



Neutral Citation Number: [2006] EWHC 3128 (Fam)

Case No: FD06PO1318

**IN THE HIGH COURT OF JUSTICE**  
**FAMILY DIVISION**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 06/12/2006

Before :

**SIR MARK POTTER**  
**THE PRESIDENT OF THE FAMILY DIVISION**

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Between :

**BPCT**

**Claimant**

**- and -**

**J**

**Defendant**

**(By the Official Solicitor, acting  
As her Litigation Friend)**

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**Mr Huw Lloyd** (instructed by **Hempsons Solicitors**) for the Claimant  
**Caroline Harry-Thomas** (instructed by **Official Solicitor**) for the Defendant

Hearing dates: 6 December 2006

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**Approved Judgment**

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

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**SIR MARK POTTER THE PRESIDENT OF THE FAMILY DIVISION**

This judgment is being handed down in public on 6 December 2006. It consists of 7 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

**Sir Mark Potter, P :**

1. By these proceedings commenced in August 2006, the claimant NHS Trust applied to the court for declarations relating to J, a 53 year old patient in their care who has, for over 3 years now, been in what is known medically as a Permanent Vegetative State (PVS), unaware of her condition and environment and wholly dependant upon the claimant's medical and nursing staff for her care needs 24 hours a day.
2. When the proceedings were issued, the claimant Trust sought declarations that
  - “(a) J lacks the capacity to make decisions as to future medical treatment
  - (b) It is not in the existing circumstances in the best interests of J for continued artificial nutrition and hydration to be provided
  - (c) The claimant and / or the responsible attending medical practitioners, nurses and healthcare staff –
    - (i) may lawfully discontinue and withhold all life sustaining treatment and medical support, including nutrition and hydration by artificial means designed to keep J alive in the permanent vegetative state, and
    - (ii) may lawfully furnish such treatment and nursing care whether in hospital or elsewhere under medical supervision as may be appropriate to ensure that J suffers the least distress and retains the greatest dignity until such time as her life comes to and end.”
3. The proceedings had the support of J's family who are devoted to her and have visited her constantly over the past 3 years; and also of the Official Solicitor who, by an order of Bennett J on 3 August 2006 was appointed as J's litigation friend responsible for representing her interests, the court declaring on that day that J lacked the capacity to make decisions as to future medical treatment.
4. At the time the proceedings were commenced, the claimant Trust relied upon the opinion of Professor Keith Andrews, an eminent and internationally renowned specialist in neuro-disability and, in particular, PVS. His view was that J was in a profound form of PVS, that further investigations of her case would add nothing to the clinical knowledge in respect of J, in whom he found no evidence of mental function which would allow her to be aware, even at a simple or basic level, of her internal and external environment. J met all the criteria for diagnosis for PVS

- promulgated by the Royal College of Physicians in 2003. The prognosis was that recovery was almost impossible and that, if no action was taken to remove the gastrostomy tube through which J is fed, and if any acute medical episodes which might occur were fully treated, J might well live on in her present state for a further 5 years or so.
5. Had that remained the state of the evidence when the matter came before me on 8 November, as I then made clear, I would have had no hesitation in granting the declarations sought.
  6. It is now well established, since the House of Lords authority of *Airedale NHS Trust v Bland* [1993] 1 FLR 1526 that the existence of a patient in what is known as the persistent vegetative state with no prospect of recovery is, by medical and legal opinion, of no benefit to the patient, and that it is lawful to cease to give medical treatment and care to a patient who is in that state, and that to do so does not involve any breach of Article 2 of the ECHR.
  7. However, by the time the matter came before me, the position had become less straightforward. Subsequent to the report of Professor Andrews, on the basis of which the proceedings had been started, there had recently been published two research articles which had come to the attention of the Official Solicitor. Both suggested that in certain cases, patients described as being in a state of PVS might nonetheless be revived to a level of wakefulness and appreciation of their surroundings which could enable them to communicate in a meaningful manner and even improve to a dramatic extent. Having considered the two articles, Professor Andrews did not consider one of them to be in any way helpful or requiring substantial consideration in relation to the case of J. The other however, gave him more pause for thought. It was an article entitled “Drug induced arousal from the permanent vegetative state” published by Ralph Clauss and Wally Nel in the journal of Neuro Rehabilitation, Volume 21, 2006 at p28. Professor Andrews had considerable reservations about the validity of the results spoken to in that article and, in particular, whether they could afford any ground for supposing that administration of the drug the subject of that article, namely Zolpidem, a drug normally used for the treatment of insomnia, would have any effect on J, given the level and duration of her condition of PVS.
  8. However in two subsequent letters of report placed before me, Professor Andrews, in the course of a fairly detailed consideration of the article, stated inter alia:

“The value of Zolpidem is as yet uncertain. Zolpidem is a sleeping medication which has been used on three patients in supposedly the vegetative state and all patients improved in the level of being awake and their brain scan showed improvement in brain perfusion.... Whilst the evidence is still debatable, there is no reason why J should not be given a trial of treatment. Zolpidem is generally safe and widely

used. I have tried it on a vegetative patient without any effect, except that she slept more. Since the medication, when it is effective is immediate, usually within 45 minutes, if there is no response in three days, then it can be presumed that there is not going to be any response.”. (Letter dated 19 October 2006)

“I suggest that since the Zolpidem is a relatively safe medication it is in J’s safe interest to try the medication for three days. It is said to have immediate effect within an hour and it has not been reported as having an effect if there is no response within three days (personal communication with Dr Clauss, author of the paper describing Zolpidem in VS)”. (Letter dated 26 October 2006)

9. In the light of those observations, when the matter was last before me the position of the Official Solicitor, unopposed by the claimant Trust, was that, before a final decision was made in J’s case, she should be administered a 3-day course of Zolpidem to see whether it would have any beneficial effect on her condition, it being quite clear that the treatment which would involve administration of Zolpidem at intervals could immediately be suspended if it appeared to have any untoward effect or to cause any distress to the patient.
10. The family, on the other hand, made clear in statements that were before me their fear that, if the proposed trial of Zolpidem were undertaken and had any effect, J might awake temporarily and realise the condition that she was in. That was a very distressing thought for the family, who had been comforted by the knowledge that J had no insight to her condition, and they feared that, if consciousness with such insight returned, it might cause her sadness and pain. They also stated that, even if Zolpidem did have an arousing effect, they did not consider that J would have any meaningful quality of life and this was not something that she herself would have wanted, given views that she had expressed to the family in former days when she was active and well.
11. In these circumstances I felt it right to hear from Professor Andrews at length and, in particular, to explore with him the likelihood that, if Zolpidem were administered, it would (a) produce any positive result in J’s case and (b) if it did, whether it might lead to any distress or suffering on J’s part as feared by the family. The position at the end of his evidence was as follows and, in this respect, I can not do better than quote from the judgment which I gave on 8 November 2006  
  
“30. He gave the reason for his view that it would be in the best interests of J to have the treatment essentially as being that, while there was a very slim outside chance of any effect being achieved, it was important that any patient in this state should be given a chance to recover if there was any such chance,

however remote. In short, the 3-day course he recommends gives a glimmer of hope, a possible upside, with no real downside in terms of patient welfare. In those circumstances, he regarded it as appropriate that there should be a short trial, pessimistic as he is as to a positive outcome.

31. I think I have already made it clear that, subject only to the recent emergence of published literature relating to zolpidem, I would unhesitatingly have granted the relief claimed. However, in the light of the evidence I have heard from Professor Andrews, I have come to the conclusion that I should accede to the submission of the Official Solicitor, whose duty is to represent the patient's interests, and the view of Professor Andrews on whom the Trust rely, that a short trial of three days should take place. I have hesitated in coming to that conclusion because it is Dr Andrews' expert opinion that the treatment is unlikely to have any beneficial effect. I also bear anxiously in mind the fears of the family. The last thing I would wish to do would be to take a decision which might, despite the best of medical intentions, revive the patient, not to her benefit, but so as to cause her suffering or anxiety. The position is however that, as the leading expert in this country, Professor Andrews, on the basis of what he has read and the enquiries he has made, considers that there is an outside chance worthy of trial, which is unlikely to involve any kind of suffering or upset should consciousness be restored. Thus, he does not regard the fears of the family to be well founded and he makes the point that, should any apparent distress be caused on the patient regaining consciousness, then of course the treatment can be stopped.

32. In those circumstances, it seems to me that the appropriate course is to sanction a short course of zolpidem in the near future with a view to a speedy return to this court for final disposal should the trial produce no positive or beneficial effect on J”.
  
12. The position is now that J has had administered to her a 3-day course of Zolpidem, witnessed by her family on 14, 15 & 16 November 2006. Professor Andrews opinion that it was unlikely to produce any positive effect has indeed proved justified. J was carefully watched for any response or sign of increased awareness. The drug produced no increased responsiveness and instead it appeared to make J fall asleep, that is to say it had its normal intended effect, Zolpidem being a form of sleeping pill marketed as effective in dealing with cases of insomnia.
13. Following this procedure, Professor Andrews, in a short report dated 20 November 2006, has stated that the Zolpidem treatment has confirmed first, that there is no evidence that J has any mental awareness and that everything has been done to provide such evidence; second, his diagnosis that J is in a state of PVS and that there are no clinical reasons why nutrition and hydration should not be removed.
14. Having considered the results of the Zolpidem treatment and, in the light all the other evidence, the effect of which was set out by me in my judgment of 8 November 2006, the Official Solicitor now supports the claimant Trust’s application for declarations to the effect sought and in particular that it is lawful, as being in J’s best interest, for life sustaining treatment and medical support designed to keep her alive in her permanent vegetative state to be discontinued. As already indicated, the family of J, namely her husband, their two daughters and J’s mother unanimously support that application.
15. On 8 November 2006, as already mentioned, I gave a very full judgment, anonymised for the purpose of being reported suffice it to say, that judgment set out the circumstances of J’s case, the evidence placed before me and the legal principles to be applied in a case of this kind. Having done so, I made clear that subject only to the question of treatment with Zolpidem, I would have considered it appropriate to make the declarations sought. Now that such treatment has been carried out to no significant effect, I am quite satisfied that I should make the declarations sought, in a form of wording agreed between the parties and now put before me.
16. I have been told that by an unfortunate error in the listing office, this case has been identified for hearing today by name. On 3 August 2006 Bennett J made orders under Part 39.2 (4) CPR anonymising, for the purposes of the proceedings or the trial; the parties, the witnesses (save for any independent expert witnesses) and the facilities where J is cared for and is to be cared for. Those orders have continued to apply and apply to the reporting of this judgment.