particular circumstances. It was very recently updated in 2025 and makes clear in the Academy statement that "*The Code does not [and*

could not] seek to be a comprehensive statement of clinical and/or legal obligations leading up to and following the death of a person.”

40. A number of cases have set out the legal position (*M (Declaration of Death of a Child)* [2020] EWCA Civ 164 and *St George’s University Hospitals NHS Foundation Trust v Casey & Ors* [2023] EWHC 2244 (Fam)). Prior to the diagnosis of death through the 2025 Code the individual concerned is not dead as a matter of law. The legal consequence is that in the absence of agreement for the tests to be conducted under the 2025 Code, including the arrangements for them, there needs to be an application to the Court of Protection for the issue to be determined in accordance with the person’s best interests.

41. The Court of Appeal made clear in *Barts Health NHS Trust v Dance* [2022] 4 WLR 83 at [31] that once the brain stem test ordered by the trial judge in that case had not taken place:

“At that stage, whilst there was clinical evidence that it was likely that death had occurred, it was clear that it was not going to be possible to establish whether or not death had occurred under the principles established in the Code. Those principles require a brain stem test. As the introduction to the Code confirms: [w]hen as patient is comatose, apnoeic and receiving artificial ventilation of their lungs, the criteria for determining irreversible cessation of brain-stem function will be the irreversible loss of brain-stem reflexes, diagnosed by clinical neurological testing”...

At [33] *“The Code, as its title firmly indicates, governs the “practice for the diagnosis and confirmation of death”. It is wide ranging and aims to cover the diagnosis of death in all situations. Whilst the Code contains an early caveat that “it does not (and could not) seek to provide guidance for every single clinical situation where a doctor is required to diagnose death”, it does contain detailed guidance on the specific task of “the diagnosis of death following irreversible cessation of brain stem function”, That guidance requires a six-stage test sequence to be followed to establish “absence of brain-stem reflexes”.*

The court continued at [35] *“No authority has been produced in which previous judges have declared that death has occurred in an individual whose bodily functioning is being mechanically maintained by a ventilator and where death is said to be established on evidence other than testing undertaken in accordance with the Code, or where the judge does not have any medical witness who has diagnosed death. The course that the judge was invited to follow in the present case was, it seems, unprecedented.”*

42. In the absence of any consensus the 2025 Code provides that legal advice should be sought. The Trust did that and, rightly in my view, issued proceedings in the Court of Protection. As a matter of law, DT had not died and the correct legal structure was to determine the issue where brain stem testing should take place within the Court of Protection, in accordance with DT’s best interests.

43. There is no issue that DT lacks capacity to make the decisions in issue in this application.

44. In her written and oral submissions at the commencement of this hearing, Ms Gollop first sought what she termed a case management determination, for the court to direct brain stem testing here. Then depending on the outcome, the court would know whether these proceedings continued. That was opposed by Ms Butler Cole and Ms Watson. I rejected that submission as the effect of it would be an abdication by the court to determine the issue between the parties as to where that test should be

undertaken. In addition, the Trust put forward what they termed a compromise position, namely that if the brain stem test was undertaken here and the diagnosis was death they would continue DT's existing treatment, which they regarded as not life sustaining and as futile, to enable DT to be transferred to Country W. In exchanges during the hearing I described that position by the Trust as perplexing. Whilst understanding the context in which it was put forward, it seemed to undermine their own case they were presenting.

45. The options the court is faced with are either to permit brain stem testing for DT here or for her to be transferred to Country W, for that testing to be undertaken there.
46. In determining that issue I am guided by what is in DT's best interests.
47. Her wishes, feelings, beliefs and values are an important consideration. Whilst there had not been a direct conversation between DT and her family as to what she would want in this situation, the evidence about the strength of her connection to Country W is compelling. It is where she was born and brought up, where her father died and where she has been based for the last ten years. Tellingly, she returned there to complete treatment for ill health in 2016, putting in practice what she had said she would do when the issue was discussed between her sisters as to where she would want to be in such circumstances. The religious and cultural connection for DT to go to Country W is also strong. YT does not share DT's religious views but was able to articulate what they meant to DT, including the religious and cultural rites around death and following death that are such an important part of DT's heritage. I am satisfied that based on the wide canvas of evidence the court has, in particular the vivid picture of DT provided by her family through YT's statement, that DT's wishes and feelings in this situation is likely to be for her to return to Country W for the brain stem testing to be undertaken there.
48. Weighed in the balance against that are the fact that it is likely to involve DT continuing to receive treatment that is considered futile and the inherent risks in a complex transfer such that she may die in transit. It is not proposed that this transfer is undertaken other than by a specialist resource and the family are fully aware of this risk. As regards the futility of continuing the treatment a curious feature of this case is on the Trust's own case that would continue after the diagnosis of death if the brain stem testing was undertaken here, in order that DT could be transferred to Country W for withdrawal of treatment to take place. These factors are, in my judgment, outweighed by the evidence of DT's wishes, feelings, beliefs and values.
49. Ms Gollop has raised two additional matters. First, the wider implications of this decision in other similar situations. The concern of the clinicians is that this could result in a rise in such requests in similar cases. Dr B is an experienced intensivist and this is the first time this issue has arisen in more than 10 years of being in this role. Whilst there have been generalised references to other situations and the international profile of the patients admitted to hospitals in this Trust there is, in my judgment, no credible evidence that, even if it was a relevant matter, this is a consideration in this case. Second, Ms Gollop submitted there is a risk that this could result in a two tier system, with options only available to those with resources with the risk of pressure for the NHS to fund such requests. That also, in my judgment, lacks substance. In any proceedings in the Court of Protection the court is only required to determine between the options that are available.
50. The final matter that Ms Gollop repeatedly made reference to was the gap between the clinical and the legal position in this case. The answer is that in situations such as this there should be a process undertaken by the clinicians, in accordance with parts 6 and

7 of the 2025 Code. In the event of agreement not being reached a best interest decision needs to be reached by the Trust in accordance with the MCA 2005 Code of Practice. In the absence of agreement about the best interest conclusion reached by the Trust proceedings in the Court of Protection should be issued to determine which of the options are in the person's best interests. There should not be any undue delay, there is likely to be significant cross over between the information gathered in each process and there should be transparency about what is being undertaken. The Court of Protection is well used to dealing with issues such as arose here and can list and determine applications like this without delay.