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PUZZLES OF THE LIMINAL DEAD: *ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST V CASEY*

MARY DONNELLY AND BARRY LYONS

INTRODUCTION

St George's University Hospitals NHS Foundation Trust v Casey[1] is the latest in a growing line of cases before the UK courts concerning objections to the determination of brain stem death (BD).[2] The case is distinguishable from most of the earlier jurisprudence because it concerned an adult[3] and, in this respect, it provides helpful clarity regarding the procedural framework to be applied in such situations. However, as we will see below, in other respects the case serves to increase confusion. One particular problem that arises from the judgment in *Casey* is how we conceptualise the legal status of an individual who has been found to be brain dead by clinicians, but this finding is disputed by families, either in respect of procedure or substance, and the courts have been asked to rule on the matter. The case also raises new questions about the operationalisation of testing for BD, which questions assume particular significance given the ongoing work to revise the Academy of Medical Royal Colleges' *Code of Practice for the Diagnosis and Confirmation of Death* (2008) (hereafter 'the Code'). This commentary will explore both of these aspects of the case. First, however, we outline the facts and identify those areas in which the legal position has been clarified.

THE FACTS IN OUTLINE

On 9 July 2023, Mr Andy Casey was assaulted in a pub garden, and was subsequently admitted to the Neurointensive Care Unit at St George's Hospital. On admission, a CT scan showed widespread bleeding in and around his brain and possible early signs of hypoxic-ischaemic brain injury.[4] Mechanical ventilation and organ support was provided to Mr Casey and although there was initially some spontaneous respiratory activity, this subsequently ceased. By 13 July, Mr Casey's treating clinicians considered that he should be tested for BD. Mr Casey's family did not agree to this and so, on 16 July, an emergency application was made to the Court of Protection and an order was made permitting brain stem testing in accordance with the Code.[5] Testing for BD was carried out on 16 July and repeated on 17 July, in the presence of Mr Casey's family. In the absence of response on either test, Mr Casey was diagnosed as brain dead, with the time of death being 23:51 on 16 July.[6]

Following a diagnosis of BD it is normal practice that somatic support is withdrawn within 24-48 hours.[7] However, Mr Casey's family disputed the diagnosis. Although the family made some references to religious and philosophical beliefs, MacDonald J identified the 'genesis of the family's

[1] [2023] EWHC 2244 (Fam); [2023] EWCA Civ 1092.
[2] For discussion of previous cases, see M. Donnelly and B. Lyons, 'Disputing Death: Brain Death in the Courts' (2023) 43(2) LS 351; B. Lyons and M. Donnelly, 'A Different Kind of Death? *Barts NHS Trust v Dance and Battersbee* 23(2) Med Law Int 159.
[3] While most prior caselaw concerned children, both *North West Anglia NHS Foundation Trust v BN* [2022] EWHC 663 (Fam) both *A Health and Social Care Trust v RL* [2022] NIFam 17 concerned adults.
[4] [2023] EWHC 2244 (Fam), [11].
[5] *Ibid*., [13].
[6] *Ibid*., [18].
[7] *Ibid*., [20].

concerns'[8] as movements by Mr Casey which they had witnessed and which they believed indicated that he was not brain dead.[9] These movements included hand, head and finger movements, some of which Mr Casey's family believed were triggered by requests by them, as well as indications on the monitor (the appearance of a two lungs symbol) that Mr Casey was attempting to breathe independently.[10] Videos of Mr Casey's movements were presented in evidence. The hospital did not dispute that these movements had taken place although it pointed out that such movements were involuntary muscle tensions, and as such were not inconsistent with a diagnosis of BD.[11] Such movements may include a grasp reflex, reminiscent of a hand squeeze, and the so-called, 'Lazarus sign' where the person raises their arms and crosses them on their chest.[12]

At the request of Mr Casey's family, the matter was referred to the hospital's Ethics Committee which agreed with the clinical approach taken. This was followed by mediation, which failed to reach a resolution. During this period, Mr Casey's family obtained a second opinion and extensive ancillary testing was completed. Ultimately, St George's Hospital made an application under the inherent jurisdiction to the Family Division of the High Court. On 23 August, at a hearing before Moor J, Mr Casey was joined as First Respondent to the proceedings and the Official Solicitor was appointed as his litigation friend.[13] However, as discussed further below, the Official Solicitor declined to undertake this role and, instead, MacDonald J invited the Official Solicitor to act as Advocate to the Court, which she agreed to do.[14]

MacDonald J noted that there was no indication that BD testing had not been carried out in accordance with the Code[15] and on this basis he refused Mr Casey's family's application that a further expert be appointed to repeat the tests.[16] Having viewed the videos, he had no difficulty understanding why Mr Casey's family believed that he was not brain dead. However, he found that, based on the totality of the evidence, the video evidence did not demonstrate an error in BD testing.[17] In light of this, he held that Mr Casey had died at 23:51 on 16 July, at which point irreversible cessation of brain stem function had been established and that in such circumstances, it was lawful to cease ventilation and not to attempt resuscitation.[18] Mr Casey's family sought leave to appeal, citing five grounds: the judge's refusal to appoint an expert; the absence of a litigation friend; the judge's treatment of BD as legal death; the judge's use of the civil burden of proof; and, the judge's not having carried out a best interests assessment. The Court of Appeal refused, finding that there were no compelling legal reasons to grant leave to appeal.[19]

CLARIFICATIONS OF LEGAL POSITION

Presumably recognising that this would not be the last case of this kind to come before the courts, the Official Solicitor invited MacDonald J to provide guidance on the use of the inherent jurisdiction

[8] *Ibid*., [20].
[9] *Ibid*., [20].
[10] *Ibid*., [21], [22].
[11] *Ibid*., [68] – [70].
[12] *Ibid*., [69].
[13] *Ibid.*, [2].
[14] *Ibid.*, [2].
[15] *Ibid*., [63].
[16] *Ibid*., [63].
[17] *Ibid*., [66].
[18] *Ibid.,* [81].
[19] [2023] EWCA Civ 1092, [33].

in respect of declarations of death s concerning adults.[20] Whilst recognising that each case is to be determined on its own facts, MacDonald J provided a summary of relevant conclusions.[21] He affirmed that, as had been established in respect of children, the diagnosis and confirmation of BD is made by doctors in accordance with the Code[22] and that, if the result of testing is that the person is dead, the matter of best interests is no longer relevant.[23]

MacDonald J also outlined the procedural steps to be taken in the event of disputes. First, where there is a disagreement about whether testing for BD should proceed, an application should be made to the Court of Protection and the matter should be determined in accordance with the Mental Capacity Act 2005. This should include the application of the best interests standard and the Official Solicitor should act as Litigation Friend for the adult. The identification of the requirement for referral to court is especially helpful given that several recent publications had advanced the proposition that consent to (and by implication court authorisation of) testing was not required.[24]

Second, where there has been a clinical diagnosis of BD, and there is a dispute between treating clinicians and family members, an application should be made to the Family Division of the High Court under Part 8 of the Civil Procedure Rules (CPR)[25] for a declaration of death under the inherent jurisdiction of the High Court. This application should be undertaken as soon as practicable after the diagnosis of death. Ordinarily, the application will be brought by the relevant NHS Trust and the respondents will be family members of the person diagnosed brain dead. On the scope of the Part 8 application, MacDonald J stated that:

> [T]he narrow issue for the court to decide on a Part 8 application is whether the patient has died, requiring the court to consider the results of the brain stem testing undertaken and ascertain whether the tests were undertaken in accordance with the 2008 Code of Practice.[26]

This should be determined on the basis of the balance of probabilities[27] and where so determined, the Court should make a declaration of death and that it is lawful for the relevant medical professional to cease mechanical ventilation, extubate the patient, cease all medications and not attempt cardio-pulmonary resuscitation.[28]

While this outline of procedural steps is helpful, as we will see below, the circumstances in *Casey* also give rise to questions which are not so easily resolved. Below, we examine in more detail some issues that arose in respect of the role of testing, and the legal status of a person who has been diagnosed brain dead but this diagnosis is challenged.

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[20] [2023] EWHC 2244 (Fam), [61].
[21] *Ibid*., [61].
[22] As established in respect of children by *Dance & Ors v Barts Health NHS Trust (Re Archie Battersbee)* [2022] EWCA Civ 1055.
[23] As established in respect of children by *Re M (Declaration of Death of Child)* [2020] EWCA Civ 164, albeit this position was arrived at without any formal analysis.
[24] See T.M. Pope, J.A. Chandler, M. Hartwick, 'Consent for determination of death by neurologic criteria in Canada: an analysis of legal and ethical authorities, and consensus-based working group recommendations' (2023) 70 Can J Anesth/J Can Anesth 570; A. Lewis, 'An Overview of Ethical Issues Raised by Medicolegal Challenges to Death by Neurologic Criteria' (2023) American Journal of Bioethics, doi: 10.1080/15265161.2022.2160516. For a critique of the position adopted, see B. Lyons and M. Donnelly, 'Consent to Testing for Brain Death' (2023) JME, doi: 10.1136/jme-2023-109425.
[25] Part 8 of the CPR is used in cases where the claimant seeks the Court's decision on a question which is unlikely to involve a substantial dispute of fact: CPR, r. 8(2).
[26] [2023] EWHC 2244 (Fam), [61(v)].
[27] *Ibid*., [50].
[28] *Ibid*., [61(vii)].

TESTING FOR BRAIN STEM DEATH

There are some unusual features to the way in which testing in *Casey* was carried out which merit closer exploration. The first relates to the process whereby testing was authorised. An emergency application was made to the Court following the family's refusal to agree to testing for brain death. As described by MacDonald J, 'in circumstances where there was a narrow window for brain stem testing to be undertaken safely, an application was made out of hours to Peel J sitting as a judge of the Court of Protection on 16 July 2023'.[29]

Out-of-hours applications to the Court of Protection are reserved for 'urgent' matters.[30] Although the Court of Protection Rules do not define urgent matters, its website indicates that emergency applications may only be made 'in a very serious situation' where there is 'an immediate risk to the person'. [31] MacDonald J had 'the benefit of counsel's note of Peel J's *ex tempore* judgment', which we lack and thus we do not know the exact circumstances surrounding the application. However, it is difficult to understand why this situation constituted an emergency. There would appear to be three possible motivations for the emergency application. The first is what was declared - that there was a 'narrow window for brain stem testing to be undertaken safely'. Yet it is uncertain what this means. The apparent risk is that Mr. Casey's physiological condition was so unstable that he was in danger of cardiovascular collapse prior to, or during, testing– that, in essence, he might die before being pronounced brain dead. On its own this would seem perverse. A second possible motivation arises from the first – a person who dies from the cessation of their heart beat cannot be an organ donor, unless this takes place in a highly controlled and prescribed way.[32] A declaration of BD better preserves the possibility of organ donation, although this seems a highly improbable outcome where a family has been forced into Court out of hours and has had their objection to proposed testing overridden.[33] A third possibility is that there was significant pressure on Intensive Care beds or ventilators, and that providing continued interventions to a person who may be dead constitutes a waste of resources which may impact directly on the care of others. This latter concern is often proposed as a justification for why brain death testing should proceed regardless of any prior wishes expressed by the patient, or current objections by the family.[34] However, if this was the reason for accelerated testing, it is difficult to see that this constitutes a risk for Mr Casey such as to merit an emergency hearing. More practically, if this was the aim, the plan was unsuccessful as, due to the entirely foreseeable appeals lodged on behalf of the family, Mr. Casey remained ventilated in the Intensive Care Unit at the time of the Court of Appeal hearing some two and a half months after his admission.

In light of the shortened preparatory time for counsel and judges, emergency applications generally concern the legal rule that should obtain while litigation is in course rather than a final resolution of

[29] [2023] EWHC 2244 (Fam), [13].

[30]See Court of Protection Rules 2007, Pt. 10, as supplemented by Practice Direction 10B: Urgent and Interim Applications, available at https://www.judiciary.uk/wp-content/uploads/2015/06/copd-pd-10b-urgent-and-interim-applications.pdf, accessed 27.12.2023.

[31]See https://www.gov.uk/emergency-court-of-protection, accessed 27.12.2023.

[32] D. Gardiner 'How the UK overcame the ethical, legal and professional challenges in donation after circulatory death' (2016) 16 *QUT Law Review* 125.

[33] This remains the case notwithstanding the introduction of 'opt-out' legislation such as the Human Transplantation (Wales) Act 2015; the Organ Donation (Deemed Consent) Act 2019 (England); the Human Tissue (Authorisation) Scotland Act 2019 (Scotland) and the Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Bill 2022 (shortly to be enacted in Ireland). In each case, a 'soft opt-out' model means that if the deceased's family (or other persons) state that the deceased would not wish their organs to be retrieved for donation, retrieval will not proceed.

[34] See eg Pope et al (n.24).

the matter. However in medical cases, such applications usually give rise to clinical actions and so the stakes are considerably higher. Concerns have occasionally been raised about the apparently peremptory nature of hearings arising from emergency applications in medical cases.[35] Notwithstanding these criticisms, the purpose of emergency applications in medical cases is largely directed towards the avoidance of potentially preventable harm. *Casey* does not fit this picture and the case raises questions about the suitability of an urgent application as an appropriate legal pathway for cases that are centrally concerned with the termination of medical interventions, and the end of a life.

The second medical issue involves the nature of the testing carried out on Mr. Casey. The Code outlines a six-step procedure for clinical testing,[36] and robustly asserts the accuracy of this process for the diagnosis of brain death. Thus, while some other jurisdictions require neurophysiological or radiological investigations in addition to clinical testing, this is not part of the standard assessment in the UK.[37] The pre-eminence of clinical testing was further emphasised by the expert witness in *Barts Health NHS Trust v Dance and Battersbee* – 'no other tests would be acceptable'[38] - an opinion that was upheld, and emphasised, by the Court of Appeal.[39]

The two consultants involved in the clinical testing of Mr. Casey[40] carried out 'the full spectrum of tests stipulated by the 2008 Code', and were satisfied that Mr Casey was dead, and that his condition was due to irreversible brain damage caused by a traumatic brain injury and a subsequent hypoxic-ischaemic encephalopathy.[41] However, the family's expert witness was not content with the examination, and raised the possibility that a cervical spine fracture may have impacted on the results. The expert thus 'strongly recommended' a series of ancillary investigations, opining 'that the performance of these additional tests would ensure that Mr Casey's family could be confident of the nature of the severity of the injury and likely prognosis of Mr Casey's condition'.[42] The institutional Ethics Committee agreed for the need to 'ensure the family had the fullest confidence in the clinical assessment'. It therefore recommended additional testing even though 'it would not itself confirm or refute the diagnosis of death'.[43] Mr. Casey subsequently underwent extensive supplementary investigations, including some at the request of the family. All the tests indicated severe neurological injury, or findings 'consistent with the clinical diagnosis of death'.[44]

Giving evidence, Dr S, a Consultant in Neurointensive Care, described the level of testing of Mr. Casey as 'highly exceptional'.[45] While further examination of the cervical spine may have been indicated in light of the concern raised, all of the other neuroradiological and neurophysiological testing appears unwarranted according to the interpretations of the Code by both the experts, and the Court of

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[35] One common example related to applications for authorisation to carry out a caesarean section against the expressed wishes of the woman: see C. Dyer 'Caesareans without consent authorised' (1996) 313 *BMJ* 705. It has now become more common practice to seek advance approval for such procedures rather than waiting for an emergency to arise: see A. Hulme, 'An Emerging Pattern?: A Further Case of Anticipated Capacity Loss in Pregnancy: *North Middlesex University Hospital v SR [2021] EWCOP 58*' (2022) 30(3) Med L Rev 544.

[36] The Code outlines the stages of the test in paras 6.1.1 – 6.1.6.

[37] A substantial number of European countries require both clinical and ancillary tests for the diagnosis of brain death to be made. See A. Lewis et al. 'Determination of Death by Neurologic Criteria Around the World' (2020) 95 *Neurology* e299.

[38] *Barts Health NHS Trust v Dance and Battersbee* [2022] EWHC 1165, [64].

[39] *Barts Health NHS Trust v Dance and Battersbee* [2022] EWCA Civ 935, [33].

[40] The first test was performed by Dr O, with Dr C observing and the second by Dr C with Dr O observing: [2023] EWHC 2244 (Fam), [17].

[41] *Ibid.,* [16].

[42] *Ibid.,*, [26].

[43] *Ibid*., [28].

[44] *Ibid*., [32].

[45] *Ibid*., [33].

Appeal, in *Battersbee*. Furthermore, guidance from the Faculty of Intensive Care Medicine states that '(A)ncillary investigations are **NOT** required for the diagnosis and confirmation of death using neurological criteria'.[46]

The approach to testing in *Casey* raises questions about variability in testing for brain death, and differing interpretations of what is required under particular circumstances. The family's expert identified a need for further investigations that the testing doctors did not deem necessary, yet these further investigations were carried out. This approach to testing extended beyond outruling potentially confounding diagnoses to the need for reassurance of the family through technical examinations. Mr Casey's treating team disagreed 'with a number of the assertions and recommendations' made the family's expert, but recognised that doctor's medical qualifications to make such suggestions.[47]

All of this points to differences in interpretation and application of the Code, and highlights its failure to provide robust and effective guidance in contested situations. This is a reflection of its history including that, at the time of its publication, deference to medical authority to determine death was unquestioned and unexamined. But recent scrutiny wrought through litigation has laid bare deficiencies in the Code, caused confusion in courts, and highlighted divergence that would otherwise have remained untested.[48] Research in other jurisdictions, notably the US and Canada,[49] has demonstrated a significant level of variability in brain death testing, differences that appear to be accentuated when families resist the diagnosis of brain death rather than acquiesce to it.[50] While variability of opinion between medical practitioners in any clinical domain is hardly newsworthy, nonetheless, where the decision fundamentally alters the legal status of the individual more definitive guidance that limits the latitude of individual decision-making is warranted.

LEGAL STATUS IN CASES OF DISPUTE

In addition to laying bare deficiencies in the Code, the proceedings in *Casey* reveal a legal conundrum inherent in challenges to BD, specifically what is the status of the person who has been diagnosed dead in accordance with the Code, but where this finding is disputed? This question has both an ethical/normative and a procedural dimension. In *Casey*, the primary focus was on the procedural aspects, and especially the role of the Official Solicitor where the diagnosis of BD is disputed. As we saw above, at the initial hearing of the case, Moor J joined Mr Casey as respondent and appointed the Official Solicitor as his litigation friend.[51] The Official Solicitor declined to take on this role, stating that, unlike proceedings before the Court of Protection regarding whether brain stem testing should

[46] Emphasis in the original. This is also endorsed by the Intensive Care Society, and is used in the *Forms for the Diagnosis of Death using Neurological Criteria*. https://www.ficm.ac.uk/index.php/diagnosing-death-using-neurological-criteria.
[47] [2023] EWHC 2244 (Fam), [28].
[48] See Donnelly & Lyons (n. 2); Lyons and Donnelly (n. 2).
[49] See for example A. Junn , DY Hwang. 'Focus: Death: Practice Variability in Determination of Death by Neurologic Criteria for Adult Patients' (2019) 92 *Yale Journal of Biology and Medicine* 719; M. Chassé et al. Clinical evaluation and ancillary testing for the diagnosis of death by neurologic criteria: a cross-sectional survey of Canadian intensivists. (2022) 69 *Canadian Journal of Anesthesia/Journal canadien d'anesthésie* 353; AR Joffe, NR Anton, JP Duff , A Decaen, 'A survey of American neurologists about brain death: understanding the conceptual basis and diagnostic tests for brain death'(2012) 2 *Annals of Intensive Care* 1.
[50] AL Flamm, ML Smith ML, PA Mayer, 'Family members' requests to extend physiologic support after declaration of brain death: a case series analysis and proposed guidelines for clinical management' (2014) 25 *Journal of Clinical Ethics* 222.
[51] *Ibid*., [2].

take place, it was not necessary to join the Official Solicitor where the person had been diagnosed dead 'given the narrow question that falls to be determined where there is a dispute'.[52]

MacDonald J agreed, finding that there is no procedural rule which requires that a person who has been diagnosed brain dead in accordance with the Code to be joined as a party where there is a dispute about this diagnosis.[53] He also noted that it had not been the practice in prior cases to join the Official Solicitor.[54] He found that this was consistent with the issue before the Court which was 'the narrow question of whether the subject of the application is dead according to the outcome of those brain stem tests and the 2008 Code of Practice'.[55]

Mr Casey's family appealed, *inter alia,* on the basis that the absence of a litigation friend rendered the High Court proceedings a nullity. They argued that 'until the court has made a declaration of death, the assumption should be that the individual concerned is alive and must be represented' and that 'by making an assumption of death before the issue has been decided by the court, the court has circumvented the important protections contained in the common law and in article 2 and 6 European Convention on Human Rights.' [56] The Court of Appeal rejected this argument,[57] albeit without any conceptual analysis. The Court stated that MacDonald J had considered this argument at some length and had concluded that it had not been necessary to add Mr Casey as a party to the proceedings 'because of the state of the evidence when they were issued'.[58] The evidence that Mr Casey was dead 'was so strong that it was reasonable for the judge to take the course he did.'[59] The Court also noted that the argument was, in any case, a 'purely formal one' and that Mr Casey's interests had been 'very fully protected by the extent of the investigation, the protection of his family and the surveillance of the Official Solicitor.'[60] With permission to appeal denied, MacDonald J's declaration that Andy Casey had died at 23:51 on 16 July stood.

What then was Mr Casey's legal status during the time between 23:51 on 16 July and the time the Court of Appeal upheld MacDonald J's declaration of death? In considering this, we can look first to MacDonald J's description of the function of the Court:

> where, as in this case, brain stem testing has been undertaken in accordance with the 2008 Code of Practice … the court … [is] concerned only with the question of whether the subject of the application is dead, requiring the court to consider the results of the brain stem testing undertaken and ascertain whether the tests were undertaken in accordance with the 2008 Code of Practice. [61]

According to the Court of Appeal in *Barts Health NHS Trust v Dance and Battersbee* it is, 'ultimately, for the court to determine whether or not to make a declaration of death'.[62] The Court here went on to reverse the earlier High Court declaration that Archie Battersbee was brain dead, having found that testing was not carried out in accordance with the Code.[63] While *Battersbee* differs from *Casey*

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[52] *Ibid.*, [56].
[53] *Ibid.*, [57]. MacDonald J. also accepted (although without hearing detailed submissions on the point), *ibid*., [55] that a judicial appointment of the Official Solicitor as litigation friend requires the agreement of the Official Solicitor.
[54] *Ibid*., [57].
[55] *Ibid.*, [57].
[56] [2023] EWCA Civ 1092, [28].
[57] *Ibid*., [28].
[58] *Ibid*., [28].
[59] *Ibid*., [28].
[60] *Ibid*., [28].
[61] [2023] EWHC 2244 (Fam), [80].
[62] [2022] EWCA Civ 935, [43].
[63] *Ibid.,* [30-35].

in respect of compliance with the Code, nonetheless the possibility of a successful leave to appeal must still be recognised. Although MacDonald J made a declaration of death, back-dated to the time of the diagnosis, it is difficult to see that Mr Casey was legally dead in the intervening period between medical and legal declarations, given that this very matter was the subject of the appeal.

Yet, it would seem that Mr Casey was not alive either. Both the High Court and the Court of Appeal were content that Mr Casey should not have the same legal entitlements as someone who is alive but lacking capacity. Thus, once he had been diagnosed as brain dead, the Court was clear that the issue of best interests no long applied and as we saw above, it was accepted that it was not appropriate for the Official Solicitor to act as his litigation friend. This meant that, as described by MacDonald J, the Court was concerned only with the 'narrow issue' of whether the patient had died.[64] Yet, as the Court of Appeal acknowledged, the matter is not always straightforward:

> Where the court after careful scrutiny accepts evidence of death following brain stem testing, there is no sensible basis upon which it could then carry out a best interests assessment. In contrast, where that evidence does not exist or might fail to withstand careful scrutiny (cf *Dance*) the court will not hesitate to address the question of best interests. If the position were to evolve during a hearing, it is open to the court to adapt its approach accordingly.[65]

It could, perhaps, be argued that, after a diagnosis of BD, a person is presumed dead. The presumption of death has a long history at common law where it allowed for the administration of the person's estate after they have been missing for a period of seven years,[66] and is now provided for in statute.[67] Yet, there is nothing in the judgments to suggest that a presumption of death applies in respect of brain death and, in fact, the requirement for 'anxious scrutiny', which was affirmed by the Court of Appeal, runs contrary to any suggestion that such a presumption might be applied.[68]

For a period of 6-8 weeks Andy Casey lay in a liminal state, neither dead enough to be a corpse, nor sufficiently alive to warrant legal representation. The established rules and ways of thinking derived from the accepted life/death binary do not appear to have been sufficient in this situation. While the usual nature of disputes in respect of the diagnosis of brain death revolve around a disagreement as to whether brain death is legal death, this particular situation is different. Here, the fact that the court has the ultimate authority to make a declaration of death has created a liminal space between medical death and legal death. Insofar as contested cases are likely to require the confirmation of the courts, this space will continue to exist. In light of this, it seems inadequate for an individual to be deprived of procedural rights (including the appointment of a litigation friend) unless the evidence evolves during a hearing, the court adapts its position, and those rights are reinstated. Rather, if the court were to treat the question of whether the individual is legally dead with the seriousness that it would seem to warrant, the converse would appear to be more appropriate.

CONCLUSION

Notwithstanding that BD has been a recognised medical and legal phenomenon in the UK for almost 50 years, *Casey* (and the cases which precede it) is a reminder of the range of conceptual and practical difficulties that arise when brain death testing is contested. The Code is currently under

[64] [2023] EWHC 2244 (Fam), [61].
[65] [2023] EWCA Civ 1092, [31].
[66] See Law Reform Commission, *Civil Law Aspects of Missing Persons* LRC 64-2011, 18-19.
[67] See eg. Presumption of Death Act 2013 (UK); Civil Law (Presumption of Death) Act 2019 (Ireland).
[68] [2023] EWHC 2244 (Fam), [30]. This standard had first been identified in *Manchester University NHS Foundation Trust v Midrar Namiq and Others)* [2020] EWHC 180 (Fam), [35].

review, although at the time of writing there is no indication as to what changes will be made. We have argued here (and elsewhere)[69] that the Code should clarify the role of ancillary testing. However, revisions to the Code cannot resolve all the difficulties with BD. As MacDonald J recognised is *Casey*, the 'blurred boundary' between life and death is more than simply a medical matter.[70] Resolving the dilemmas posed by BD will require new ways of legal thinking about the liminal space between life and death which is made apparent in *Casey*.

[69] See Lyons and Donnelly (n. 2).
[70] [2023] EWHC 2244 (Fam), [80].