

THE LEGAL DEFINITION OF DEATH IN THE UK: AN ANALYSIS AND A PROPOSAL

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Abstract The UK does not have a statutory definition of death. Since the 1980s, an emerging clinical concept of death, named ‘Death determined using Neurologic Criteria’ (DNC), has gradually been acknowledged by the UK courts. While several recent cases have contested this position, DNC is now regarded as the medical and legal definition of death. The absence of a statutory definition of death, coupled with the complex and counterintuitive nature of DNC, has provided sceptics ambiguity with which to challenge the medicolegal status quo. The common law approach to defining death appears increasingly unsatisfactory; there is now a strong argument to enact relevant legislation in the UK. This paper proposes legislation which would bring greater legal clarity, certainty and consistency to the determination of death, and would address many of the practical and conceptual problems that currently exist.

Keywords

brainstem death,
definition of death,
death by neurologic
criteria,
intensive care,
legislation



1 Introduction

Death represents a moment of enormous personal, cultural, philosophical and legal significance. Yet the legal boundary between life and death is looking increasingly controversial in the UK. Medical advances have forced clinicians, lawyers and scholars to think more precisely about what differentiates life from death, and the diagnosis of death has now become highly nuanced. The emergence of modern intensive care medicine in the mid-20th century created many new dilemmas, including the clinical phenomenon now named 'Death determined using Neurologic Criteria' (DNC). There is no statutory definition of death in the UK. Instead, the legal definition of death represents the common law endorsement of current medical practice. In recent years, however, several domestic cases have contested this position. Protracted legal disputes have many adverse effects: they propagate uncertainty about the definition of death or an individual's legal status, they cause costly delays, and they lead to conflict and distress for relatives and healthcare staff.

This doctrinal research paper examines the legal definition of death in the UK and sets out a case for enacting a statutory definition. It explores the academic literature concerning the history of death and the emergence of DNC, as well as the UK's evolving clinical guidelines; it describes the current legislation related to death and the 'statutory gap' which seemingly arises; and it analyses the series of court cases which have gradually fashioned a common law definition of death in the absence of legislation. It concludes by proposing and justifying wording for a statutory definition of death for the UK. Such legislation would arguably bring greater clarity and certainty to the medicolegal position surrounding death in a more satisfactory and timely way than the common law approach.

2 Defining Death: Historical, Medical and Legal Context

2.1 A Brief History of Death

For most of human history the identification of death was relatively straightforward and reliable, requiring only the observation of physical signs such as decapitation, rigor mortis or decomposition (Johnson, 2017, p. 267). Ancient writers recognised the significance of respiration, with passages describing the 'breath of life' found in ancient Egyptian medical papyri, the Quran and the Old Testament. By early modern history the importance of the heartbeat was becoming clear. In 1846, the Academy

of Sciences in Paris awarded Dr Eugène Bouchut a prize for his proposal to diagnose death by listening for heart sounds using the recently invented stethoscope (Gardiner & McGee, 2020, p. 138). From this period onwards, the concept of death as the loss of circulation and respiratory function attained ‘near universal acceptance, across cultures and religious traditions’ (Johnson, 2017, p. 267). In the 1950s, the development of resuscitative techniques, in particular cardiopulmonary resuscitation and mechanical ventilation, cast new doubt on the assumed interdependence between the body’s circulatory, respiratory and neurological functions (Lewis & Bernat, 2022, p. 12). Patients who had suffered cardiorespiratory arrest – who would previously have been declared dead – could now be resuscitated and sustained on a ventilator despite permanently losing brain function (Gardiner & McGee, 2020, p. 139). Mollaret & Goulon (1959) first described this clinical syndrome, publishing a case series of twenty-three deeply comatose patients with absent brainstem reflexes and brain activity. They called it *‘le coma dépassé’* (‘a state beyond coma’). Doctors working in newly established Intensive Care Units (ICUs) began to speculate if these patients were in fact already dead. In 1968, the Ad Hoc Committee of the Harvard Medical School published an influential paper proposing that death could be determined using neurological criteria alone. This permitted the withdrawal of futile life-support from patients with profound neurological injuries.

2.2 Medical Consensus in the UK

2.2.1 Medical Guidelines

In 1976, the Conference of Medical Royal Colleges published a statement entitled ‘Diagnosis of Brain Death.’ This stated, ‘It is agreed that permanent functional death of the brainstem constitutes brain death and that once this has occurred further artificial support is fruitless and should be withdrawn.’ The UK neurologic criteria differed from the earlier Harvard publication by focusing specifically on brainstem function (as opposed to the ‘whole brain’ approach adopted in the US). This 1976 statement was principally concerned with legitimising withdrawal of life-support in futile situations but did not make the conceptual leap to claim that brain death represents the death of the person. An amended guideline was published three years later:

It is now universally accepted, by the lay public as well as the medical profession, that it is not possible to equate death itself with cessation of the heartbeat ... It is the conclusion of the conference that the identification of brain death means that the patient *is dead* (Conference of Medical Royal Colleges, 1979, p. 332).

A subsequent review by the Royal College of Physicians (1995) recommended that the preferred terminology – in the UK at least – was ‘brainstem death’. This paper uses the terminology now recommended by leading scholars in the field: ‘Death determined using Neurologic Criteria’, or ‘DNC’ (Lewis & Bernat, 2022, p. 5).

In 2008, the Conference (now called the Academy) of Medical Royal Colleges published an updated consensus guideline called the ‘Code of Practice 2008’ (hereinafter: Code 2008). The Code 2008 articulated the underlying medical definition of death (one predicated upon the loss of brainstem function) and set out exacting standards for the preconditions, exclusions and confounders relevant to brainstem testing. It detailed the specific diagnostic tests and processes required to confirm death. The Code 2008, therefore, provided comprehensive and authoritative clinical guidance for the diagnosis of all adult and child deaths in the UK. An updated version of the Code of Practice was released in January 2025 (hereinafter: Code 2025), providing revised practical guidance for the diagnosis and confirmation of all deaths. The updated Code 2025 is clear that it does not represent a redefinition of death but instead reiterates the brainstem-centred definition found in the 1995 and 2008 versions (indeed, the same definition which has been accepted in UK clinical practice since 1979). The Code 2025 therefore provides important continuity and reassurance that historical diagnoses of death remain valid (Scott & Thomas, 2026).

2.2.2 A Unifying Concept of Death

A so-called ‘unifying concept of death’ has therefore emerged in recent decades (Gardiner et al, 2012, p. 16), one which has been reiterated in each update of the Code. Death has come to be defined as the death of the brainstem (that is, the irreversible loss of the capacity for consciousness and the irreversible loss of the capacity to breathe). However, this single underlying condition can be identified using different criteria: somatic, circulatory or neurological. The criterion used to identify that death has occurred will depend on the particular clinical circumstances (for example, circulatory criteria used after a failed resuscitation attempt, or

neurological criteria used in a ventilated ICU patient with profound brain injuries). Importantly, the underlying definition of death remains the same in every case. These distinctions become important later when considering possible statutory language, and the respective contribution of clinicians and parliamentarians in the legislative process.

2.3 The Significance of Death and the ‘Statutory Gap’

Whilst laypeople might assume there is a clear dichotomy between life and death, clinicians often perceive death as a transformative process without a clearly definable end-point (Laurie, Harmon & Dove, 2019, p. 572). Body systems decline and stop at different times, a process which can now be manipulated or delayed by medical intervention. The circulatory or neurologic criteria used by doctors to identify that death has occurred necessarily strike a pragmatic balance between convenience, certainty and timeliness (Gardiner & McGee, 2020, pp. 64–65). It is not clear therefore where a justifiable legal dividing line should be drawn along the continuum of bodily disintegration. For myriad reasons though, the law does require a clear distinction. Death has significant implications for probate and inheritance, the disposal of bodies, and coronial or criminal investigations. It is also the moment at which most rights and interests are lost, or after which life-support can be withdrawn and organs donated (Brazier, Cave & Heywood, 2023, p. 531). As Wicks summarises, “There needs to be a clear-cut, and unambiguous, definition of death within the law because legally we treat a dead body very differently from the way we treat a living person” (Wicks, 2017, p. 120).

It is perhaps surprising there is still no statutory definition of death in the UK. Numerous domestic statutes deal with various matters arising after death. The Births and Deaths Registration Act 1953 govern the requirements for certifying and registering a death, whereas The Removal of Bodies Regulations 1954 concerns the repatriation of bodies outside of England. The Coroners and Justice Act 2009 outlines the powers a coroner has to investigate unnatural or suspicious deaths. Recently, The Medical Certificate of Cause of Death Regulations 2024 established a new statutory basis for Medical Examiners to scrutinise and certify all non-coronial deaths in England and Wales. Yet none of these statutes or regulations actually define what death is or when it occurs. Considering the various requirements, restrictions or powers bestowed by legislation, the absence of a precise definition seems incongruous. Only one Act of Parliament has previously raised the possibility

of a statutory basis for defining death, but ultimately a definition never materialised: the Human Tissue Act 2004, and the related Human Transplantation (Wales) Act 2013, which governs the use of human organs for research and donation. Within this framework, the Human Tissue Authority (HTA) was granted statutory authority to issue relevant codes of practice, including on the ‘definition of death for the purposes of [the] Act’ (Human Tissue Act 2004, s26(2)(d)). Yet the HTA has never done so, and their latest guidance simply refers back to the clinical definition of death given by the Code of Practice (Human Tissue Authority, 2023, p. 12). As such, a statutory definition of death remains elusive.

2.4 Legislating Death in the United States

In this respect the UK is an outlier, as a large number of countries have enacted legislation concerning the definition or diagnosis of death (Bernat & Beresford, 2013, p. 430). For example, the US has enacted a statutory definition of death in the majority of states for over 40 years. The Uniform Determination of Death Act (hereinafter: UDDA) 1980 simply states:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards.

This model statute thereby aimed to create uniformity between all states (Sarbey et al., 2022, p. 277). It provides common language to determine all deaths, principally by incorporating a neurologic criterion into their existing (common-law) circulation-based definition of death (Gardiner, McGee & Bernat, 2020, p. 1224). Strictly speaking, the UDDA does not provide a definition of death, but does provide the *criteria* for determining death has occurred (Uniform Law Commission, 2014, p. 2). The Uniform Law Commission argues the UDDA was a necessary statutory solution to address growing interstate confusion and inconsistency. They claim the UDDA brings national uniformity to the determination of death; reduces confusion regarding a patient’s legal status; limits needless delays; reduces court litigation; and promotes more equitable and efficient provision of ICU resources (Uniform Law Commission, 2014, p. 2).

3 The Definition of Death in UK Common Law

3.1 DNC in the Courts

During the second half of the 20th century, whilst doctors slowly grappled with new clinical and ethical dilemmas arising from the emergence of DNC, a number of contested cases began filtering into the legal arena. The UK courts first formally acknowledged DNC in *R v Malcherek*; *R v Steel* [1981], where the Court of Appeal conjoined two criminal cases. In each case a victim had been assaulted, DNC had been declared and life-support was withdrawn. Yet both murderers argued it was the doctors who had ‘killed’ the victims by discontinuing life-support. Both appeals were dismissed on the basis of causation, but the obiter remarks proved insightful into the court’s reaction towards the novel clinical element of the cases:

Modern techniques have undoubtedly resulted in the blurring of many of the conventional and traditional concepts of death ... There is, it seems, a body of opinion in the medical profession that there is only one true test of death and that is irreversible death of the brainstem ... When that occurs, it is said the body has died (*R v Malcherek*; *R v Steel* [1981], p. 694).

The judges cautiously acknowledged the emerging medical consensus without expressly endorsing it. They also differentiated the contrasting professional responsibilities in this area, suggesting the courts were being guided by – but not scrutinising – the medical consensus. The judges held, “It is no part the task of this court to inquire whether the criteria, the royal medical colleges’ confirmatory tests, are a satisfactory code of practice” (*R v Malcherek*; *R v Steel* [1981], p. 695).

3.2 Re A [1992]

This deference to medical expertise was later reinforced in a civil case which directly addressed the issue of DNC. In 1992, Johnson J heard a case concerning an infant who had been admitted to hospital due to cardiac arrest (*Re A* [1992]). Two ICU consultants tested him according to “... the criteria now generally accepted in medical circles ... Both doctors concluded that A was brainstem dead”. The parents promptly lodged an application to prevent the removal of life-support. Johnson J found the medical evidence compelling, holding, “I have jurisdiction to make a declaration that A is now dead for all legal, as well as medical, purposes”. This

confirmed in common law the guidance from the Conference of Medical Royal Colleges (1979), which stated that DNC indicated the death of the individual. Johnson J did not rule that the legal definition of all death was therefore ‘brainstem death’ (which would have created a very narrow, technical definition); he did, however, hold that death can be declared using brainstem criteria alone. Furthermore, the ruling did not direct clinicians to withdraw life-support but provided reassurance they would not be acting unlawfully if they decided to do so. Johnson J merely made a determination of fact regarding the diagnosis of death and the patient’s legal status. The medical concept of DNC was thereby formally endorsed in common law.

3.3 Airedale NHS Trust v Bland [1993]

The following year, the common law definition of death was strengthened further. In *Airedale NHS Trust v Bland* [1993], the Law Lords considered the case of a patient who had sustained a severe hypoxic brain injury resulting in a Permanent Vegetative State (PVS). An important presumption for their Lordships was that Bland was not yet dead: “In the eyes of the medical world and of the law a person is not clinically dead so long as the brainstem retains its function” (p. 856). Lord Goff expanded the point:

... doctors no longer associate death exclusively with breathing and heartbeat, and it has come to be accepted that death occurs when the brain, and in particular the brainstem, has been destroyed; ... Anthony’s brainstem is still alive and functioning and it follows that ... he is still alive and should be so regarded as a matter of law. (p. 863)

Lord Browne-Wilkinson made further comments acknowledging how evolving medical science had led doctors to redefine historical certainties: “Until recently there was no doubt about what was life and what was death. A man was dead if he stopped breathing and his heart stopped beating ... [Recent developments have] led the medical profession to redefine death in terms of brainstem death ...” (p. 878)

Bland was highly significant. Despite principally being concerned with the withdrawal of life-sustaining treatments from living patients, the Law Lords authoritatively confirmed that death defined in terms of brainstem function represented the legal definition of death. It is interesting the Lords adopted the concept without actually analysing or justifying it (Donnelly & Lyons, 2023, p. 356), instead opting for passive

acceptance of medical expertise. This indicates “... the legal definition of death in the UK is merely the judicial application of the current medical definition of death” (Wicks, 2017, p. 119).

3.4 Re A [2015]

In *Re A (A Child)* [2015], Hayden J conspicuously linked the legal definition of death to the specific wording of medical guidelines for the first time. A 19-month-old boy had choked on a piece of fruit, resulting in a severe hypoxic brain injury. Brainstem testing was undertaken in accordance with Academy of Medical Colleges’ Code of Practice (2008), confirming the child was dead. His family however questioned ‘whether brainstem death was synonymous with clinical/legal death.’ Hayden J quoted from the Code 2008 at length, reiterating its brainstem definition of death. He revisited *Bland*, commenting how the clinical predicament incredulously described by Lord Brown-Wilkinson as the ‘ventilated corpse’ was now commonplace. Applying this to A, Hayden J held the child had indeed died and authorised the withdrawal of life-support to allow him ‘dignity in death’.

Re A (A Child) [2015] therefore confirmed that irreversible cessation of brainstem function – determined in accordance with the Code of Practice – constituted both medical and legal death. The Courts adopted the practice of quoting directly from the Code of Practice in several subsequent judgments (see *Oxford University NHS Trust v AB* [2019] and *North West Anglia NHS Foundation Trust v BN* [2022]). There is, however, something of a circular argument emerging here. The Code 2008 notes that although courts have consistently upheld previous iterations of the guidelines, the courts adopted these guidelines because they represent the consensus view of the medical profession. Each profession seemingly derives legitimacy and validity for the Code 2008 from the tacit endorsement of the other. Whilst this self-reinforcing circularity may help to strengthen the acceptance of DNC in both medical and legal circles, it might seem questionable to external or lay observers who seek a robust, externally valid and independent medicolegal definition of death which does not rely on circular reasoning or inter-professional reinforcement.

4 Recent Controversies and Legal Challenges

4.1 Re M [2020]

By 2020, the common law approach to DNC in the UK appeared settled. Yet in recent years this position has been strongly contested in a number of high-profile cases. In January 2020, a hospital sought a declaration that it would be lawful to discontinue mechanical ventilation of a four-month old baby (*Manchester University NHS Foundation Trust v Namiq and others* [2020]). After careful observation it became clear to clinicians that the infant had sustained a profound brain injury following an umbilical cord prolapse at birth. Brainstem testing confirmed DNC, yet the parents refused to accept this conclusion or the implication that life-support should be withdrawn. In the High Court, Lieven J concluded the infant was dead based upon the clinical evidence, by applying the Code of Practice, and by considering the previous authorities, which she referred to as ‘plainly correct’. The parents attempted to appeal but their application was denied. In *Re M (Declaration of Death of Child)* [2020], the Court of Appeal ruled that ‘brainstem death’ was “established as the legal criteria in the United Kingdom by the House of Lords decision in *Bland*. It is not, therefore, open to this court to contemplate a different test.” The Court of Appeal went further to add it was not their role to consider whether a different criterion should replace the DNC formulation found in the Code of Practice.

Re M is notable for a number of reasons. First, the Lordships prior comments in *Bland* regarding the brainstem and death were, strictly speaking, obiter (Butler-Cole, 2020, [28]). *Bland* had bestowed significant authority to the concept of DNC, despite principally being concerned with the withdrawal of nutrition from a living patient. Despite this, *Re M* seemingly elevates obiter comments in *Bland* to binding precedent. The Court of Appeal in *Re M* declined the opportunity to scrutinise the robustness or coherence of the UK’s DNC criteria or consider alternative formulations. Furthermore, *Re M* strengthens the notion that the diagnosis of death is an entirely clinical matter with which the courts will seldom interfere. The courts instead determine factual questions about whether the accepted medical standards have been applied and satisfied. As Butler-Cole points out, “[It is] impossible to imagine any other outcome where there is a consensus of medical opinion as to the existence of brainstem death than an order confirming the same” (Butler-Cole, 2020, [66]). The time delay involved in the case was significant. Four months passed

between the diagnosis of death and *Re M* reaching the Court of Appeal. The judges were keen that applications to court were made far earlier in future cases.

4.2 Archie Battersbee

In April 2022, twelve-year-old Archie Battersbee was found in a state of cardiac arrest. It took approximately 40 minutes to resuscitate his heart, after which he was placed onto life-support. After being assessed for several weeks, the hospital sought permission from the courts to perform DNC testing on Archie (*Barts Health NHS Trust v Dance & Battersbee* [2022a]). Arbuthnot J ruled that testing should be ‘carried out with great care following strictly the guidance’. At a subsequent hearing however, it transpired the clinicians had been unable to complete the required DNC tests due to a technicality (*Barts Health NHS Trust v Dance & Battersbee* [2022b]). This meant they were unable to proceed with testing. Instead, the hospital submitted abundant clinical evidence and expert opinions, seeking a declaration that Archie was dead. Arbuthnot J carefully considered the family’s counter submissions, which included the legal ambiguity created by the lack of a statutory definition, the reliability of DNC tests, and the extent to which prior case law was binding. She held that she was bound by the decisions in *Bland* and *Re M* regarding the brainstem definition of death. However, she then misdirected herself by relying on the ancillary evidence in lieu of the Code’s tests:

The earlier authorities ... have been based in recent years on the results of the brainstem death tests. In my judgment, the lack of the test in Archie’s case caused as it is by his very severe brain damage, does not prevent me from anxiously considering the abundant clinical evidence in these proceedings and coming to a conclusion... [172]-[173]

Arbuthnot J thereby separated the determination of DNC from the Code’s requirements, instead making the declaration a matter of judicial interpretation of ancillary investigations and expert opinion. This was unprecedented in the legal history of DNC in the UK. On this erroneous basis she ruled that Archie was dead. The Code is clear however that it is not possible to diagnose DNC without the required tests. This had been established in *Re A (A Child)* [2015] and confirmed in numerous subsequent cases (see *Oxford University NHS Trust v AB* [2019], *North West Anglia NHS Foundation Trust v BN* [2022], *HSC Trust v RL* [2022] and *Re M* [2020]).

It is difficult to know whether Arbuthnot J's ruling reflected her unfamiliarity with the underlying science and case law, or indicated a misguided attempt to extend the common law using judicial interpretation. In the absence of DNC tests, it would have been more appropriate for her to have proceeded by evaluating Archie's best interests in order to determine if mechanical ventilation should be discontinued. Unsurprisingly, Archie's family appealed, arguing that Arbuthnot J had been wrong to declare death in the absence of the Code's tests. In *Barts Health NHS Trust v Dance & Battersbee* [2022c], the Court of Appeal overturned the earlier judgment, noting that none of the doctors involved had proposed declaring death in the absence of the tests and that the Code was clear that specific testing was required to demonstrate loss of brainstem function:

We...strongly caution judges in future cases of this kind from being drawn into attempting to declare death on a basis outside the Code where none of the medical witnesses has themselves made a diagnosis of death. [37]

The court held Arbuthnot J had been wrong to declare death once it became clear the DNC tests could not be performed and that a best interest's analysis was required instead. *Battersbee* therefore eventually confirmed that the Code of Practice tests *must* be performed before DNC can be established; if not, the patient cannot be declared dead using neurologic criteria (Choong, 2022, p. 43). As with *Re M* [2020], it had taken a prolonged legal process to reach this inevitable outcome.

4.3 Baby A

Following *Battersbee*, a number of cases soon made their way to court. In *Guy's & St Thomas' NHS Foundation Trust v A (A Child)* [2022a], a hospital applied for a declaration of an infant's death. Baby A sustained a hypoxic brain injury following cardiac arrest, with DNC tests confirming the child had died. Several days later, however, the infant started to breathe independently again. Presented with a case in which doubt was cast upon the certainty and reliability of DNC testing was thrown into doubt, Hayden J remarked that the court was in 'unfamiliar territory'. An expert witness later suggested the apparent recovery was because the infant's unfused skull bones allowed the intracranial pressure (and hence brainstem compression) to be relieved over time (*Guy's & St Thomas' NHS Foundation Trust v A (A Child)* [2022b]). This case presented the first instance in which the reliability of the tests was seriously

questioned. It may therefore provide unwarranted hope to the sceptical families who find themselves doubting a hospital's diagnosis of DNC.

4.4 Recent Cases

In *St George's University Hospitals NHS Foundation Trust v Casey* [2023a], a declaration was sought that a brain-injured patient had died following an assault. His family however argued that DNC did not equate to 'ordinary' death. They also questioned both the reliability and the validity of the DNC tests. They further argued that, following *Battersbee*, the legal approach had changed to one of weighing the best interests of the person involved. MacDonald J rejected their arguments, noting that *Battersbee* was distinguishable from other cases precisely because the DNC tests had not been performed – it therefore provided no authority in cases where the tests had been successfully administered. It ultimately took 11 weeks for the legal processes to be exhausted and the inevitable death declaration to be granted. Similarly, in *UHBW NHS Foundation Trust v The Mother of G* [2024], a mother refused to accept a DNC diagnosis following her daughter's self-poisoning. The clinical evidence of death, including the 'rigorously conducted' Code of Practice tests, was overwhelming. G's mother did not provide any substantive argument why she disagreed with the clinicians; she simply wanted more time to allow for a miracle.

Casey and *The Mother of G* demonstrate the way in which the lacuna created by the absence of a statutory definition of death, coupled with uncertainty or confusion generated by *Battersbee* and *Guys v A*, can lead to prolonged and adversarial court proceedings. In *Casey* [2023a], the Official Solicitor ominously suggested that legal challenges are becoming more prevalent, as evidenced by the increasing number of DNC cases coming before the courts (Lyons & Donnelly, 2023, p. 160). The rulings in such cases, however, have been universally supportive of the clinicians' determination of DNC. The Court of Appeal in *Casey* [2023b] was clear:

... the approach in [*Bland* and *Re M*] reflects a widely held consensus ... that brainstem death, correctly diagnosed, is the proper indicator of death in the legal sense. The contrary is not reasonably arguable at any level of court.' [29]

If this position is genuinely not arguable, it is concerning how much time and resources such cases consume as they slowly progress through the legal system. Peel J criticised the time delays in *The Mother of G*, commenting that it is 'unreasonable to

wait any length of time for determination of such sensitive matters.’ Similar cases continue to come before the courts. As of January 2026, the High Court has now formally endorsed the Code of Practice 2025 and its definition of death (*Barts Health NHS Trust v MC and ML* [2025]). However, as long as sceptical and grieving families continue to dispute the neurological elements of the Code, hospitals and the courts will continue to expend significant time, money and resources to litigate these ultimately futile appeals.

5 The Case for a Statutory Definition of Death

The absence of a statutory definition of death, and the resulting ambiguities and uncertainties, provide families with the legal ammunition to legally challenge the validity of the medical approach to determining death, particularly when using neurological criteria. This is unfortunate, as protracted legal proceedings can have several adverse implications.

5.1 Common Law Consequences: Ambiguity and Uncertainty

First, prolonged proceedings result in uncertainty concerning the patient’s legal status. Following *Battersbee* [2022c], the Court of Appeal confirmed it was ultimately for the courts to declare death in contested cases. Donnelly & Lyons (2024) highlight the enigmatic period which seemingly arises between completion of DNC tests and the subsequent declaration by the courts. In *Casey*, they suggest legal proceedings created a ‘liminal state’ between medical and legal death, arguing that for several weeks Casey was ‘neither dead enough to be a corpse nor sufficiently alive to warrant legal representation’. They notice he was not entitled to the same legal protections as a living but incapacitated patient, yet there was a presumption that his interests did not apply (Donnelly & Lyons, 2024, p. 117). Until the clinical determination of death was retrospectively confirmed by the Court of Appeal, it seems Casey was not truly dead. Donnelly and Lyons therefore suggest that, in between DNC testing and legal ratification, such patients should only be ‘presumed dead’.

Uncertainty arises in other ways. To most clinicians, DNC is an established and widely accepted medical concept. Yet it remains unfamiliar and counterintuitive to the lay public, perhaps owing to deeply ingrained historical notions of what constitutes death. The fact that families increasingly challenge the determination of DNC in court – and are perhaps encouraged to do so by ideologically-motivated

legal representatives (Wolley, 2022) – undermines the validity and security of DNC declarations in the public's eyes. It portrays DNC as an obscure concept which remains open to reasonable doubt and dispute. Conversely, death determined by somatic or circulatory criteria is a more intuitive concept for the lay public and more closely aligned with familiar notions of death (Capron, 2022, p. 90). For example, following a cardiac arrest it has never been argued in court that a refrigerated corpse in a mortuary is not dead. Death in that context appears understandable and self-evident, with bereaved relatives readily accepting the criteria used to establish that death has occurred. The same acceptance cannot be assumed for neurological criteria. In such cases, the courts inevitably become a forum for sceptical families to challenge the legal validity of the clinicians' counterintuitive concept.

5.2 Common Law Consequences: Delays and Circularity

Aside from conceptual and legal ambiguity, the current approach of retrospectively endorsing DNC diagnoses has other adverse effects. Recent disputes have demonstrated the significant time it can take for legal processes to be exhausted (*Re M* [2020]). For the entirety of legal proceedings, these dead patients occupy a scarce ICU bed connected to multiple pieces of life-support equipment, cared for on a one-to-one basis. This clinical undertaking has considerable practical, financial and resource implications, representing an enormous opportunity cost. In a publicly funded healthcare system with finite resources such as the UK's National Health Service (NHS), the provision of futile intensive care to a deceased patient is neither equitable nor economical, given that such resources could instead be directed towards living patients who are able to benefit or recover. The emotional toll and moral distress that may arise for healthcare staff whilst providing this care (whilst also undertaking adversarial court proceedings) should also not be underestimated (Mir, 2022).

Furthermore, it is arguable that the legal process is little more than a 'rubber-stamping' exercise – indeed, there has never been a successful legal challenge to a medical determination of DNC (Gardiner, McGee & Shaw, 2021, p. 294). The courts merely determine whether the Code has been properly applied. Hayden J's recommended wording for a legal declaration of DNC in *Re A (A Child)* [2015] was later adopted verbatim in *Re M*, *Casey* and *The Mother of G*. It seems once the medical facts have been established, legally ratifying DNC becomes automatic and formulaic, making lengthy delays all the more unjustifiable. Formulaic legal proceedings also

reinforce the inherent circularity in which the legal and medical professions each derive legitimacy for the Code when they apparently endorse the other. There appears to be no independent standard with which to calibrate or justify this self-reinforcing medicolegal position.

Finally, common law evolves incrementally. Judgments are necessarily predicated upon particular facts, arguments and appeals in specific cases (Capron, 2020, p. 85). As *Battersbee* [2022b] also demonstrated, it is possible for judges to err when adjudicating complex medical concepts. For an authoritative body of DNC jurisprudence to develop, relevant contested cases must be adjudicated. With a complex concept such as DNC, it is perhaps easy to appreciate why the common law has failed to develop ‘clearly, quickly or uniformly’ (Capron, 2020, p. 85). This current legal approach to determining death – where courts ratify medical standards and criteria – appears increasingly adversarial, prolonged, circular, formulaic and unsustainable. Whilst it is true that the courts have so far proven uniformly supportive of DNC declarations, the ensuing legal processes lead to delays, conceptual ambiguity, costly utilisation of resources and considerable emotional distress for relatives and staff.

5.3 Benefits of Legislation

5.3.1 Improved Clarity, Certainty and Consistency

Enshrining the medical definition of death (along with its diagnostic criteria) in legislation would induce greater certainty and consistency in future cases by providing an unambiguous and incontrovertible medicolegal standard. This would help negate some of the self-reinforcing circularity and time delays generated by retrospective court endorsement of the Code of Practice. Legislation would more legitimately cement the definition of death (with its circulatory *and* neurologic criteria) into law, emphasising to all parties that, when properly established by clinicians, a diagnosis of DNC emphatically signals medical and legal death. It would circumvent the ambiguous ‘liminal state’ arising between the diagnosis and a later court declaration (Donnelly & Lyons, 2024, p. 119), by removing the need to later judicially ratify DNC.

A statutory definition would signal to families that determining DNC in accordance with accepted medical guidelines is a diagnostic matter entirely for clinicians. Codifying the medical definition of death into legislation appears the most appropriate mechanism to emphasise the biological basis of DNC (Bernat and Beresford, 2013, p. 430) and the clinical experience required to make the diagnosis, whilst simultaneously pre-empting superfluous judicial interference or delay. In overruling *Arbuthnot J in Battersbee* [2023c] the Court of Appeal “was, entirely reasonably, concerned about the judicial assumption of clinical responsibility”. A US appellate court has likewise pithily cautioned against judges overreaching in medical cases, writing, “The judiciary is called upon to serve in black robes, not white coats. And it must be vigilant to stay in its lane and remember its role” (*Tex. Health Huguley Inc v Jones* [2021]).

5.3.2 Practical Benefits

Strengthening the clarity and consistency around the legal definition of death would engender practical benefits. Reducing the need to judicially ratify death should hopefully reduce the number and duration of legal challenges. Clinicians would be empowered to make defensible decisions about treatment limitations or the withdrawal of futile life-support, reassured by the knowledge that their factual determination of death was recognised in statute. This should hopefully spare clinicians and potential litigants ‘the expense and exhaustion of court proceedings’ (Skegg, 1976, p. 191) to debate the definition and diagnostic process. Promoting faster resolutions and avoiding protracted legal proceedings also has beneficial effects in terms of maximising scarce ICU resources, and in reducing the associated emotional distress and distraction for the healthcare staff. The formation of a statutory definition of death also presents an opportunity to revise and harmonise many other death-related statutes and regulations. A standardised, stand-alone statutory definition may help to address some of the inconsistencies or omissions currently found in other legislation.

5.3.4 The Role of Parliament

The medical definition of death, as we have seen, is a highly nuanced, technical concept encompassing detailed neuroanatomical understanding and philosophical deliberation over many years (President’s Council on Bioethics, 2008). It seems inescapable that any statutory language will be strongly influenced by current medical

understanding and practices. Indeed, the *definition* and *criteria* used to diagnose death are arguably the exclusive preserve of the medical profession: after all, it is a highly consequential condition identified using clinical assessment, professional judgment and practical skills. Given the range and magnitude of legal, personal and social consequences arising from a determination of death, it would be inappropriate for the definition or diagnosis to be subject to personal preferences, interpretation or religious belief. Individuals, society, clinicians and the courts all require a clear and certain answer to the question – when is a person dead? Arguably, only the medically endorsed definition and criteria can satisfy such exacting requirements.

This is not to say that Parliament would have no effective role in the legislative process. Capron (2022) has argued that any legal definition of death encompasses value judgments about what it fundamentally means to be a living part of civilised society. When considering any statutory endorsement of the medical definition of death, Parliament might consider some of the ancillary issues which *are* amenable to public engagement and debate. Parliament could explore issues such as religious objections to the use of neurological criteria to diagnose death, similar to that seen in the US state of New Jersey (Sarbey et al., 2022, p. 281). Equally, Parliament might debate the need (or not) to obtain consent from relatives prior to DNC testing, or review the composition and Terms of Reference of the medical group, which is to provide the consensus guidelines, or when and how these guidelines should be reviewed. Parliamentary scrutiny could allow for broader public engagement with a complex issue and hopefully the opportunity to better educate the public (Brazier et al., 2023, p. 537). Some semblances of public engagement or education may help make the resulting legislation more palatable to the public when attempting to incorporate controversial medical, social or moral issues into laws that affect the status of all citizens.

5.4 The Case Against Legislation

5.4.1 Should DNC be Defined in Legislation?

It is debatable whether such a technical clinical issue is appropriate for statutory recognition, given the comprehensive medical guidance available. It might also be argued that the neurological criteria used to determine death vary around the world, indicating a reasonable degree of uncertainty or inconsistency with the concept (*Re M* [2020]). This might undermine the case for enacting prescriptive legislation. But

the international variation in DNC diagnoses may not be as significant or relevant as is supposed. The US legislation utilises a ‘whole-brain’ criterion of death, requiring cessation of *all* functions of the *entire* brain. Conversely, the UK and a smaller number of Commonwealth countries utilise a ‘brainstem’ criterion, requiring cessation of brainstem function alone. In practice, injuries severe enough to permanently damage the brain cortex inevitably damage the brainstem as well; similarly, the clinical tests used in ‘whole-brain’ jurisdictions are merely tests of brainstem function. As such, ‘brainstem’ and ‘whole-brain’ criteria can effectively be regarded as synonymous in clinical practice (Laurie, Harmon & Dove, 2019, p. 577). Indeed, a growing number of international consensus guidelines appear to be slowly gravitating towards the UK’s brainstem criterion of DNC, including those from the World Brain Death Project (Greer et al., 2020), the Canadian Journal of Anaesthesia (Shemie et al., 2023), and the Australian and New Zealand Intensive Care Society (2021).

5.4.2 Discrepancies in Medical Guidelines

The statutory definition of death in the US (described by the UDDA 1980) has faced increased criticism. There is concern amongst clinicians and academics that it is outdated and incoherent because it requires cessation of *all* functions of the *entire* brain, yet, it does not require similar all-encompassing cessation of circulatory functions (Gardiner & McGee, 2022, p. 69). Further confusion arises because the UDDA does not specify which medical standards are considered authoritative, so there appears to be growing divergence between medical guidance and the wording of the UDDA (Gardiner & McGee, 2022, p. 71). Judges therefore have to determine whether or not the medical guidelines are consistent with the statute’s requirements, at times leading to emotive and prolonged legal disputes (*In re Guardianship of Hailu* [2015]). Medical practice often evolves at a rapid pace. It is possible that legislation which has failed to make adequate allowances for future developments may require alteration in order to keep legal standards consistent with medical practice. Conversely, as long as the matter is treated as a question of medical fact, ‘changes in medical approach can be accommodated within the law without any requirement for further legislation’ (Brazier, Cave & Heywood, 2023, p. 536). Gardiner & McGee (2020) argue that this makes the UK’s current approach more flexible than jurisdictions with legislation, because the common law approach is better able to adopt to future medical advances. But this argument merely gives weight to the

notion that any statutory language must be carefully worded, future-proof, and perhaps qualified by reference to currently accepted medical standards.

Finally, when drafting statutory language, there might be uncertainty regarding the 'level' of definition required (Capron & Kass, 1972, p. 102). A definition of death that is too philosophical or conceptual would be impractical when addressing real-world questions about the status of particular individuals. Conversely, a highly technical, criterion-based definition might prove too inflexible or prescriptive, or soon become out-of-date in light of medical advances. A significant challenge, therefore, in drafting legislation is to strike an appropriate balance between clarity, inclusivity and specificity, yet remaining accommodative of future medical developments without the need for later statutory reform.

6 A Statutory Definition of Death for the UK?

This final section proposes and justifies hypothetical language for legislation defining death, informed by current medical understanding in this highly technical area. Statutory wording such as this would arguably provide greater legal clarity, certainty and consistency for all stakeholders than the current common law approach.

6.1 A Proposed Statute

The following wording could be used to enshrine a clear and concise definition of death into legislation in the UK:

- 1) Death is the permanent loss of the capacity for consciousness combined with the permanent loss of the capacity to breathe.
- 2) An individual is dead when they have sustained either –
 - a. permanent cessation of circulation to the brain, or
 - b. permanent cessation of brainstem function.
- 3) The confirmation of death must be made in accordance with accepted medical standards as set out in the Code of Practice by the Academy of Medical Royal Colleges or its successor organisation.

The statute would apply to all deaths in the UK, ensuring national uniformity and consistency. It is independent from all other legislation regulating end-of-life events and processes, including organ donation, death registration, coronial investigation

and Medical Examiner scrutiny. It mirrors the dual-criteria approach of the UDDA (Uniform Law Commission, 2014, p. 1), yet is firmly modelled on both the definition *and* criteria found within the latest Code of Practice.

Section (1) provides a conceptual definition of death which is clinically and philosophically robust and increasingly endorsed worldwide. It articulates the same underlying definition of death found in the Code of Practice 2025, the President's Council on Bioethics (2008) and the World Brain Death Project (Greer et al., 2020). It describes the loss of the two most relevant capacities – both anatomically mediated in the brainstem – which allow an individual to engage and interact with the world at the most fundamental level. Loss of these capacities emphatically indicates death.

Section (2) provides the diagnostic criteria to confirm that death has occurred. The statute refers to 'individuals', making it applicable regardless of age, race, sex, geographical location or personal characteristics. The phrase 'is dead' is a clear and determinative statement about an individual's current legal status, but which does not contain inferences about rights, actions or obligations.

'Cessation of circulation' remains the most intuitive and familiar criterion of death to the lay public; it is also the most frequently used in clinical practice (Capron, 2022, p. 90). The inclusion of the circulatory criterion into legislation acknowledges this reality. To foster legitimacy and broad support, any statute must be acceptable to the public at large. Lord Bingham once argued that all laws must be 'accessible, intelligible, clear and predictable' (Bingham, 2011, p. 47). The proposed legislation therefore 'allows public perception to change incrementally rather than radically' (Capron, 2022, p. 90) in this complex area by not enforcing a sole neurologic criterion of death.

Section (3) requires the confirmation of death to be made 'in accordance with accepted medical standards as set out in the Code of Practice'. For many decades in the UK, the Academy of Medical Royal Colleges has produced the widely accepted consensus guidelines for diagnosing and confirming death, including DNC; the Academy is therefore specifically named in the legislation. This aims to avoid the uncertainty and conflict seen in the US, caused by the UDDA's imprecise wording, where it is not clear exactly which medical guidelines are determinative (Russell et al., 2019, p. 228). Reference to 'accepted medical standards' prevents the statute from becoming overly detailed and prescriptive, or too weighed down with medical

minutiae. This includes technicalities such as the specific clinical tests or ancillary investigations required; the practical conduct of DNC testing; the requirement (or not) to obtain consent before testing; or the precise meaning of current medical terminology. This allows the legislation to remain pragmatic and usable, but also flexible and adaptive to future developments in medical understanding and practices. The statutory wording is thereby ‘future-proofed’ against later medical developments, creating legal certainty whilst allowing for medical evolution and innovation. This also ensures that the legislation will not need to be amended each time there is a new clinical development in this complex and evolving area.

6.2 Exclusions

A number of elements are deliberately excluded from the legislation, in part to keep the statute as clear, concise and universal as possible. These additional elements would arguably be more amenable to Parliamentary scrutiny than the underlying scientific principles, prior to inclusion in accompanying guidance or explanatory materials. They might include some of the social, moral or religious issues raised by the definition and diagnosis of death. For example, the proposed statute deliberately avoids reference to subsequent rights, obligations or related activities such as organ donation or the withdrawal of life-support. This is because death should be independently defined and established in law, not merely an instrumental designation in order to accomplish another end. For clarity and coherence, any legal definition of death must stand separately from its ramifications. For example, an individual’s legal status as either ‘dead’ or ‘alive’ cannot depend on whether or not they are potentially an organ donor; this inconsistency might generate public unease and widespread loss of confidence in organ donation processes.

The legislation also does not include accommodation for a religious objection to diagnostic criteria, in particular the neurologic criteria. This is to ensure universal applicability and consistency of a concise statute based upon current medical principles; the definition of death should not vary based on personal, religious or family preferences. That said, case law repeatedly demonstrates that members of some faith groups are reluctant to accept the neurological criteria as a means to establishing death (most recently, *Barts Health v MC* [2025]). Freedom of conscience and religion is important (and protected) in a pluralistic multicultural society (Human Rights Act 1998, Article 9(1)), although some limitations on religious expression can be imposed for lawful reasons (Human Rights Act 1998, Article 9(2)). Consideration

of religious exemptions would therefore seem appropriate for scrutiny and debate by an inclusive, democratically elected body, which may choose to provide additional guidance or (non-statutory) exemptions for individuals belonging to particular faith groups.

Similarly, Parliament might consider or debate the need to obtain consent before DNC testing. Many international guidelines state there is no need to seek family consent for testing (Greer et al., 2020), and consent is likewise not mentioned in the latest Code of Practice. This issue has been debated in court (*Casey* [2023a]), but currently remains unresolved; for now, the decision whether or not to test appears to remain one for clinicians. Given the uncertainty and potential for a wide variety of conflicting opinions on this contentious issue, it seems appropriate for parliamentary discussion and debate before drafting any legislation.

7 Conclusion

Death is a highly significant moment in an individual's existence. Given the medicolegal ramifications which follow the determination of death, it is perhaps surprising there is no statutory definition in the UK. The concept and definition of death have been repeatedly (and increasingly) challenged in the courts, leading to debate, confusion and uncertainty about the definition of death and the criteria used to diagnose it. Clarity and consistency of legal terminology is important if laws and decisions are to be applied uniformly and justly. The absence of a statutory definition of death in the UK, coupled with the unfamiliar and counterintuitive nature of DNC, has provided sceptical families ambiguity with which to repeatedly challenge and doubt the medicolegal *status quo*.

There is now a strong argument to enact a statutory definition of death in the UK. It would bring greater clarity, certainty and consistency to the legal definition of death. Legislation would cut through the formulaic circularity generated between the common law and medical guidelines by providing a robust, independent and incontrovertible legal standard. By circumventing prolonged legal disputes, a statutory definition of death would reduce uncertainty, delays, and the consequent inefficient utilisation of scarce ICU resources. This paper proposes a statute that is medically and philosophically robust, concise, precise, universal and justifiable. Such a statute would provide the requisite certainty, clarity and consistency regarding an individual's legal status in a definitive yet timely manner.

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Povzetek v slovenskem jeziku

V Združenem kraljestvu ni zakonske opredelitve smrti. Od leta 1980 britanska sodišča postopoma priznavajo nastajajoči klinični koncept smrti, imenovan »smrt, ugotovljena na podlagi nevroloških merik« (DNC). Čeprav je bilo to stališče v nekaterih nedavnih primerih izpodbijano, se DNC danes šteje za medicinsko in pravno opredelitev smrti. Odsotnost zakonske opredelitve smrti, skupaj z zapleteno in protislovno naravo DNC, je skeptikom ponudila dvoumnost, s katero lahko izpodbijajo medicinsko-pravni status quo. Pristop common law k opredelitvi smrti se zdi vse bolj nezadovoljiv. Tako obstaja močan argument za sprejetje ustrezne zakonodaje v Združenem kraljestvu. Članek predlaga zakonodajo, ki bi prinesla večjo pravno jasnost, gotovost in doslednost pri ugotavljanju smrti ter bi obravnavala številne praktične in konceptualne težave, ki trenutno obstajajo.