**THE HIGH COURT**

[2021]_IEHC_318

**[WOC 10410]**

**IN THE MATTER OF C., A WARD OF COURT**

**BETWEEN**

**A.**

**APPLICANT**

**AND**

**PATRICIA HICKEY, COMMITTEE OF THE WARD**
**AND HEALTH SERVICE EXECUTIVE**

**RESPONDENTS**

**JUDGMENT of Ms. Justice Mary Irvine, President of the High Court delivered on the 10th day of May, 2021**

1. This is a profoundly tragic case concerning a young woman who is a ward of court because of devastating brain injuries she sustained following a misadventure of catastrophic proportions some nine years ago. She is in what in medical terms is called a persistent vegetative state. She is artificially fed, and her doctors do not anticipate any possible improvement in her condition.

2. Because the court, at an early stage of the proceedings made an order pursuant to s. 27 of the Civil Law (Miscellaneous Provisions) Act 2008 prohibiting the publication or broadcast of any matter relating to the proceedings which would likely identify the young woman in question as a person with a medical condition, I have prepared two judgments. In this judgment, in order to comply with reporting restrictions, I have referred to the young woman as Katie and I have given her siblings and family different names to their true identities, as I have her general practitioner who I have referred to as Dr Smith. In the second judgment, prepared solely for the benefit of Katie's mother, I have referred to everyone by their true names. Otherwise the judgments are identical.

3. This judgment is the result of an application brought by Katie's mother, seeking the court's permission to terminate the artificial delivery of nutrition and hydration to her daughter so that she can pass away. It is impossible to imagine any application more difficult for a mother to have to bring before a court. Having spent a number of days in court in the presence of Katie's mother and her family, and having heard the evidence of her mother and her sister, Jane, I want to express my sincere admiration for the remarkable strength and fortitude they have shown for so many years in the face of what can only be described as the worst imaginable type of family catastrophe.

**Background**

4. Katie was born in 1993 and is 28 years old. Tragically, on a date in 2011, when she was only eighteen years of age, she suffered irreversible hypoxic/anoxic brain injuries following a major cardiac arrest. Katie was taken to Beaumont Hospital where she was admitted to the Intensive Care Unit ("ICU"). She was put into an induced coma and ventilated. An EEG and an MRI scan were carried out which confirmed the presence of severe brain damage.

5. Although her family and treating doctors anticipated that Katie would pass away when ventilation was withdrawn, this did not occur. She started breathing on her own and her vital functions stabilised such that she could be moved onto a ward. There, it was expected that Katie would likely succumb to a chest infection or an infection from the nasogastric tube that had been inserted to provide her with hydration and nutrition. Again, the doctors underestimated Katie's resilience. Subsequently, Katie's family was informed that the nasogastric tube could no longer remain in place and that a decision would have to be made as to whether a PEG-feeding tube should be inserted or whether Katie should be allowed to pass away following the removal of the nasogastric tube.

6. At the time when Katie's mother was faced with this heart-breaking and vitally important decision, she was led to believe that Katie might feel pain if artificial nutrition and hydration were terminated and, therefore, agreed to a PEG feeding tube being inserted. Due to the excellent care that Katie has since received from both her family and the medical and nursing team at the nursing home where she has resided for the last nine years, her condition has remained relatively stable. However, as will be discussed in greater detail later, Katie's brain and body have continued to deteriorate in a progressive fashion over the years.

7. Although I will make more detailed findings later in this judgment as to Katie's medical condition, it is useful to give a brief synopsis of her current clinical presentation.

8. As a result of the prolonged depravation of oxygen at the time of her cardiac arrest, Katie's brain is severely damaged. She is, as already stated, in a persistent vegetative state. She does not respond to visual, auditory, olfactory or tactile stimuli. She has severe spastic quadriparesis and cannot purposefully move her limbs. Katie's knees are extended and her ankles inverted. Due to spasticity in her upper limbs, which is particularly severe and is only partially controlled by a Baclofen pump, she has developed severe contractures of her wrists and elbows. Katie requires 24-hour supervision and nursing care for all of her needs and she is artificially fed and hydrated. In addition, she has epileptic type seizures. Now, over nine years on from her initial injuries, Katie's medical team are universally of the opinion that her condition will never improve.

**The proceedings**
*Wardship petition*

9. On 13th February, 2020, a petition was brought by the HSE to take Katie into wardship. The petition was initially presented in circumstances where Katie's clinicians felt that she needed surgery to release the contractures in her arms, but because of her long-term brain injury lacked the capacity to make decisions regarding her care and treatment. However, prior to the presentation of the petition on this basis, the HSE was advised that Katie's family was anxious for the court to consider, as an alternative to providing consent to the surgery proposed, the possibility of an order that would permit the withdrawal of her nutrition and hydration so that Katie might be allowed to die.

10. The petition was verified by the affidavit of Jarlath Tunney, disability manager for the HSE and supported by a medical affidavit sworn on 27th February, 2020, by Dr Mark Delargy, clinical director of the National Rehabilitation Centre in Dún Laoghaire and a second medical affidavit sworn on 11th February, 2020 by Dr Albi Chiallsery, consultant neurologist at Connolly Hospital. Both doctors averred to the fact that Katie was not capable of making any informed decisions concerning her care and that she did not have the ability to manage her affairs.

11. An inquiry as to whether Katie met the threshold for wardship was initiated by court order dated 4th March, 2020, and, by further order made on 25th March, 2020, Bernadette Parte, solicitor, was appointed as Katie's guardian *ad litem*. In her affidavit sworn on 24th April, 2020, Ms. Parte helpfully exhibited the notes of various interviews carried out by Eileen O'Callaghan of the Sage Support and Advocacy Service with Katie's family and friends. I will return in due course to the content of those interviews.

12. For the purposes of the inquiry a number of additional medical reports were procured to assist the court. Two medical reports were obtained from Dr Smith, Katie's general practitioner and the treating doctor at her place of residence. These are dated 28th May, 2019, and 24th January, 2020. A report was also obtained from Ms. Orla Flannery, consultant orthopaedic and hand surgeon at Connolly Hospital and Cappagh National Orthopaedic Hospital dated 30th April, 2019, wherein she specifically affirmed the need for the surgery proposed to deal with Katie's contractures, to maintain her skincare and prevent further infection. Finally, the court's own medical visitor, Dr Mary Cosgrove, consultant psychiatrist, provided a report dated 13th March, 2020 in which she concluded that Katie was of unsound mind and incapable of managing her affairs.

13. By declaration order made on 26th May, 2020, Katie was brought into wardship and the General Solicitor for Minors and Wards of Courts, Ms. Patricia Hickey, was appointed committee of her person and estate. The court also gave the HSE liberty to make an application in respect of the surgery it considered necessary to address Katie's contractures and in so doing directed that her mother be put on notice of that application. Even more important is the fact that the court gave Katie's mother liberty to bring an application to discontinue the treatment she is currently receiving as regards nutrition and hydration. I will discuss the evidence upon which the wardship application was grounded in some detail later in this judgment given that all parties are agreed that it should form part of the evidence upon which I can rely in making my decision on the present application.

*The within application*

14. By motion for directions grounded on an affidavit sworn on 9th June, 2020, Katie's mother applied for orders in the following terms:

    (a) an order that it is in the best interests of the ward that all further medical treatment in the form of artificial nutrition and hydration be discontinued;

(b) an order directing that all necessary pain relief or sedation be provided to the ward as is deemed necessary in the opinion of her treating clinician following on from the discontinuation of the said medical treatment; and,

(c) an order directing the HSE to take all necessary steps to ensure compliance with the aforesaid orders of this Honourable Court.

15. By order dated 15th June, 2020, the court ordered the HSE to discharge the costs and outlay of Katie's mother in respect of the aforementioned application.

16. Following the aforementioned order, the parties started to assemble the evidence which was put before the court in the course of the hearing that took place in recent weeks.

17. The HSE obtained an updated report from Ms. Grainne Colgan, consultant hand and orthopaedic surgeon, wherein she stated that Katie's contractures needed to be addressed but that surgery would not be appropriate until the court had determined whether her current treatment should or should not be withdrawn. It also commissioned a report from Dr Clare McAleer, consultant in palliative medicine at St. Francis Hospice, Dublin, dated 6th November, 2020 and obtained a supplemental report from Dr Delargy dated 1st February, 2021. And, in her role as Katie's committee, the General Solicitor obtained two expert reports from Dr Regina McQuillan, consultant in palliative medicine at St. Francis Hospice, Dublin. These are dated 22nd September, 2020, and 24th February, 2021.

18. On 1st October, 2020, I ordered that an electroencephalogram ("EEG"), somatosensory evoked potential study ("SSEP") and an MRI be performed on Katie. Subsequently, I received a report from Dr Norman Delanty, dated 28th October, 2020, following his examination of Katie and a review of her MRI and EEG. Katie's mother procured further reports as to her daughter's condition from Dr Ronan Kilbride, consultant neurologist at Beaumont Hospital and the Mater University Hospital and Prof. Gerard Curley, professor of anaesthesia and critical care medicine at the Royal College of Surgeons in Ireland. Dr Kilbride's report is dated 25th November, 2020, and Prof. Curley's report dated 1st December, 2020.

19. The hearing of the issues the subject matter of this judgment took place on 24th, 25th and 26th March, 2021. And, although conducted during Level 5 restrictions due to Covid-19, having regard to the importance and sensitivity of the issues to be determined, the hearing largely proceeded in person with only some of the medical evidence being heard remotely.

*The relief sought*

20. Prior to dealing in greater detail with the evidence and the submissions of the parties it is perhaps opportune at this point to refer to the content of a draft order as to the relief that might be granted by the court on the present application. This was prepared by Mr. Donal McGuinness, counsel for the HSE, following the conclusion of the evidence. Importantly, it

included a preamble to the effect that the HSE had obtained confirmation from Katie's treating doctor, Dr Smith, that he would take all steps necessary to comply with any order made by the court. The draft order, in relevant part, provides as follows:

"IT IS ORDERED by the President of the High Court that:

1. Pursuant to s. 27 of the Civil Law (Miscellaneous Provisions) Act 2008 the publication or broadcast of any matter relating to the proceedings which would, or which would be likely to identify the ward as a person suffering from a medical condition be prohibited, including the identifying information such as her place of care or family.
2. That in deciding that the withdrawal or withholding of life prolonging treatment or supports from the ward would be in the best health and welfare interests of the ward, the clinicians involved in the care of the ward, their servants or agents, would not be acting unlawfully by withdrawing the said life-prolonging treatment or supports from the ward.
3. If necessary, and appropriate, that consent be provided to those doctors and nurses and carers involved in the end of life care of the ward:
    (i) To withdraw and/or withhold life prolonging treatments or supports from the ward that are not considered by the ward's treating doctors to be in the best medical or welfare interests of the ward.
    (ii) To carry out such medical, and nursing or/and ancillary treatment of the ward as they consider in the exercise of their clinical judgment to be appropriate and in the best health and welfare interests of the ward, including but not limited to providing palliative treatment and care to the ward."

**Katie's family and friends and their evidence**

21. Notwithstanding the fact that Katie's mother and father separated when she was six years of age, Katie comes from a tightknit family. Her mother and stepfather are devoted to her. Her stepfather visits Katie every morning and her mother visits her every evening when she assists with her care. Katie also has several other siblings, including Jane, earlier mentioned, who gave evidence at the hearing. She also has a number of stepsiblings.

22. Katie's mother described Katie before her misadventure as a truly funny person with a huge personality. She was affable, loved her family and friends and had an engaging mischievous streak. Katie was also very involved in her community. She loved to entertain and was a great singer and enjoyed eating out. Katie's mother told the court that her daughter had a keen sense of style stating that "you could send her to Penneys with €50 and she would come out as on a catwalk in Paris". She observed how her daughter cannot do any of these things now with the result that she views Katie's life as "horrendous". She explained how Katie's seizures are difficult to watch given that during a seizure Katie often screams, lifts her body and twists her head. And, she described how Katie's eyes take on a strange look and her skin turns "white as a sheet". Importantly, she also explained that Katie was very private about her body and modest in the way she

dressed, always keeping herself well covered. She said Katie would be dreadfully upset to think that her body was exposed to all involved in her everyday care and treatment.

23. Katie's mother told the court that it was not until six years after the accident, on the day of Katie's 24th birthday, by which time Katie's friends had stopped visiting her, that she realised that Katie was never going to recover and that she should probably be allowed to slip away peacefully.

24. Katie's mother also recalled a conversation during which Katie had stated that if she was ever reduced to a condition of the type she is currently in, she would want to be allowed to die. Katie's mother described how, after a series of male suicides in her school, Katie had come home from the funeral of a friend and described the arrangements she would like for her own funeral. Concerned that her daughter was contemplating or perhaps glorifying suicide she explained to her that some people fail in their efforts to commit suicide and end up being left permanently disabled for the rest of their lives. To that observation, so her mother recalled, Katie responded that she would not want to be kept alive in such circumstances.

25. Katie's sister, Jane, described Katie as a great person to be around. She was always telling jokes and she made everyone happy. She was a great singer and took part in many karaoke competitions. Echoing what her mother had said, Jane confirmed that Katie was very private and modest regarding her body and that she found it heart-breaking to see her in her present condition knowing how she would feel about the constant exposure of her body to those caring for her. Katie had been "adamant" that she would not want to live in a state such as that which she is in at the moment.

26. In the Sage reports mentioned above, Katie's biological father echoed what Jane and Katie's mother told the court. He said that Katie was "full of life" and a great singer who had a true passion for it. He said that Katie would not have wanted the life she has now and that he would not have agreed to the PEG feeding tube being inserted if he had known then what he knows now. He also said that he believes Katie is already dead and that it is just her body that is being kept alive.

27. Lucy, another of Katie's sisters, also emphasised how private Katie was about her body, stating that she would find her present care regime embarrassing. She also said that she believed that Katie would want her artificial feeding terminated. Lucy said that Katie's ultimate passing would be a "heartbreak" but it would be the right thing to do. Julie, Katie's third sister, emphasised that Katie was very sociable, that she had a great singing voice and had a phenomenal sense of style. She said that Katie really enjoyed her hairdressing job and that she wanted to have children, go on holidays and enjoy life. Julie said that she believes Katie is already dead and it is only her body that is being kept alive. She also noted that "we are keeping her for us, not for her" and that it was cruel to have kept her alive for so long. She further explained that when visiting Katie, she believed she was distressed and in pain, principally because of her screaming during her seizures. Julie also expressed the view that even if Katie was to make some minor recovery, she would still not be able to enjoy a meaningful life. She echoed what her

sisters had said to the effect that whilst removing Katie's feeding tube would be heart-breaking, it would be the right thing to do. Julie also said that Katie's present condition had had a negative impact upon the family and in particular on their mother and stepfather. Siobhan, Katie's aunt, stated that she believed that Katie feels pain and that she would hate her current state, particularly the personal nature of her care needs.

28. A number of Katie's friends were also interviewed. Their views of Katie as a person and what she would want in her current circumstances mirrored those expressed by her family. Some said they found visiting Katie very difficult having regard to her condition which they felt denied her of dignity. Like her family, Katie's friends said they would be deeply saddened but also relieved if her feeding tube was removed.

**Katie's clinical presentation and prognosis**
*Katie's brain injury*

29. Because what is at stake on the present application could not be more serious, concerning as it does the life and death of a young woman so devastatingly injured in the prime of her life, it is important to set out in significant detail the extent of her injuries as detailed by the many renowned medical experts who examined her over the past eighteen months.

30. The medical experts are unanimous in their view that Katie has sustained an irreversible and severe hypoxic brain injury from which she will never recover. Dr Kilbride, consultant neurologist, told the court that he examined Katie on 21st October, 2020, and 22nd October, 2020 and that, having reviewed her patient history, he was satisfied that she was unresponsive to the outside world. She did not respond to a clinical threat test and this indicated that she lacked awareness. Her eyes did not fix on or follow an object, one of the most recognisable signs of emerging consciousness, and she did not respond to simple verbal commands. He noted that Katie manifests motor responses, i.e. movements in response to noxious stimuli, such as loud noise. However, these movements are not indicative of any form of consciousness. Rather, these so called "startle responses" are pathological reflex reactions to noxious stimuli in persons with severe brain damage.

31. Dr Kilbride stated that Katie's EEG supported the diagnosis of persistent vegetative state. The EEG, which measures electrical potentials (brainwaves) in the human brain, showed no evidence of the background oscillating brainwave activity found in healthy individuals. Katie's brainwaves were of low voltage and pathologically slow in comparison to what one would normally expect of a person her age. He also commented on the somatosensory evoked potential ("SSEP") test performed on 22nd October, 2020. This test establishes the integrity of sensory nerves including the brain and determines whether a signal can travel along the nerve pathways. It showed that, although Katie's peripheral nervous system was intact and could conduct a nerve signal, the part of the brain that interprets and further passes on those signals, the thalamocortical pathway, is disrupted. Dr Kilbride also analysed the MRI most recently performed on Katie. He compared it to an MRI carried out shortly after her initial cardiac arrest and noted that brain tissue originally seen on the scan, but noted as damaged, is now completely absent and has been

replaced by spinal fluid. Importantly, he observed that anatomical parts of the brain which are believed to be required for any form of consciousness, such as the thalamus, are no longer present. He also reported that Katie's loss of brain tissue is progressive and that the brain does not generate new nerve cells meaning that once they are gone, they are gone forever.

32. Dr Delanty, consultant neurologist at Beaumont Hospital, gave evidence which echoed that of Dr Kilbride. He adopted Dr Kilbride's observations regarding the EEG and MRI as set out in his report dated 25th November, 2020. Having reviewed Katie's medical history, Dr Delanty stated that the MRI, the SSEP and the EEG all established with great certainty that there was no normal function in Katie's cortex. He described her injuries as severe and irreversible and noted the cortical atrophy earlier described, i.e. loss of brain tissue, on her MRI scan. He also said that there was "no hope" for any meaningful recovery.

33. Prof. Curley, professor of anaesthesia and critical care medicine, also gave evidence as to Katie's brain injury. Having reviewed her medical history including the EEG and MRI, he was satisfied that no other reversible condition could account for her current clinical presentation. He also advised that a firm diagnosis that a patient is in a persistent vegetative state is usually only made after many assessments carried out over a period of time by different practitioners. During his examination conducted on 27th November, 2020, he observed that Katie's eyes were wide open and that they rolled about spontaneously, i.e. without any trigger. Her pupils responded to light but there was no evidence of tracking or fixation. Katie did not close her eyes following a sudden movement but did exhibit a startle response which is a primitive reflex indicating that, although her visual pathways are intact, there is no higher cortical function to interpret any signal. He also observed a startle response following a loud noise but no response to a simple verbal command. This, Prof. Curley stated, indicates that although Katie's auditory pathways are intact, her cortical functions are severely disrupted. He also noted Katie's spasticity. Her arms and wrists are bent, her knees are extended and her ankles inverted. This is referred to as a decortical position and is further evidence of the severity of Katie's brain injury. Prof. Curley also noted an abnormal flexion response to a painful stimulus and he said that, having spoken to Katie's other clinicians, it would appear that she has never exhibited any purposeful movement since her accident. These factors were all indicative of a diagnosis of persistent vegetative state.

34. Prof. Curley also commented on Katie's EEG and MRI. In relation to the EEG, he observed the absence of brain potentials which are indicative of the fact that Katie will not recover from her injuries. In relation to the MRI he noted that her cortex is severely injured and that the scans are in keeping with a diagnosis of severe anoxic brain injury. Katie's abnormal brain structure and the length of time that has passed since the accident are further indicators of a persistent vegetative state. Importantly, Prof. Curley expressed the view that, due to her brain injury, Katie is not capable of experiencing pain or indeed any form of sensation.

35. Dr Delargy, rehabilitation consultant, also gave evidence as to Katie's brain injury and current condition. His reports and his oral evidence were based on examinations of Katie carried out on 1st November, 2019, 15th November, 2019 and 11th December, 2020. Similar to the conclusions drawn by Dr Kilbride, Dr Delanty and Prof. Curley, in his reports Dr Delargy details that Katie has no visual awareness. Her eyes do not fix or track and, although her pupils respond to light, she does not demonstrate any blink response following a standard clinical visual menace/threat test. On examination, she did not recognise an image of herself or respond to the scent of her own perfume. She did not react to a joke or to a video of herself singing a song sung by her favourite performer. Neither did she respond to a dog barking or a phone ringing. He observed that Katie exhibited a pathological shoulder jerk movement in response to a painful stimulus as opposed to a localisation movement, i.e. moving the hand towards the painful stimulus, found in healthy individuals.

36. Dr Delargy diagnosed Katie as being in a persistent vegetative state. He stated that she does not exhibit any of the indicators thought clinically necessary for a diagnosis of minimally conscious as opposed to persistent vegetative state, including (i) consistent movement to command, (ii) object recognition, (iii) object localisation, (iv) visual pursuit, (v) fixation on one's own image, (vi) functional use of an object, (vii) object manipulation, (viii) localisation of noxious stimuli, (ix) intelligible vocalisation and (x) functional or intentional communication of any kind. He also clarified that, although he speculated in his reports that Katie's eyelids may be under her control, this is not in fact so. Whilst he noted that the grunting and chewing movements made by Katie were consistent with her injuries and diagnosis, he also stated that he considered the level of her screaming, as reported, to be somewhat unusual.

37. In his report dated 1st February, 2021, Dr Delargy suggested that a functional MRI ("fMRI") be carried out on Katie to confirm her diagnosis. An fMRI is a somewhat novel diagnostic tool which has yielded results in other cases where patients thought to have been in a vegetative state were shown to exhibit some brain activity that was unexpected for a person so diagnosed. The test involves a person being invited to imagine they are playing tennis or walking around their home while their brain activity is recorded. However, when questioned regarding the value of any such testing, Dr Delargy accepted that in Katie's case the EEG is the more powerful indicator. As to the possibility of any improvement in Katie's condition, Dr Delargy referred to materials published concerning the trial of a drug called Zolpidem which had been reported as restoring some level of functioning and awareness in nineteen patients who had received it. When asked whether this drug could possibly have any impact on Katie's condition, he accepted Dr Kilbride's evidence that the anatomical parts of the brain necessary for consciousness are gone in Katie's case, with the result that any likelihood of this treatment resulting in a positive response was "minimal". It was unlikely to bring back any form of consciousness having regard to Katie's loss of brain tissue, particularly in the thalamus. Dr Delargy also noted that any improvement she might possibly make would not provide her with an existence that she would have valued.

38. In his report, Dr Challessery, consultant neurologist, describes Katie as having epileptic type seizures which can last for up to five minutes and which sometimes involve her screaming or crying. She has tonic and clonic movements in both upper limbs and some tonic posturing. Katie is currently on anti-seizure treatment which has improved her condition somewhat, but her seizures remain an issue. It is largely unknown what triggers the seizures, but some appear to be triggered by loud noise.

*Katie's ability to feel pain and the proposed palliative care*

39. One of the important considerations in this case is the effect the proposed withdrawal of treatment will have upon Katie and, in particular, whether it will be distressing for her. All of the clinicians questioned as to whether Katie currently feels pain or whether the withdrawal of treatment might cause her pain were unanimous in their opinion that she is not capable of feeling pain.

40. Prof. Curley gave definitive and detailed evidence that people in a vegetative state are not capable of experiencing pain. The brain injury in such patients is so severe that they are believed not to experience pain as a sensation of discomfort. Dr Delargy, when questioned about Katie's screaming during some of her seizures said that, as far as he could tell, the screaming was not a response to pain. Dr McQuillan, consultant in palliative medicine, stated that in her opinion Katie does not experience sensations such as pain, thirst or hunger and that she would not expect her to suffer should nutrition and hydration be withdrawn.

41. A number of the clinicians nonetheless cautioned that Katie's body might respond to the withdrawal of hydration and nutrition in a manner that might suggest that she was in pain. Prof. Curley said that, although in most cases end of life care results in a peaceful death, the body may react with certain jerks or other autonomic responses that might suggest to the observer that the patient was experiencing pain, but that these responses are not indicative of pain. Dr McAleer, consultant in palliative medicine, distinguished between signs and symptoms to describe Katie's potential reaction to the withdrawal of hydration and nutrition. She explained that Katie does not experience symptoms as something unpleasant as would be the case with a person with normal cortical or brain function. Rather, when treatment is withdrawn, her bodily functions would be disrupted leading to potential autonomic responses such as increased tonic posturing or bowel movements that may look like a reaction to pain but that pain is not something she believes Katie can or will experience. Any such movements are therefore better characterised as signs as opposed to symptoms. She also advised the court that it is possible to relieve most of these signs with medication, should the need arise. Notwithstanding the fact that both palliative care consultants stated they did not believe that Katie could possibly experience any pain following the withdrawal of treatment, they were agreed that it would be reasonable to give her pain-relieving medication such as benzodiazepines or opioids in the event of hydration and nutrition being withdrawn. Whilst she did not require these in terms of pain relief, their administration would provide

reassurance to her family that she could not be suffering due to the withdrawal of nutrition and hydration.

*Continuing with Katie's current treatment*

42. The court also had the benefit of expert evidence as to what will happen to Katie should it be decided that hydration and nutrition should be continued. As previously mentioned, Dr Kilbride told the court that Katie's loss of brain tissue is progressive. Her condition will deteriorate. He also stated that there will be ongoing muscular-skeletal decline which will impact on her spasticity and contractures, something echoed by Prof. Curley. She will need the surgery proposed by Ms. Orla Flannery in her medical reports. Dr Kilbride also noted that persons who are immobile for long periods of time become prone to chest infections which may ultimately lead to a failure in their cardiorespiratory system. Prof. Curley echoed the evidence given by Dr Kilbride and stated that Katie's condition will continue to deteriorate and that she will suffer a more undignified death the longer she lives.

*Clinicians' ethical views*

43. Although I will discuss the relevance and meaning of this evidence in a short while, I should briefly set out the evidence that was adduced in relation to the clinician's ethical views regarding the withdrawal of Katie's treatment, much of which concerned the provisions of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners (8th edn., Medical Council, 2019) ("the Guide"). Particular reliance was placed upon paras. 45.2 and 46.3 which provide as follows:

> "45.2 If a patient is unable to take sufficient food or drink orally, you should consider giving nutrition and/or hydration by subcutaneous, intravenous or enteral feeding routes. You should assess whether doing this will be of overall benefit to the patient, taking into account the patient's views, if known, and balancing the benefits, burdens and risks of each form of treatment. You should be sensitive to the emotional impact on the patient and their family of not providing nutrition and/or hydration. If you decide that providing artificial nutrition or hydration through medical intervention will not be of overall benefit to the patient, you must make sure the patient is kept as comfortable as possible and their symptoms addressed. Where possible, you should tell the patient and/or those close to them of your decision and the reasons for it (see also paragraph 46.5).
>
> […]
>
> 46.3 Usually, you will give treatment that is intended to prolong a patient's life. However, there is no obligation on you to start or continue treatment, including resuscitation, or provide nutrition and hydration by medical intervention, if you judge that the treatment:
>
> - is unlikely to work; or

- might cause the patient more harm than benefit; or is likely to cause the patient pain, discomfort or distress that will outweigh the benefits it may bring."

44. Prof. Curley gave the following evidence in an exchange with Mr. Durcan, Counsel for the committee:

"Q […] In your professional opinion are the circumstances of [Katie] such that a doctor who is treating her would be entitled to withdraw artificial nutrition pursuant to paragraph 45.2 and paragraph 46.3 of the guidelines?

A So I had better open up those guidelines to make sure that I understand.

[…]

A So if you give me a moment to refresh my reading of those.

[…]

A So in answer, Mr. Durcan, I absolutely agree that it is consistent with these guidelines that it will not be of overall benefit to the patient to continue providing artificial nutrition.

Q So a doctor treating [Katie] would be entitled and it be ethical, pursuant to those provisions, to withdraw artificial nutrition?

A That is my belief and understanding of those guidelines. Yes."

45. Dr Delanty gave the following in evidence:

"Q So from a medical perspective are you satisfied that withholding of nutrition and hydration would be within the four corners of the Medical Council Guidelines that I have just read out?

A At this point in time and in the current tragic circumstances, yes."

46. Dr McQuillan gave evidence in the following terms:

"Q Could I bring you briefly to paragraph 45.2 and 46.3 [of the Guide]?

A Yes, yeah.

Q Firstly, do you think those paragraphs are applicable in the present situation, in the situation of a person wo has been getting life-sustaining treatment for a significant period?

A Yes, I think they are applicable […]

[…]

Q Equally, is the doctor ethically entitled not to provide treatment or cease treatment?

A Yes. Doctors are ethically entitled not to give treatment which they believe is not in clinical interest – is futile. I think doctors are ethically obliged to act in a patient's best interests. So they should not give treatment which they believe is not in a person's best interests.

Q I see. Are the two relevant paragraphs there in regard to hydration, paragraph 45.2 and 46.3? Do they summarise the circumstances in which ethically a doctor can decide to either not give such treatment or to cease giving such treatment?

A They do, yes. Yes.

Q I asked one of the witnesses this morning, and perhaps I could ask you as well – Prof. Curley I think I asked – have you a view, have you any professional view as an expert witness of whether the circumstances in which [Katie] is in at the moment it would be open to a doctor treating her to come to the conclusion that it is ethical to cease the artificial nutrition pursuant to [para.] 45.2 and [para.] 46.3?

A I think it would be. It is open to a doctor to consider; would it be ethical to stop giving artificial nutrition and hydration, in line with those two articles of the Medical Council Guidelines. Yes. I think it is open that it is ethical for a doctor to stop artificial nutrition and hydration.

Q I see. That is looking at it, if I might put it that way, from the doctor's perspective, what the doctor is entitled to do ethically?

A Ethically, yes, yeah."

**Legal issues**

47. Despite the fact that all parties were in agreement that Katie's hydration and nutrition should be brought to an end, they were, to some extent, in disagreement as to how this should be achieved legally. Principally, there were some differences, albeit minor in character, between the parties as to the relief to be granted. Specifically, the parties disagreed as to whether the court should make an order giving or withdrawing its consent for the continuation or cessation of life-sustaining treatment or whether it is appropriate to merely make a declaration that it would be lawful for Katie's clinicians to terminate her hydration and nutrition.

48. Counsel for Katie's mother, Mr. Fitzpatrick, S.C., argued that, although the family would be content with a declaration as to lawfulness, it would be preferable if the court was to make an order giving substituted consent on Katie's behalf as to the next steps to be taken in terms of her medical treatment. The family wanted certainty that any medical treatment decided upon by the court would be embarked upon. Mr. Fitzpatrick, nonetheless noted the preamble in the draft order which specifically records the fact that

the HSE and Katie's treating doctors had agreed to take all necessary steps to comply with the terms of any order as might be made by the court.

49. Counsel on behalf of the committee expressed significant concern that a case such as this, where the views of the family, the doctors and the expressed wishes of the patient aligned, should not have required a lengthy and expensive trial. Rather, where all that was legally needed was a declaration of lawfulness as to the treatment proposed, a case such as this should be capable of being dealt with in a much more efficient manner.

50. Counsel for the HSE took a more cautious stance and argued that the court's consent to the withdrawal of nutrition and hydration was required in a case such as this and that a declaration of lawfulness would not be sufficient. The HSE primarily argued that the constitutional rights of the ward must be protected and that a declaration of lawfulness would not be suitable in these circumstances. In this context it should be noted that all parties were agreed that, regardless of which avenue the court might take, every legal test and evidential threshold was met with the result that no issue arose as to the availability of any of the reliefs identified in the draft order.

**The law in relation to withdrawal of life-sustaining treatment**

51. The Constitution does not recognise a right to die but rather it acknowledges that the right to life encompasses a right to die a natural death. In a frequently cited passage in *In re a Ward of Court (No. 2)* [1996] 2 I.R. 79, Hamilton C.J. said as follows at p. 124:

> "As the process of dying is part, and an ultimate, inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death and, unless the individual concerned so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which is intended merely to prolong life.
>
> This right, as so defined, does not include the right to have life terminated or death accelerated and is confined to the natural process of dying. No person has the right to terminate or to have terminated his or her life, or to accelerate or have accelerated his or her death."

52. In the High Court in that same case, Lynch J. put it as follows at p. 94 of the report:

> "Death is a natural part of life. All humanity is mortal and death comes in the ordinary course of nature and this aspect of nature must be respected as well as its life-giving aspect. Not infrequently, death is welcomed and desired by the patient and there is nothing legally or morally wrong in such an attitude. A person has a right to be allowed to die in accordance with nature and with all such palliative care as is necessary to ensure a peaceful and dignified death."

53. As there is no right to die but merely a right to die a natural death, it is important to recognise that the courts have consistently held that artificial life-support is a form of medical treatment, meaning that its withdrawal cannot be viewed as an intervention that accelerates death. Rather, it is an intervention the withdrawal of which allows the

individual concerned to die a natural death. Most notably, this position was affirmed in *In re a Ward of Court.* In that case, the court was concerned with a young woman who suffered severe and irreversible anoxic brain damage following an operation that had left her in a persistent vegetative state with only minute signs consistent with her being in a minimally conscious state. Whilst initially fitted with a nasogastric tube, she was subsequently provided with a gastronomy tube which her family sought to have removed in addition to an order permitting all further life-support to be terminated. In that case, the High Court found, and the Supreme Court agreed, that the treatment the ward was receiving constituted medical treatment which could be withdrawn so as to allow death to take its natural course. In his judgment, Hamilton C.J. stressed specifically that the true cause of the ward's death would not be the withdrawal of her life support but the injuries she initially sustained.

54. Ordinarily, it would be for a person who has capacity and is on life-support to decide whether or not life-sustaining medical treatment should be terminated. However, where the person is incapable of deciding on their future medical treatment, including the giving or withholding of consent to a continuation of life-sustaining treatment, for example where by virtue of their injury they are on life support, substituted consent has to be obtained. In cases where the person is a child, this is often done through the family. But in cases involving adults who cannot give their consent to medical treatment by reason of mental incapacity, routinely the court will be asked to consent on their behalf and an application will be made to bring them into wardship for this purpose. Where a person is not yet a ward of court and an urgent medical procedure needs to be carried out, the court may exercise its inherent jurisdiction to give consent to it. However, before doing so, if time permits, the court will normally appoint a guardian *ad litem* to ascertain the views of the intended ward concerning the procedure proposed, regardless of their perceived capacity or lack thereof.

55. When exercising its wardship jurisdiction or its inherent jurisdiction in relation to a minor, the court acts in *loco parentis* to the ward/intended ward. However, Katie is an adult who has been brought into wardship by reason of her lack of capacity. Accordingly, and in principle, it falls to the court to make the decision for Katie as to whether her life-sustaining treatment should be withdrawn and to make that decision consistent with her best interests.

56. Nevertheless, as was pointed out by the parties, obtaining consent, or substituted consent through the courts, may not be necessary in certain circumstances, as was set out in the majority's judgment in *In re J.J.* [2021] IESC 1 (Unreported, Supreme Court, 22nd January 2021), which brings me to the central disagreement in this case.

57. The general rule in relation to medical treatment is that the consent of the patient is required. In a case such as this, where it is the court that has to give substituted consent, it must decide whether to give that consent by reference to a set of well-established principles. First, the court has to have regard to the sanctity of life which gives rise to a strong but, in recognition of the right to die a natural death, a rebuttable presumption in

favour of sustaining life-prolonging treatment. *In HSE v. J.M. (a Ward of Court)* [2017] 1 I.R. 688 at p. 713 Kelly P. observed:

> "'The nature of the right to life and its importance imposes a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances' (per Hamilton C.J. in *In re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79 at p. 123).

There exists a 'constitutional presumption that the ward's life be protected' (per Denham J. in *In re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79 at p. 167). These observations are made in the context of rights derived from the Constitution. But the position is no different at common law as is clear from the views expressed by Baker J. in In re M. (Adult Patient) [2011] EWHC 2443 (Fam.), [2012] 1 W.L.R. 1653 at p. 1687 where he said:

> 'The first principle is the right to life. As Lord Goff observed nearly 20 years ago in [*Airedale N.H.S. Trust v. Bland* 714 H.C. [1993] A.C. 789 at p. 863], 'the fundamental principle is the principle of the sanctity of human life'. Munby J. in [*R. (Burke) v. General Medical Council* [2004] EWHC 1879, [2005] Q.B. 424, at para. 213(o), p. 495] spoke of the 'very strong presumption in favour of taking all steps which will prolong life' ... 'The principle of the right to life is simply stated but of the most profound importance. It needs no further elucidation. It carries very great weight in any balancing exercise.'"

58. But, at para. 90 he noted:

> "There is no absolute duty imposed on the court to consent to medical treatment on behalf of a ward of court in order to attempt to prolong life at all costs and without regard to any other consideration or circumstances of the ward's best interests. Neither is there any absolute duty on a doctor to provide, or a patient to consent to, medical treatment in order to attempt to prolong life at all costs and without regard to other matters concerning the patient's best interests"

59. Therefore, whilst the court, in the exercise of its discretion as to whether to give or withhold consent to a medical intervention, must take as its starting point a presumption that the ward's life should be maintained, this may be rebutted.

60. Such rebuttal is justified where the court is satisfied that it is in the bests interests of the ward to give or refuse any such consent. And, in determining what is in the ward's best interests, the court is required to have regard to all the circumstances of the case. Denham J. in *In re a Ward of Court* set out the following list of factors that the court may have regard to, whilst stating that the list is non-exhaustive. At p. 167 she set out:

> "(1) The ward's current condition.
>
> (2) The current medical treatment and care of the ward.

(3) The degree of bodily invasion of the ward the medical treatment requires.

(4) The legal and constitutional process to be carried through in order that medical treatment be given and received.

(5) The ward's life history, including whether there has been adequate time to achieve an accurate diagnosis.

(6) The prognosis on medical treatment.

(7) Any previous views that were expressed by the ward that are relevant, and proved as a matter of fact on the balance of probabilities.

(8) The family's view.

(9) The medical opinions.

(10) The view of any relevant carer.

(11) The ward's constitutional right to:

(a) Life.
(b) Privacy.
(c) Bodily integrity.
(d) Autonomy.
(e) Dignity in life.
(f) Dignity in death.

(12) The constitutional requirement that the ward's life be (a) respected, (b) vindicated, and (c) protected.

(13) The constitutional requirement that life be protected for the common good. The case commences with a constitutional presumption that the ward's life be protected.

(14) The burden of proof is on the applicants to establish their application on the balance of probabilities, taking into consideration that this Court will not draw its conclusions lightly or without due regard to all the relevant circumstances."

61. In *In re J.J.*, the Supreme Court observed that when assessing the best interests of the ward, the court should approach the matter from the standpoint of a loving and considerate parent appraised of all the relevant facts. At para. 176 they stated:

"[…] In our view, the test is to consider what a loving and considerate parent would do once apprised of all the relevant information. Such a parent would take into account the views of the child, if expressed, and the character of the child, and would make a decision as to the best interests of the child in that context. It is important that, while an assessment of the benefits and burdens of a treatment are relevant to the

decision, that does not involve the court making judgments as to the quality of the life being lived by the patient […]"

62. But, in *In re J.J.,* the majority also pointed out that in certain circumstances consent is not required and thus, the court need not give substituted consent and therefore need not have regard to the best interests test. *In re J.J.* was concerned with an application by a severely brain-damaged child's treating doctors to obtain confirmation from the court that, *inter alia,* certain life-sustaining measures such as CPR or mechanical ventilation might be withheld should the need for them arise. The doctors maintained that to administer such treatments would not be in the child's best interests and would be unethical. In that case, the question arose as to whether the court's consent was required at all in circumstances where the doctors were not seeking the court's consent to the administration of a particular regime of treatment, but rather were asking the court to declare it lawful for them to withhold various medical interventions in certain circumstances. In relation to this question the judges observed as follows in paras. 156-157:

"John's family and, in particular, his mother, supported by John's father, do not wish this course to be taken insofar as it implies that other interventions would not be carried out, but wish every step to be taken that would keep John alive. It is commonplace to speak of a family "consenting" to a treatment plan and it is normally highly desirable that the broad course of treatment is agreed with the patient and/or his or her family. That is not just for the benefit of the doctor or, indeed, the patient, but is also much in the interest of the family members themselves since, otherwise, the grief caused by the death of a loved one can be compounded by a lack of acceptance, and feelings of conflict and guilt. However, as a matter of law, consent of the patient, or substitute consent provided by a family, is not a legal pre-requisite of all treatment decisions and, in particular, a decision not to institute aggressive life-sustaining measures. As the *Guide to Professional Conduct,* referred to at para. 84 above, makes clear, while doctors will usually give treatment intended to prolong a patient's life, there is no obligation to start or continue treatment if the doctors judge the treatment might cause more harm than benefit, or is likely to cause the patient pain, distress, and discomfort that will outweigh the benefits it may bring.

In circumstances involving the withholding of treatment, in accordance with the Guidelines, the legal issue is not whether the patient or the patient's family consents to the course proposed by the doctors, but rather whether it is lawful for the doctors to do so; i.e., whether the judgement is one to which they can properly come to. For those reasons, we would, and with respect, not agree with the portion of the judgment of Baroness Hale of Richmond in *Aintree University Hospital* quoted by Kelly P. in *JM*, and set out at para. 80 above, to the effect that it becomes lawful to withhold life-sustaining treatment if a court considers that it is not in the patient's interests to give the treatment, and will not give its consent. While, in most cases, it will not matter how the issue is phrased, it appears to us that if it is

appropriate to withhold treatment then the court's consent – or lack of it – does not alter the legal position. If it is lawful to withhold the treatment, then the court's positive consent to that treatment would not require it to be administered or make its withholding. The legal issue, therefore, in respect of withholding of life-sustaining treatment, is: whether it is lawful in all the circumstances of the case; whether the patient is an adult or a child; and, whether the patient or family consent or not. In practical terms, however, it would normally be the case that the hospital and treating doctors would want to bring a patient and family to the same position so that they could be said to "consent" to the course of treatment, and, in cases where that was not possible, it is prudent to seek confirmation, if necessary, from a court that it is permissible to do so."

63. They further observed at para. 159:

"[…] Parents (or patients) in this situation cannot dictate the form of care which is provided. Any influence they have is negative: by withholding consent to certain treatment where such consent is necessary; and/or by raising, either expressly or by implication, the possibility of a threat of action. But for parents to ensure that a child receives certain treatment which they consider desirable, there must be doctors willing to provide it. That is why treatment decisions are best made by discussion and agreement between the parents and the clinicians. No one wishes to address this issue by reference solely to what can be required or not as a matter of law […]"

64. In para. 160 the court noted:

"The fact that the treatment to be afforded is not a matter solely for the decision of the patient or parents was reflected in the decision *In re a Ward of Court* where, while the High Court determined that it would be lawful to withhold the nutrition and hydration being provided to the ward by artificial means, the court nevertheless refused to make any order directed towards the institution then caring for the ward, because such a course of action would be against the ethical principles of the institution."

65. In para. 177(vi) the court summarised as follows:

"The withholding of treatment to a child does not necessarily require parental consent to be lawful if it [sic] based on a properly made decision as to the best medical interests of the child and it would be contrary to medical ethics to provide the treatment. However, it may be prudent in cases of dispute to seek a determination from a court that such a proposed course is not unlawful. In practice, the question of consenting to some treatment or withholding other treatment will often be interlinked and treated as a general issue of medical treatment, and if the wardship jurisdiction is invoked, the issue can be determined in a single set of proceedings."

**Is substituted consent required in Katie's case?**

66. Counsel for Katie's mother and counsel for the HSE both sought to distinguish *In re J.J.* Counsel for Katie's mother pointed out that when the current application was brought, no decision had been made by Katie's clinicians that her hydration and nutrition should, for any reason, be terminated. It therefore fell to the court to give its consent to her mother's application that it should be terminated because to do so would be in Katie's best interests.

67. Counsel for the HSE argued that the reasoning in *In re J.J*. was confined to emergency situations and that, in addition, the ward's constitutional rights had to be protected and vindicated, meaning that the court had to determine the issue before it based on what it considered to be in Katie's best interests. Those rights could not be protected by an assessment confined to the lawfulness of any decision as might be made by a clinician to refuse to withdraw Katie's continued nutrition and hydration.

68. The first thing to say in response to these arguments is that I do not agree with the submission that the decision in *In re J.J*. can be stated to apply only at times of medical emergency. Nothing in the judgment nor in the facts of that case indicate that the reasoning set out in the majority's *dictum* is confined to emergency situations.

69. However, it is important to state that the present case is significantly different to that with which the court was concerned in *In re J.J*. in a number of respects. First, as counsel for Katie's mother pointed out, in this case no decision has been made by Katie's treating clinicians that her nutrition and hydration ought, for any reason, ethical or otherwise, be withdrawn. Furthermore, although the position of the treating clinicians in *In re J.J.* and the expert witnesses in this case were similar in that both were of the view that certain lifesaving treatment should (in *In re J.J.*) or could (in this case), for ethical reasons be withheld from the patient so as to allow the patient die a natural death, they came to their respective positions from very different directions. In *In re J.J.*, it was the doctors that were the driving force behind the application. They had decided not to commence life-sustaining treatment which the child's parents were insistent should be deployed should his condition further deteriorate and wanted that decision declared lawful. Their evidence in support of that application was that it would be unethical to provide the said treatment. In sharp contradistinction, it is Katie's mother who is the driving force behind the present application. She believes that it is not in Katie's best interest that her life be further prolonged artificially. The clinicians in this case are not the applicants but are expert witnesses called by the parties to give evidence that it would be ethical for a clinician involved in Katie's care, having regard to the Guide, to decide that they could no longer support Katie's current treatment regime. However, none of the clinicians, let alone Katie's own treating clinician (who was not called to give evidence and who provided no report for the purposes of this application but merely for the application to take Katie into wardship) took the view that it would be unethical for them to continue her current regime. And, that such evidence was not adduced is not surprising. Given that it is only now, nine years after artificial feeding and nutrition commenced, and at the instigation of her mother, that the appropriateness of continuing Katie's current treatment is being canvassed, none of Katie's treating clinicians must have seen anything unethical

in the fact that she has been artificially fed and hydrated for all of this time. What happened on the present application is that a number of the independent medical experts, principally called to give evidence regarding Katie's condition and prognosis, also gave evidence that it would be within the four corners of the Guide for any treating clinician charged with Katie's care not to support a continuation of her hydration and nutrition. However, no such decision was made by any of Katie's treating clinician either before or since Katie was made a ward of court.

70. The question that consequently arises is whether any of these differences mean that substituted consent must be sought or whether it remains appropriate to dispose of this case by way of declaration of lawfulness as was the case in *In re J.J.* Looking more closely at *In re J.J.*, the passages cited above as well as its factual background, I do not believe that the Supreme Court intended that all that should be required to have life terminated in all cases is a declaration of lawfulness simply because it is a withdrawal/withholding type intervention and a doctor deems the withdrawal ethical under the Guide. To interpret the words of the majority of the court in this way would lead to absurd results whereby the carrying out of relatively minor medical interventions concerning the care of a ward would require that a higher threshold be met i.e. proof that the interventions were in the best interests of the patient/ward, whereas something as profound as the withdrawal of life support would merely require evidence by a medical practitioner/practitioners that to take such an approach would be within the boundaries of the Guide without a consideration of the best interests of the ward.

71. Instead it appears to me that the Supreme Court envisaged that the declaration of lawfulness route can only be availed of in very specific situations. In this regard, it is important to understand precisely the circumstances in which the relief in *In re J.J.* was granted. In its capacity as applicant, the hospital's position was that its clinicians did not consider it would be ethical for them to institute life-saving measures for a patient who, if his life was saved, was destined for a life of pain and further deterioration. As doctors cannot be compelled to perform treatment they consider to be unethical, the court declared the withholding of such treatment to be lawful. The clinicians in *In re J.J.* relied upon their right not to carry out treatment they considered to be unethical. It was the exercise of this right that permitted the court to declare lawful the withdrawal of treatment and dispense with the prerequisite of consent. Here the clinicians do not seek to rely upon their right not to have to perform treatment they consider unethical. Rather, the clinicians, in their capacity as expert witnesses as opposed to applicants, merely gave evidence that it would be ethical for a doctor, on the facts of this case, to withdraw from treating Katie under her current treatment regime.

72. This difference in position is echoed in the evidence given in relation to the ethics surrounding the withdrawal of treatment in *In re J.J.* and that given in this case. As touched upon above, the clinicians in *In re J.J.* gave evidence that the further provision of treatment would be unethical whilst in this case the evidence was that withdrawal would be ethical or that it would fall within the four corners of the Guide. Although these positions appear very similar, they are fundamentally different. To withdraw treatment on

the basis that the withdrawal would be ethical for an individual clinician would set the threshold far too low to ensure that the rights of the patients who cannot protect themselves will be protected and vindicated. A party seeking the withdrawal of life-sustaining measures, if they look hard enough, is always likely to find a medical practitioner willing to give evidence that the withdrawal of any treatment is ethical. For a doctor to reach the conclusion that they would consider the withdrawal of certain treatment as ethical and within the scope of the Guide is a conclusion reached much more readily than that the further provision of medical treatment would be unethical. A doctor's principal duty is to save lives and do no harm. For a doctor to come to the view that this duty is best exercised by withdrawing life-sustaining treatment without any express direction from the patient, unusual circumstances must prevail i.e. that it would be unethical to continue treatment. It is only in those exceptional circumstances that the court can dispense with the prerequisite of consent, as was the case in *In re J.J.* Here, the situation is not as such. None of the clinicians, and none of Katie's treating clinicians, gave evidence that the continued provision of life-sustaining measures would be unethical. In circumstances where Katie's clinicians do not seek to rely upon their right not to carry out treatment they consider unethical and have not given evidence to that effect, I find that the declaration of lawfulness route cannot be availed of in the present case. I would therefore distinguish this case from *In re J.J.* and hold that this case is better dealt with under the general rule that consent needs to be obtained as set out in In *re a Ward of Court*.

**Decision**

73. Based upon the medical evidence before me, I am satisfied as a matter of fact that Katie is in a persistent vegetative state. Although her condition was described by Dr Delanty as being on the continuum between a persistent vegetative state and a minimally conscious state, he himself stated that her presentation was in keeping with a persistent vegetative state. This finding is also consistent with Dr Kilbride's explanation regarding the absence of brain tissue of the type necessary for awareness and Dr Delargy's assessment regarding the absence of any of the indicators necessary to allow for a clinical diagnosis of a minimally conscious state. Additionally, although Katie exhibits certain reflexes and responses to noxious stimuli, all the clinicians were agreed that these are pathological and consistent with a diagnosis of persistent vegetative state.

*Katie's best interests*

74. Having regard to the factors set out by Denham J. in *In re a Ward of Court*, I have first considered Katie's condition and having done so I am satisfied that her current treatment, insofar as it primarily consists of hydration and nutrition, is of no curative benefit to her. The medical experts were unanimous and unequivocal in stating that Katie will not recover from her injuries and that she will not improve in any meaningful way from the state in which she currently finds herself. She cannot communicate with the outside world or with her family and cannot take part in a life of the type she would have valued. I have had regard also to the fact that Katie has expressed the wish not to be left on artificial life support in the kind of circumstances in which she presently finds herself. Relevant also to

my decision is the fact that that Katie has always been very private about her body and that her current care and treatment is at odds with her wishes and preferences in that regard. The 24-hour nursing care, the invasive feeding and her other treatment are an interference with Katie's right to privacy, dignity, autonomy and bodily integrity and, although they have kept her body in good condition, such treatment does not treat her underlying condition. I have taken into account Katie's mother's evidence regarding all of the things Katie loved to do which she can no longer enjoy such as her interests in fashion, singing, socialising with friends and eating out. And, she will never experience again the love and joy of being part of a wonderfully kind and close-knit family who cherished her for all of her individual characteristics earlier described. I have also had regard to the evidence of Katie's sisters that Katie wanted a full and meaningful life and in particular their evidence that she greatly enjoyed her job as a hairdresser and had ambitions to have children and travel, all entirely reasonable expectations so cruelly taken from her.

75. I have also attached weight to the evidence concerning the effect that the withdrawal of nutrition and hydration will have on Katie, from the perspective of possible pain and discomfort. I accept the evidence that, although Katie may show signs of what an outsider might interpret as a response to pain, persons in a persistent vegetative state do not experience pain, hunger or thirst. In this regard I am comforted, in particular by the evidence of Dr Kilbride's that the anatomical parts of Katie's brain that are necessary for consciousness, are no longer present.

76. As a result, taking the view of a loving and considerate parent appraised of all the facts, I find that it is in Katie's best interests that her life support be withdrawn.

**Role of the General Solicitor**

77. Before I conclude I wish to briefly address one particular submission made by counsel on behalf of the committee in the course of the proceedings. This was to the effect that it was part of the role of the General Solicitor in the present application to seek clarification in these proceedings as to how *In re J.J.* might be applied in other cases concerning medical treatment in the context of those who may lack capacity.

78. I have to say that this is a submission with which I disagree for a number of reasons. It is important to reflect upon the fact that the General Solicitor is a party to the within application because she is the committee of the ward. As such, her role was to advise the court as to what she considered to be in Katie's best interests by procuring any evidence she considered might assist the court on that issue and in ensuring that the law, insofar as relevant to this particular application, was correctly identified and applied.

79. However, I believe that the committee went beyond the limit of her role in asking the court to give guidance as to how the decision *In re J.J.* might apply to facts and circumstances in other cases as might in the future come before the court. I say this because it is principally for the court to decide how the law should be applied to the issues that require determination in a given case and any pronouncements as to how the law might apply in other circumstances will, in any case, be *obiter*.

80. Even if some type of authoritative restatement of the law following on from *In re J.J.* might be considered helpful in the context of future applications concerning medical treatment, I am of the view that any clarification as to how the decision *In re J.J.* might be applied beyond the four corners of this application should be left over to be considered in a case in which it arises, when the court will have the benefit of fulsome legal argument from those whose rights are at stake. Furthermore, for better or for worse, the common law develops in a piecemeal fashion and it is only after a number of coherent authorities have been handed down in a particular area that the law can be accurately restated. With a very recent new development in the law, it is simply not possible or indeed desirable to anticipate the direction in which the law will now progress.

81. Accordingly, whilst I am exceedingly grateful to the role which the General Solicitor has played in this case in her efforts to demonstrate what she considers is in Katie's best interests and can understand why Mr. Durcan S.C. made the submission he did on her behalf, I must conclude that in this one modest respect she has overstepped her role.

**Conclusion**

82. For all of the reasons earlier stated I will grant the relief sought by Katie's mother by reference to the draft order. I will remove the relief claimed at para. 2 thereof and make the appropriate changes to para. 3 in light of that alteration.