***Para 3.11** Note, in relation to the penultimate paragraph of p 49 of the text, the decision of the Supreme Court in *A NHS Trust v Y* [2018] UKSC 46, where the issue was whether a court order must always be obtained before clinically assisted nutrition and hydration (CANH), which is keeping alive a person with a 'prolonged disorder of consciousness' (PDOC), a term which encompasses both a persistent vegetative state (PVS) and a minimally conscious state (MCS).

Before discussing this issue the Supreme Court reviewed the main provisions of general application of the post-*Bland* Mental Capacity Act 2005 (MCA 2005) which were relevant to it. It noted that that Act now provides the statutory context within which treatment decisions are taken in relation to those who lack capacity.

The Court started with two provisions which place the best interests of the person who lacks capacity at the heart of the process. First, by s 1(5), an act done, or a decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. Second, by s 4, where a person is determining, for the purposes of the Act, what is in a person's best interests, all the relevant circumstances must be considered, and the steps listed in s 4 must be taken. They include:

- considering, so far as reasonably ascertainable, the person's wishes and feelings, and the beliefs and values that would be likely to influence his decision if he had capacity, as well as the other factors that he would be likely to consider if he were able to do so;
- account must be taken of the views of various specified people who have some responsibility for or are interested in his welfare;
- where the determination relates to life-saving treatment, a person considering whether the treatment is in the best interests of the person concerned must not be motivated by a desire to bring about his death.

Section 5 allows carers, including health professionals, to carry out acts in connection with (inter alia) the treatment of a person who lacks capacity to consent. It provides a significant degree of protection from liability, provided that the act is done in the reasonable belief that capacity is lacking and that the act is in the patient's best interests. If these conditions are satisfied, no more liability is incurred than would have been incurred if the patient had had capacity to consent and had done so.

The Supreme Court noted that someone acting in a professional capacity in relation to a person who lacks capacity must have regard to any relevant code issued by the Lord Chancellor to give guidance on subjects under the MCA 2005, and that if it appears to a court conducting any criminal or civil proceedings that a provision of a code, or a failure to comply with a code, is relevant to a question

arising in the proceedings, the provision or failure must be taken into account in deciding the question (s 42).
Having examined *Airedale NHS Trust v Bland* [1993] AC 789, the Supreme Court held that the House of Lords had not in that case imposed a common law requirement that in all cases of PVS patients an application must be made to a court before CANH was discontinued. Instead, the House had recommended as a matter of good practice that guidance be obtained from the court. That position had been judicially confirmed before the MCA 2005.

Accordingly, when the MCA 2005 (which made no such requirement) came into force there was no universal requirement, at common law, to apply to a court for guidance prior to withdrawing CANH. Nor was one imposed by any post-MCA 2005 case. Turning to the Mental Capacity Act 2005 Code of Practice issued by the Lord Chancellor, the Court stated that it was somewhat ambiguous about the point at issue and did not create an obligation as a matter of law to apply to court in every case.

Having reviewed the relevant case law on the European Convention on Human Rights, the Supreme Court also held that the Convention did not generate a requirement in domestic law for an application to court in the present type of case.

The Supreme Court therefore concluded that neither the common law nor the ECHR gave rise to a mandatory requirement to involve the court in deciding upon the best interests of every PDOC patient before CANH could be withdrawn. If the provisions of the MCA 2005 were followed and the relevant guidance observed, and if there was agreement upon what was in the best interests of the patient, the patient could be treated in accordance with that agreement without an application to the court. However, although application to the court was not necessary in every case, there would undoubtedly be cases in which an application would be required (or desirable) because of the particular circumstances that appertained, and there should be no reticence about involving the court in such cases.

***Paras 3.39 – 3.41, 3.47 and 3.49** Note in relation to these paragraphs the Court of Appeal's decision in *Wallace* [2018] EWCA Crim 690, tragic and unusual case involving very special and particular facts (as the Court recognised).

In September 2015, D threw acid over V, whose resulting injuries left him disfigured, completely paralysed, partially blind and in a permanent state of unbearable constant physical and psychological pain. In November 2016, V's father took him to Belgium, where, after being told that his condition was permanent with no prospect of improvement, V was euthanised under Belgian law by doctors at his request. At D's trial for murder, the trial judge accepted a

plea of no case to answer, ruling that V's request for euthanasia, and the actions of the Belgian doctors in providing it, were independent free and voluntary acts which broke the chain of causation between D's conduct in throwing the acid, and V's death.

The Court of Appeal allowed the prosecution's appeal against this ruling and ordered a retrial, holding that that the actions of V and the Belgian doctors in seeking V's death as a response to his horrific injuries did not preclude the jury finding that V's decision to ask for euthanasia, and the Belgian doctors' acts in carrying it out, were not only direct and discernible results of the injuries that D had inflicted upon V, but decisions which were not truly free and voluntary. The intervening acts of V and the Belgian doctors were not random extraneous events or acts unconnected with the fault element of D's conduct; they were inextricably bound up with it. Looked at in this way, V's request to the doctors and the act of euthanasia itself carried out in accordance with his wishes were not discrete acts or events independent of D's conduct, nor were they voluntary, in the sense that they were the product of the sort of free and unfettered volition, and therefore the situation was clearly distinguishable from that with which the House of Lords was concerned in *Kennedy (No 2)* [2007] UKHL 38 (dealt with in particular in paras 3.40 and 3.41 of the text). Instead they were a direct response to the inflicted injuries and to the circumstances created by them for which D was responsible. If the question was then asked whether, on a common-sense view, D's conduct merely set the stage for V's death, or was instrumental in bringing it about, the jury could properly answer that question in the prosecution's favour.

The Court held that, although the Belgian doctors considered V's request to be 'voluntary' for the purposes of the Belgian law on euthanasia, this did not determine whether his decision was voluntary for the purposes of the different legal issues arising in the case; on its very special facts, the jury might conclude that there was nothing which could decently be described as voluntary either in the suffering or in the decision by V to end his life, given the truly terrible situation he was in.

Although the doctors who carried out the euthanasia were not obliged under Belgian law to participate in it, so in that sense their actions were entirely voluntary, the Court of Appeal did not consider that this was a determinative distinction. It said (at [85]):

'It would... seem an odd result, if a defendant who paralysed one victim but not another in identical circumstances (so the second could take their own life, but the first could only do so through the intervention of a third party) would be legally responsible for the death of the second victim but not the first. In the event we consider that the jury could conclude on the facts as they were here that the acts of [V] and the doctors were not sensibly divisible; that the doctors'(lawful)

conduct in carrying out with their hand what he could not carry out with his own was but one link in the chain of events instigated by [D] and , notwithstanding the intervening act of [V] and/or the doctors, [D's] conduct could fairly be said to have made *a* significant [see para 3.28, n 90] contribution to [V's] death ...[I]n the light of the decision in *Dear* [see para 3.47] the seeking of death … as a response to horrific injuries does not preclude the jury finding that [D's] conduct made a significant contribution to [V's] death.'

The Court of Appeal held that the issue of foreseeability was relevant to D's liability and would need to be decided at the retrial. The jury would need to be sure that at the time of the acid attack it was reasonably foreseeable that V would commit suicide as a result of his injuries. In answering that question the jury would need to consider all the circumstances, including the nature of the attack, what D did and said at the time and whether or not V's decision to undergo voluntary euthanasia fell within the range of responses which might have been expected from a victim in his situation.

Para 3.56 *Morby* (1882) 8 QBD 571, CCR, cited at n 153, was applied by the Court of Appeal in *Sellu* [2016] EWCA Crim 1716 who said that it was the classical statement for the point referred to in the text. *Morby* was applied shortly after *Sellu* in *Bawa-Garba* [2016] EWCA Crim 1841.