IN THE HIGH COURT OF JUSTICE

No. COP12957961

FAMILY DIVISION

[2016] EWCOP 57

Royal Courts of Justice

Wednesday, 23rd November 2016

Before:

MR. JUSTICE HAYDEN

B E T W E E N :

ABERTAWE BRO MORGANNWG UNIVERSITY LOCAL HEALTH BOARD

Applicant

- and -

(1) RY
(by his litigation friend the Official Solicitor)
(2) CP

Respondents

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MR. M. CHISHOLM (instructed by NWSSP Legal & Risk Services) appeared on behalf of the Applicant.

MS. K. GOLLOP QC (instructed by the Official Solicitor) appeared on behalf of the First Respondent.

MR. V. SACHDEVA QC (instructed by Sinclairs Law) appeared on behalf of the Second Respondent.

J U D G M E N T

(As approved by the Judge)

MR. JUSTICE HAYDEN:

1 On 12th October this year the applicant Health Board applied to this court for declarations both as to 'capacity' and 'best interests' under the Mental Capacity Act 2005, concerning RY, to permit withdrawal of ventilation, withholding of life-sustaining treatment, and provision of palliative care only. RY's daughter has from the beginning asserted that, when ventilation is removed, life-sustaining treatment should be provided. I am asked to approve an order filed with the consent of all the parties which provides for some life-sustaining treatment, but not CPR or further intensive care.

2 RY is eighty years of age. He has been in hospital in South Wales since the middle of June of this year having been admitted there in consequence of a very significant cardiac arrest. He was given, initially, a very protracted period of CPR upon his collapse but he was unable to breathe for a significant period of time. It is the conservative consensus that there was deprivation of oxygen for approximately half an hour. The consequences of this are profound.

3 Unsurprisingly, RY has been in the Intensive Therapy Unit since his admission ie. approximately 5 months. He has an endotracheal tube inserted, which seems to go almost entirely unnoticed by him. He has been subject to a prolonged disorder of consciousness throughout. The endotracheal tube helps to keep the airways open and there has been some supportive ventilation. In addition to this he is, inevitably, catheterised and fed by an NG tube.

4 Mr. Chisholm, who appears on behalf of the Health Board, has, in his helpful case summary, drawn together the broad consensus of the various medical disciplines that have been involved in RY's treatment. It is convenient to repeat them:

i) RY has suffered devastating global hypoxic brain injury which has caused prolonged disordered consciousness;
ii) Although there has been the inevitable (as I understand it) reflexive bodily movement, there has been little to suggest any great level of awareness, although it is that which is the focus of debate at this hearing;
iii) There is, at present, very little, neurologically, to suggest that there is higher brain function;
iv) The assessments to date using the conventional WHIM and CRS models have failed to reveal a significant level, either of consciousness or potential for it.

However, there have been a number of recent videos taken of RY which have been sent to Dr. Badwan, an expert consultant in rehabilitative medicine

well-known to these courts, and which have been carefully examined by him, which have led him to conclude that RY is not in a vegetative state, but is in a minimally conscious state with some signs of being in upper minimally conscious state.

There is a consensus that the clinical presentation, even were one not to incorporate into that RY's advanced age, reveals a poor prognosis. There is little to suggest in this case of devastating and global hypoxic injury that there is any real prospect of recovery to his previous state or a real prospect of a quality of life that would be objectively evaluated as being in his best interests.

5 This morning the very experienced advocates in this case presented a plan, by agreement, in which it was proposed that RY underwent a tracheostomy under general anaesthetic and, transferred to a suitable unit for further treatment and/or assessment. That course was supported by Ms. Gollop QC who appears on behalf of the Official Solicitor.

6 As I noted during exchanges with Mr. Sachdeva QC, who appears on behalf of a family member, I have been concerned in a number of cases now by the apparent readiness of the profession involved in Court of Protection cases to adjourn these difficult applications for a wide and ever-varying variety of enquiry. This is all entirely well-motivated and there is no doubt that the proper instinct to preserve the sanctity of life must always remain in clear focus when evaluating a course that may lead to the death of a patient. However, it is well established that this important principle does not exist in a vacuum.

7 In **Re N [2015] EWCOP 76** I made this observation (at para 70):

> *As is clear from the above analysis this case is not concerned with a right to die. No such right exists. What is in focus here is Mrs. N's right to live her life at the end of her days in the way that she would have wished. I am required to evaluate the 'inviolability of life' as an ethical concept and to weigh that against an individual's right to self determination or personal autonomy. Not only do these principles conflict, they are of a fundamentally different complexion. The former is an ideological imperative found in most civilised societies and in all major religions, the latter requires an intense scrutiny of an individual's circumstances, views and attitudes. The exercise is almost a balance of opposites: the philosophical as against the personal. For this reason, as I have already indicated, I consider that a formulaic 'balance sheet' approach to Mrs. N's best interests is artificial.*

8 The well known passage in **Pretty v United Kingdom [2002] 35 EHRR 1** requires to be restated here:

> "65 *The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."*

9 In **Airedale NHS Trust v Bland [1993] AC 789**, Hoffman LJ observed:

> *But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person.*

10 As well as considering P's likely wishes and feelings, the Court and the medical profession also have responsibility to preserve the intrinsic dignity of the individual human being, surveying the spectrum of all the available evidence, driven by the best interests of P. I considered some of these issues in Re N (supra) at para 28:

> *I have given both these passages very considerable thought. I draw from them only this: where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interest's'.*

> *Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them. Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment. Mr Patel, counsel acting on behalf of M, has pointed to recent case law which he submits, and I agree, has emphasised the importance of giving proper weight to P's wishes, feelings, beliefs and values see* ***Wye Valley NHS Trust v B [2015] EWCOP 60; Sheffield Teaching Hospital Foundation Trust v TH and TR [2014] EWCOP 4; United Lincolnshire Hospitals NHS Trust v N [2014] EWCOP 16.***

11 As a Judge sitting in the Court of Protection, I have experience of litigants seeking very extensive assessments and re-assessments, in a way that occurred in the Family Division in Children Act 1989 proceedings, most particularly in public law care proceedings. The reasons for both strike me as similar, namely that the decisions the Court is asked to make are of such great importance and carry such profound consequences that there is, I think, a forensic instinct to leave no stone unturned. I am bound to say however, that I sometimes feel that I am being asked to authorise a petrological survey on the upturned stone. Just as the Family Justice reforms have re-emphasised the real dangers to vulnerable children caused by avoidable delay, so to, it seems to me, practitioners in this field must recognise that delay which is not, on a true analysis, either constructive or purposeful is almost certainly damaging and thus inimical to P's welfare.

12 Though avoidance of delay is not a statutory imperative in the Mental Capacity Act 2005 the principle is now so deeply embedded in the law of England and Wales and across every jurisdiction of law that it should be read into Court of

Protection proceedings as a facet of Article 6 and 8 ECHR. It requires to be restated that the Court of Protection Rules provide for the Court to restrict expert evidence and assessment, application must be made by completing form COP9. Thus:

> *The court may give permission to file or reduce expert evidence only if satisfied that the evidence:*
>
> *(a) is necessary to assist the court to resolve the issues in the proceedings; and*
>
> *(b) cannot otherwise be provided.*

13 I have revisited these core principles because I have real misgivings whether the proposals for further assessment and inevitably further expert opinion can properly be said to be in RY's best interests. RY, I have been told, is a deeply religious man. His family are similarly committed to their faith. Mr Sachdeva agrees that their position can be stated starkly and without nuance. They would wish RY to have life no matter how fragile or vestigial. Though others might regard their father's life as entirely compromised or even debased they would prefer that to his death. This is a fundamental tenet of their beliefs which resonates throughout the Judeo-Christian and Islamic faiths.

14 Having watched the clinicians from the Health Board in the courtroom this afternoon I had a very strong sense that they were unconvinced as to whether this proposed course was consistent with their ethical obligations to their patient. Their unease was almost palpable, even before Mr Chisholm informed me that the clinicians shared many of the concerns that I articulated during the course of exchanges with counsel. Indeed, and this requires to be recorded, the Health Board articulated its position in respect of the tracheostomy in this way, in Mr Chisholm's helpful position statement:

> *"In terms of <u>best interests</u> and the issue of the <u>tracheostomy</u>, the Applicant contends that this is on a very fine balance. While a tracheostomy would permit RY to leave the ITU for the ward and potentially thereafter a nursing home, the suctioning which will still be required via the tracheostomy will be highly invasive and uncomfortable for RY and will have to be performed regularly (day and night) depending upon his secretion load. The operation itself carries risks, including at least a 1-3% chance of mortality, bleeding, infection and scarring alongside anaesthetic risks. If the Court is willing to sanction the procedure with that in mind, the Applicant is willing to undertake it. The Court may be assisted by hearing brief evidence from Dr Gorst on that point."*

15 Dr Gorst, consultant in intensive care medicine at the treating hospital, expressed hismelf, in what I consider to be clear, sensitive and admirably succinct terms, in his most recent statement dated 7th November 2016:

> '*Sanctity of life and 'any chance of life' are very noble principles which I agree with. However any chance of life does not mean any chance of life no matter what the pain, indignity and burden it entails and no matter what the chances of recovery are. Few people have had the first-hand experience of receiving or delivering the interventions that are necessary to support life during Intensive Care treatment for short periods never mind many months. It is difficult to imagine how anyone, without either previously receiving or delivering critical care interventions, can predict the distressing nature of such interventions and balance them against 'any chance of life*'.

16 In August, Dr. Badwan concluded that should RY be weaned off a ventilator and should he have a further cardiac or respiratory arrest, it was his opinion that it would not be in RY's best interests to be ventilated further. Dr Badwan also stated that in consequence of this extensive diffuse hypoxic brain injury there was little prospect of improvement in RY's very minimal level of consciousness.

17 As I have foreshadowed, however, Dr Badwan has since been shown a number of videos. It would appear from his most recent report, which was filed late and which the parties have, therefore, had to consider over a relatively limited period, that the videos revealed a level of consciousness that was not consistent with the rest of the available clinical information. This one feature in the broad medical canvas struck Dr. Badwan as so potentially significant that it might cause him to alter his view. In his recent report he says this:

> *"RY suffered from a hypoxic brain injury. He has shown continuing slow improving trajectory being in coma at the initial stage and prolonged disorder of consciousness thereafter. He is presently in MCS and has obviously not plateaued, as yet. It remains to be seen whether RY continues to improve or remains in his present state. MCS would be considered permanent if lasting three to five years."*

18 He was then asked what the likelihood is of RY recovering to an extent that he would be able (1) to sit outside and watch wildlife in the garden, (2) to be able to watch television and (3) to be able to hold simple conversation. To that question he responded thus:

> *"RY is in a minimally conscious state. He is aware of himself and the environment around him at times but such awareness varies. Therefore, when RY is aware he will probably be able to appreciate the first of the two factors that I have referred to above. The third is dependent on other factors including the state of his vocal folds and, at present, it is not possible to comment on that."*

19 If Dr. Badwan will forgive me for saying so, his analysis of points one and two I have not found easy to understand. Counsel have explored it during the course of the day. What it seems to me he is saying, having regard to the evidence as a whole, is that which Ms. Gollop advances on behalf of the Official Solicitor i.e. there may be a chance of some improvement in the level of consciousness that might enable RY **to achieve** (my emphasis) the first of the two objectives. I am bound to say that from what I have read that prospect appears to be very slim. Equally, it must be said that whilst common things happen commonly, sometimes in these cases there are quite unexpected and wholly unanticipated improvements. Therein lies the challenge.

20 Given the scale of the hypoxic damage, the preponderant evidence suggests that any significant improvement may be rather a forlorn hope. I think RY's family should be under no delusion as to the prospects. That 'flicker of hope', says the Official Solicitor, is one that should be pursued on RY's behalf. Ultimately, I have acceded to that submission but I do so on a very particular basis and that is that the assessment process, which has been outlined in framework this afternoon, is carefully monitored and that the SMART assessment, is commenced no later than 6th December. If, at any point between today and the end of January when I anticipate this case will return to me, those treating RY feel that this delicately poised decision has shifted, so that ongoing treatment and/or assessment does not continue to be in his best interests, I spell out in clear and unambivalent terms that I regard it as the duty of the Health Board to return the case to Court expeditiously. Sympathetic though I am to the views of RY's family and the complete integrity with which they seek to convey RY's views to the Court, their own views and feelings must always remain subordinate to RY's best interests, objectively assessed.

21 The care plan requires to be specific, focused, choate and detailed, bearing in mind, as I have emphasised that prolongation of the investigation may be contrary here to the patient's best interests. On this basis, and for these reasons, I am prepared to make the declarations that the parties seek today, including the necessary step of a tracheostomy which I understand, all being well, will be completed within the next twenty-four to forty-eight hours.

22 By way of postscript, I should like to pay tribute to all the medical staff, doctors, nurses and experts who have been involved in this case to date and to the lawyers; their collective professionalism has made this challenging case far less difficult than otherwise it could have been.

23 I order a transcript of this extempore judgment to be prepared at public expense, expeditiously.

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