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Case No. COP12850318

IN THE HIGH COURT OF JUSTICE

COURT OF PROTECTION

Royal Courts of Justice

Date: Monday, 25th April 2016

Before:

MR. JUSTICE HAYDEN

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B E T W E E N :

Re: O

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J U D G M E N T (As approved by the Judge)

MR. JUSTICE HAYDEN

1 I am concerned with O. At fifty-eight, she is a proud grandmother of eight grandchildren. She comes originally from Nigeria, but she has worked most of her life here in the UK for the National Health Service as a phlebotomist and as a carer. She is, I have been told by her daughter, a woman who is full of energy but very humble and somewhat shy. Nonetheless, her daughter described her as a fighter. It seems to me there is something of that in the next generation too.

2 On 16th February 2015, O was found unresponsive at home. The ambulance crew were immediately able to put resuscitation in place at the scene and she was admitted to the Emergency Department and onto the Intensive Care Unit at the Kings College Hospital in London. There a brain CT scan was undertaken and was reported as being compatible with severe hypoxic brain injury, that is to say that there has been deprivation of blood and oxygen to the brain. When sedation was discontinued, O failed to wake up. A PEG tube was inserted to facilitate her feeding as she was not able to swallow herself and, from March onwards, she was breathing spontaneously without ventilator support.

3 For various differing reasons O had a number of admissions to hospital in September and October, one involved biting her tongue and the other involved Hypoglycaemia. On 8th October 2015 there are entries in the notes at the nursing home that O was able to open her eyes spontaneously, but not to any stimulation. Her pupils were equal, they reacted to light and there were movements in her arm. She would become agitated during nursing. Her daughter has told me that she believes those movements in her arm not only persist, but effectively are more frequent and indicate to her that her mother is improving.

4 Nearly a year later, that is to say almost to the day after the first cardiac arrest, there was a second cardiac arrest on 11th February 2016. O became unconscious. The ambulance was called. On their arrival her breathing was shallow and irregular. She then became apnoeic and a systolic. CPR was started five minutes after the arrival of the ambulance crew and she was bagged to get air into her lungs. It is recorded that, during the course of that process, there was severe resistance. It was felt that she had very poor chest rise and some obstruction in the tracheostomy that had taken place the previous February. It was, however, possible to restore the heart rhythm with a slow heart rate.

5 Inevitably, there was a repetition of some of the earlier investigations and so it was that on 15th February 2016 there was a further CT scan. That CT scan is described as follows:

> "Comparison is made with the previous study on 23rd February 2015. There is a marked low density and interval parenchymal volume loss to the cerebral hemispheres. There is diffuse involvement of the cortex with a relative sparing of the frontoparietal convexity cortex. This is most markedly low density involving loss involving the corpus striatum bilaterally. This is consistent with previous established global hypoxic ischemic injury."

In other words, there were widespread changes on both sides of the brain which suggested that there had been a significant acute hypoxic ischemic event.

6 O has seen a number of highly respected specialists not simply those who have treated her clinically, but those who have been involved in investigating her circumstances and condition for the purpose of the application that I am presently considering.

7 On 9th March 2016 she was examined by Dr. Moran, who is a Consultant Neurologist. He noted that she remained dependent on ventilation, despite having been off sedation or any anaesthetic medication for what was by that time several weeks. Nursing staff had not observed eye opening or any voluntary movements. On neurological examination, there were no voluntary movements and no response to pain. There was frequent posturing. There was spasticity in the upper limbs, entirely flaccid muscle tone in the lower limbs. There were no spontaneous eye movements and no ocular reflex. The pupils did not respond to light. There was no gag reflex. There was no jerking of the jaw. Dr. Moran made a diagnosis of "very severe global cerebral cortical damage".

8 It is instinctive in human nature to make every effort to preserve life no matter how vestigial it might have become and to investigate all possibilities as thoroughly as modern medicine allows, recognising that doctors do not always get it right and that today's medical consensus may not be tomorrow's. So, on 10th March 2016, O was examined further, this time by a Dr. Tom Best, who is a Consultant in Intensive Care. He reported that he found no response to noise or to verbal stimulation. The pupils were unreactive to light and both were fixed at three millimetres. There was no eye movement. There was no gag reflex. There was no response to pain. No movement at all of the legs was seen. It was observed that O made only one single spontaneous breath during this period. Dr. Best concluded, as had Dr. Moran, that there was

overwhelming evidence of irreversible severe hypoxic brain injury. He considered that the injury was so extensive that the majority of her brain stem was also involved, although some small part of it was spared which accounted for the very occasional spontaneous breaths.

9 The treating clinicians had concluded that it was no longer in O's interests to continue her life by ventilation, artificially, in the way that was taking place. The Trust made an application to this court seeking an application that their staff might lawfully withdraw and withhold mechanical ventilation and, further, that they might lawfully withhold any escalation of treatment such as cardiopulmonary resuscitation, organ support, antibiotics. Such treatment was, in their evaluation, no longer in O's best interests. In response to that application the Official Solicitor was instructed and he sought a further expert. This time a Dr. Peter Newman who is a Consultant Neurologist of national renown. He provided a report, which, largely, concurred with the views of the treating clinicians.

10 So it was that the case came before me on 14th April 2016. By this stage, there was a compelling consensus of very distinguished medical evidence concluding that the damage to O's brain was so profound that there could be no feeling that there was in reality no sentient life and no prospect of a recovery. Her situation following that second heart attack was markedly different to that following the first heart attack, the brain and brain stem having both been substantially damaged.

11 Nonetheless, there had been a tentative agreement amongst the experienced advocates before me, driven by the desperate commitment of the family that there should be a further expert involved. As the three daughters - who are all sitting here today at quarter to six in the evening - are all too well aware, I found it difficult at that point to disentangle their wishes to explore every avenue available to them from my obligation to protect their mother. Individuals in the situation that O finds here are entitled to respect for their own autonomy and to their own dignity. But such is the intensity of this family's feelings for their mother and their love for her that I permitted their wishes to prevail. I authorised the instruction of a yet further expert knowing that it would protract things further for O. I wanted to strike a balance between what I feared might be compromising her rights and, at the same time, offering the family every conceivable opportunity to explore the options for their mother. I also hoped that if hope was truly exhausted for the family they could work with the doctors and hospital staff to make dignified and peaceful arrangements for ventilation to be withdrawn.

12 Professor Udo Kischka, a Neurologist and Consultant in Neurological Rehabilitation currently at Kings Hospital, was able to prepare a report. He

complied with my expedited timescale, which I judged to be O's entitlement. I am satisfied that, in his thorough and sensitive report, he considered all of the information that was available to him and was able to view the significant parts of the twelve hours of video material that this highly committed family had themselves provided. I did not view the videos myself, I simply do not have the training or expertise to go beyond what all the doctors have seen and recorded. I am not in a position to evaluate the difference between a reflex action and an active neurological function. At the end of that process, he came to the conclusion that the other doctors who had examined O were correct in their assessment. In his report, he states as follows:

> "I agree with Dr. Newman and Dr. Best's conclusions that O's very severe damage to the cortex of the brain, the subcortical structures of the hemispheres of the brain and the brain stem, the source of life to the brain itself, are profound and irreversible. I also agree with Dr. Newman that there is no possibility of significant improvement in cerebral function. There have been minimal recovery responses in recent weeks, which are all on a reflex level without signs of awareness or purpose of movement."

It is so easy to understand how those simple reflex responses will have been latched on to by the family and have fed their hope.

13 Professor Kischka noted that the best possible or conceivable outcome regarding O's breathing is that she might be able to breath perhaps slightly better than she does now, but her ability to breath will always remain so fragile that she will need to remain on some sort of ventilation for the rest of her life. The situation now, he said, is very different. Due to the additional brain damage in February 2016, which he describes as "quite dramatic", the cortex and the brain stem are affected to a far more severe degree than before. So Professor Kischka considered the options, weighed up the information and all the arguments - plainly having listened, in my judgement, as I have already mentioned, carefully and attentively to the family - and came to the view that it would no longer be in O's best interests to keep her on ventilation.

14 I would go further. I consider it would now be inimical to O's welfare to sustain her artificially in such circumstances. There is a strong presumption in favour of life saving treatment but this is not irrebuttable, nor is the contemplated treatment here life saving. I remind myself that the Court, doctors and family members all have different roles see *In* ***re J (Wardship: Medical Treatment)*** **CA [1991] Fam 33** at 41 where the court stated that:

> *"No one can dictate the treatment to be given to the child- neither courts, parents nor doctors. There are checks and*

balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B but they cannot insist on treatment C. the inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents."

15 Lord Donaldson in *In **re J*** (a case concerning mechanical ventilation) referred to the balancing exercise to be performed in assessing best interests. *"As this court observed in In **re B** account has to be taken of the pain and suffering and quality of life which the child will experience if life is prolonged. Account has also to be taken of the pain and suffering involved in the proposed treatment itself."* Balcombe LJ in *In **re J*** deprecated any all-embracing test of intolerability (mentioned in the earlier case of *Re B*) *"since the circumstances of the cases are so infinitely various."*

16 The Mental Capacity Act Code of Practice addresses life-sustaining treatment at para 28 thus:

"5.31 all reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile , overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.

5.32 As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist should be considered, and in particular, the decision maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.

5.33 Importantly, section 4(5) cannot be interpreted to mean that doctors are under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen. Doctors must apply the best interests checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests. If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the court of Protection may be asked to decide what is in the person's best interests."

17 I reviewed the law more widely in this area in **Re N [2015] EWCOP 76,** it is unnecessary for me to do so again here. The Courts must not pursue the principle of respect for life to the point where life has become empty of real content or to a degree where the principle eclipses or overwhelms other competing rights of the patient i.e. in this case simple respect for her dignity.

18 Her daughters tell me that O displayed, throughout her life, a strong sense of 'fairness'. I take that to mean she treated people equitably and in an open minded way, discarding self interest. I have no doubt that the daughters do not believe that it would be fair to grant the application the Trust seek. Despite the compelling, entirely unanimous and substantial body of medical opinion that has now been gathered the daughters are simply unable to let their mother go. The medical evidence shows that independent life of the body and mind has now gone for O. Hers has become a life without content. It is painful for the family to hear this, but it is important to identify the accurate medical situation. The daughters have my profound sympathy as well as my understanding. I propose to grant the declaratory relief sought by the Trust.
