Case No: HQ11X04768

Neutral Citation Number: [2015] EWHC 3250 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 November 2015

Before :

THE HONOURABLE MR JUSTICE BLAKE

- -

Between :

Elaine Winspear (Personally and on behalf of the estate of Carl Winspear, Deceased)	**Claimant**
- and -	
City Hospitals Sunderland NHS Foundation Trust	**Defendant**

- -
- -

Jeremy Hyam and Kate Beattie (instructed by **Leigh Day**) for the **Claimant**
Angus McCullough QC (instructed by **Bevan Brittan LLP**) for the **Defendant**

Hearing dates: 2 & 3 November 2015

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Judgment

The Honourable Mr Justice Blake:

Introduction

1. The claimant is the mother of Carl Winspear. Carl was twenty-eight years old when he died shortly after 11.00 pm on the 3 January 2011. He had suffered all his life from cerebral palsy, epilepsy, spinal deformities and other associated health conditions. At the time of his death and all other relevant times he lacked capacity within the meaning of the Mental Capacity Act 2005.

2. He had been unwell for a few days beforehand and suffered from chest infections. He was admitted to his local hospital in Sunderland on 2 January 2011 around 3.00 pm. His mother had called an ambulance and she accompanied Carl in the ambulance to the hospital. A close family friend Sandra Noble followed in her car behind. After a wait for a bed in the Accident and Emergency Department Carl was admitted to a ward around 7.00pm. The claimant understood from conversation with the nurses that he had a chest infection and was receiving oxygen, fluids and a high dose of antibiotics. She stayed with Carl from his arrival at the hospital until about 9.00pm. When she left she had no particular concern for his future.

3. Before she went to bed that night she contacted the hospital around 10.00pm and was told that Carl was the same. She contacted the hospital again the following morning around 11.00am and was told again that Carl was stable and was on his oxygen. Shortly after this call she received a further call and was told that the doctors wanted to speak to her before visiting hours had started. She did not have the impression that this meeting was urgent because of a deterioration in Carl's health. She arrived later that morning and had a conversation with Dr Farrer who is a consultant cardiologist and was Clinical Director of the directorate of emergency care of the hospital. He had held that position since 2008.

4. Although the precise terms of that conversation are a matter of dispute, there is no doubt that the question of cardiopulmonary resuscitation arose in the course of it. Ms Winspear expressed her strong disagreement with the suggestion that if Carl stopped breathing resuscitation should not be attempted. Although he was severely disabled she did not want him treated differently from any other patient and considered he enjoyed a reasonable quality of life at home with her.

5. At 3.00 am that morning, Dr Swarbrick, the specialist registrar in cardiology, had placed on Carl's clinical record a notice to the effect that cardio-pulmonary resuscitation should not be attempted (DNACPR). This was done without consultation with Ms Winspear or any other family member or person representing Carl's interests.

Dr Swarbrick's decision

6. Dr Swarbrick made that decision on clinical grounds as a result of information he had about Carl's condition. He noted that Carl had cerebral palsy, limited communication and was bed-bound. He had pyrexia and hypoxia on arrival at A&E; he had a severally deformed spine (kyphosis); it was considered that he was likely to be suffering pneumonia and was in a frail state. He concluded that CPR would be inappropriate in the event of a cardiac arrest because Carl's severe kyphosis and

contractures in his arm made effective performance of it impossible. He records in his witness statement made for these proceedings that he did not want to inflict on Carl a treatment that was distressing, painful, undignified and futile because it had no chance of success.

7. He did not think that there was an imminent risk of cardiac or respiratory collapse but made the decision that he did to avoid the possibility of the nursing staff being obliged to administer CPR, even if the chance of it needing to be administered was remote (paragraph 7 of his statement).

8. He recorded in Carl's medical record "DNAR. Speak to family in the morning". The printed DNACPR notice itself was not fully filled in; the sections dealing with the date of order, with whom the decision was discussed and the counter signature by the consultant were not completed. The decision was to last 48 hours.

9. In his witness statement (paragraph 8) he explained why he did not first discuss the matter with Ms Winspear as Carl's carer:

> "firstly because I did not think that the deceased was at high risk of unexpected deterioration over the next five hours and in my view was, although unwell, in a stable condition. Secondly because the decision was not based on a judgement about his quality of life at the time but rather the futility and ineffectiveness of CPR as a intervention in his case. In these circumstances I did not think that it was necessary or appropriate to call his next of kin at that time. It is correct that the form was not fully completed. My intention was that the missing part would be completed the following morning after discussion with the next of kin."

10. Carl's condition was reviewed by Dr Swarbrick and a consultant Dr Carey at 8.30 am shortly before Dr Swarbrick went off night duty. No further completion or variation of the DNACPR notice occurred. The medical notes of that meeting set out five items for the treatment plan of which point four reads "speak to family later re res(uscitation) status".

Subsequent developments

11. Carl was examined at 11.00am by Dr Batt the specialist registrar for the day shift. He noted some deterioration in his condition, the fact that there was a DNACPR form in place and posed the question whether Carl was a candidate for the intensive treatment unit. It was probably his examination that led to the nurse being asked to call Ms Winspear to come to the hospital.

12. There is an action recorded by a nurse at 11.43 that either at or by 11.38 she contacted the family at the request of doctor. This supports the claimant's oral evidence at trial as to the time she received the call from the hospital, having examined the time of her call to the hospital by reference to her mobile phone bill.

13. Following Ms Winspear's discussion with Dr Farrer, the DNACPR notice was cancelled. Although neither the conversation nor the cancellation decision are timed in the medical records, it seems likely from the billing information provided at trial

that the conversation took place shortly after midday and the cancellation would have been effected between 12.30 and 13.00.

14. Carl was moved to an intensive care unit at 14.40 after his treatment plan was adopted after consultation with his mother. It included non-invasive support for his breathing. Dr Farrer had explained why transfer to a ventilator was not suitable: his physical strength was such that if once placed on one he would be unlikely ever to be weaned off it. His condition deteriorated that evening and he died of a bronchial-pneumonia illness at 23.05hrs.

The proceedings

15. In December 2011 the claimant issued these proceedings by way of a Part 7 claim form. She contends that placing the DNACPR notice on Carl's medical record from 3.00 am until it was cancelled some time after 12.30 without any consultation with a person who had been caring for or representing his interests was a procedural failure and has resulted in Carl's right to respect for private life under Article 8(1) of the European Convention on Human Rights (ECHR) being interfered with without justification. After a defence and reply had been served the proceedings were stayed pending the determination by the Court of Appeal of the case Regina (Tracey) v Cambridge University Hospital NHS Foundation Trust and another [2014] EWCA Civ 822 [2015] QB 543 (Tracey). Judgment in Tracey was delivered in June 2014 and this case was then restored for trial.

Oral evidence

16. At the trial of this matter, the essential narrative of events as set out above was not in dispute. I did not hear live evidence from Dr Swarbrick as his witness statement and the clinical judgment reflected in it was not in dispute.

17. I heard from Ms Winspear, her mother and Ms Noble as to the timing of their meeting with Dr Farrer and their recollection of the contents of the meeting. I found them to be all honest witness doing their best to recall traumatic events nearly five years ago.

18. Ms Winspear (supported by her other witnesses) was adamant that the conversation with Dr Farrer started with a reference to whether she had considered the issue of no resuscitation. She is sure that she was not told that a notice had been in place since 3.00am. She had previously, in 2007, expressed opposition to a similar course being taken when Carl had to attend hospital. If she had known such a notice had been issued without her being consulted she would have raised this in her complaint made on 11 January 2011 to the hospital about other aspects of his treatment. She only found out about the notice months later.

19. I also heard from Dr Farrer for the defendant. He relies for his recollection of the conversation on the notes taken by Dr Batt of it that he has counter signed as accurate. He is sure that Dr Batt was present at the time of the meeting with the family although neither Ms Winspear, her mother nor Ms Noble recall this.

20. The notes made by Dr Batt record:

> "Discussion [with] p[atien]t's mother, aunt & grandmother by Dr Farrer.
>
> All feel that pt has got good quality of life. Goes to day centre 5 times/week. Has been unwell in the past but has always come round [therefore] they have expectations that pt will come round.
>
> Explained by Dr Farrer that pt is not well at present.
>
> Septic with chest infection & also has flu? Swine flue.
>
> Also explained that pt is being currently actively treated but his current condition suggests that the chest inf[ection] & flu has affected his breathing & he is not getting enough O2 to his lungs.
>
> Further deterioration means that this breathing might need to be supported by a ventilator however given his comorbidities he will not have the strength to come off ventilation on his own.
>
> Also explained to family that DNAR form was signed by SpR over night.
>
> Family completely disagrees [with] DNAR decision & feels that pt is entitled to for full level of care like any other.
>
> Dr Farrer has explained that we will get ITU Consultant to [review] Carl & give his opinion whether ITU would be appropriate for him.
>
> Family would also like to sit together & discuss amongst themselves re this. They would like to d/w [discuss with] ITU consultant once pt is reviewed by ITU."

21. I accept Dr Batt's recorded account of the conversation as broadly accurate. It is inconceivable that he was not there and had compiled the note from a subsequent conversation. The note is clear that the fact that a decision had previously been made was communicated to the family and it was cancelled.

22. I accept Dr Farrer's evidence that he cancelled the notice as he could see that its existence was an obstruction to family cooperation with Carl's future treatment.

23. Discussion with Dr Morrison, the ICU consultant, revealed that there was a method of treating Carl's problems with a non invasive assistance to breathing. Dr Farrer did not think that the absence of a DNACPR notice would give rise to a risk of inappropriate treatment. In that respect at least subsequent events proved him right.

24. It may well be that once the issue of resuscitation had been raised Ms Winspear's concern was for the future and she did not take in the information that a previous direction had been made that was to be cancelled. If she had done so, I consider it likely that she would have mentioned this as a concern in the complaint made on 11

January. However, in my view, her recollection along with those of her witnesses that the topic was never raised is erroneous.

The law relating to decisions to refuse treatment

25. There is little doubt that a DNACPR decision is a significant medical decision. In the light of Tracey it is now clear that such a decision engages (is within the ambit of) Article 8(1) ECHR that is to say is an aspect of the duty of respect for the private life of the patient (see at [41] to [42]).

26. In its decision in Tracey the Court of Appeal (per Lord Dyson MR) further concluded:-

i) Decisions involving the treatment of a patient with a terminal or possibly terminal illness gave rise to procedural obligations inherent in the notion of respect within the meaning of Article 8 although the decree of involvement turns on the circumstances of the case and the nature of the decisions to be taken ([52]).

ii) Whilst decisions as to what treatment should or should not be given to a patient were ultimately a clinical judgement for the medical professional, there should be a presumption in favour of patient involvement in the decision making process and there needed to be convincing reasons not to involve a patient ([53] and [55]);

iii) It is inappropriate to involve the patient personally in the process if the clinician considers that to do so is likely to cause the patient to suffer physical or psychological harm but the mere fact that the subject matter is likely to distress the patient will generally not be sufficient to justify excluding the patient from the decision-making process ([54]).

iv) The fact that a physician considers that the treatment is futile is not a sufficient reason not to communicate the decision. ([55]). Lord Dyson said

> "I would reject this submission for two reasons. First, a decision to deprive the patient of potentially life-saving treatment is of a different order of significance for the patient from a decision to deprive him or her of other kinds of treatment. It calls for particularly convincing justification. Prima facie, the patient is entitled to know that such an important clinical decision has been taken. The fact that the clinician considers that CPR will not work means that the patient cannot require him to provide it. It does not, however, mean that the patient is not entitled to know that the clinical decision has been taken. Secondly, if the patient is not told that the clinician has made a DNACPR decision, he will be deprived of the opportunity of seeking a second opinion."

v) On the particular facts of the case, there was a breach of the procedural obligation in Article 8 by placing a DNACPR notice on the patient's files without involving the patient in the process ([58]).

vi) The fact that a subsequent DNACPR was placed on file after the patient and her family were consulted does not mean that 'the decision making process as a whole' was compliant with Article 8 ([58]).

27. Tracey concerned an adult patient with capacity with a terminal disease but who had expressed the wish to be consulted about treatment decisions, until a time came when she expressed the wish no longer to be consulted.

28. The present case concerns a patient who did not have and has never had capacity and was consequently unable to express any view on treatment, who should represent his interests or his values and beliefs. There is an issue between the parties as to the extent to which the principles in Tracey can be read across to a case of an adult patient without capacity.

29. In Tracey the lack of participation of the patient was egregious. Mrs Tracey had communicated a wish to be consulted and yet was not consulted about the DNACPR decision. The notice reflecting the decision provided for no planned consultation; it was maintained for several days without review until it happened to be spotted by the patient's daughter.

30. By contrast, in the present case the initial decision was taken by Dr Swarbrick at 3.00am on 3 January and the clinical notes reveal that part of the treatment plan was to discuss the decision with the family. Carl's mother was invited to the hospital by a call made around 11.30 and had a meeting with Dr Farrar as a result of which the notice was cancelled around 12.30 and not restored while Carl was treated in intensive care.

31. Mr McCullough QC for the defendant invited the court to look at 'the decision-making process as a whole' (a term derived from Tysiac v Poland (2007) 45 EHRR 947 at 115). He submits that looked at as a whole the process respected Carl's Article 8 rights. He also points to the use by Lord Dyson MR of the past tense in rejecting the defence submissions in Tracy at [55], to found a submission that it was sufficient discharge of the procedural obligation if the patient (or next of kin) was informed reasonably promptly after the event that the decision had been taken.

32. I reject this last submission. It seems to me that, read in context, what Lord Dyson was considering at [55] was the clinical decision reached by the treating physician that needed to be discussed with the patient before a DNACPR notice was decided on and placed on the patient's file. It is clear from other passages of the judgment that the whole essence of the decision was that absent convincing reasons to the contrary, the patient had to be involved in the process that led to the notice being completed, in particular at [59]:

> "there was a breach of the Article 8 procedural obligation to involve Mrs Tracey before the first notice was completed and placed in her notes."

33. Although Lord Dyson provided the leading judgment with whom each other member of the court agreed, the concurring judgment of Ryder LJ is both pertinent and compelling:

“95. The duty to consult is integral to the procedural obligation to ensure effective respect for the article 8 right, without which the safeguard may become illusory and the interest may not be reflected in the clinical judgment being exercised. That interest is the autonomy, integrity, dignity and quality of life of the patient. It is accordingly critical to good patient care. The duty to consult is of course part of a clinical process. That process is individual to each patient albeit that it is informed by good clinical practice.

96. The importance of the interest that is to be safeguarded by the duty may sometimes be obscured by the sensitivity of the decision to be made within the clinical process and the stress of the circumstance in which it is made. That is an issue which needs to be identified so that it can be properly considered on the facts of each case i.e. there should be a strategy to deal with discussions and decisions. That is a separate consideration from whether it is clinically inappropriate to enter into discussions about treatment with a patient who does not want to have those discussions. There should be convincing reasons not to involve a patient in treatment discussions and decisions, for example, when the clinician considers that it would likely cause the patient to suffer physical or psychological harm.

97. It is important not to elide the principle that a patient cannot direct a clinician to provide a certain form of treatment although she may refuse it, with the principle that a patient should be involved in her own care. In this case, the Trust published guidelines on 29 April 2014 entitled the 'Universal Form of Treatment Options (UFTO) Guidelines' which recognised a distinction between active and passive care informed by the patient's wishes. There is now an accessible policy which helpfully describes the patient's right to be consulted before a DNACPR decision is made.

98. In the context of this court's decision, it may be helpful to re-consider the oft repeated GMC guidance that was endorsed by Lord Phillips of Worth Matravers MR in *R (Burke) v General Medical Council* [2006] QB 273 at [50] which can be summarised as follows:

i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated;

ii) The doctor offers those treatment options to the patient, explaining the risks, benefits and side effects of the same;

iii) The patient then decides whether he wishes to accept any of the treatment options and, if so, which one;

iv) If the patient chooses one of the options offered, the doctor will provide it;

v) If the patient refuses all of the options he may do so for reasons which are irrational or for no reason at all or he may inform the doctor that he wishes to have a form of treatment that the doctor has not offered;

vi) If, after discussion with the patient, the doctor decides that the form of treatment requested is not clinically indicated he is not required to provide it although he should offer to arrange a second opinion."

34. The statutory regime for decisions affecting people who lack mental capacity is regulated by the Mental Capacity Act 2005 (MCA) and the Code of Practice made under it to which the court is enjoined to have regard by s. 42 (5) of the Act.

35. The following statutory provisions are relevant for present purposes;

i) Section 1(5) requires that a decision made for a person who lacks capacity must be made in his best interests.

ii) Before the decision is made s 1 (6) requires regard to be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights.

iii) A person making a decision in the patient's best interest needs to follow the steps set out in s.4 (3) to (7).

iv) This applies in particular where it relates to life sustaining treatment (see s.4(10)).

36. Section 4(6) states that decision maker :

"must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) other factors that he would be likely to consider if he were able to do so."

Subsection (7) continues:

"He must take into account, if it is practicable and appropriate to consult them, the views of—

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

(b) anyone engaged in caring for the person or interested in his welfare,

(c) any donee of a lasting power of attorney granted by the person, and

(d) any deputy appointed for the person by the court,

> as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)."

Code of Practice

37. MCA Code of Practice gives guidance on when it is reasonably ascertainable to obtain the patient's views. Paragraphs 5.39 and 5.51 are relevant to the practicability of communication with carers.

> "5.39 How much someone can learn about a person's past and present views will depend on circumstances and the time available. 'Reasonably ascertainable' means considering all possible information in the time available. What is available in an emergency will be different to what is available in a non-emergency. But even in an emergency, there may still be an opportunity to try to communicate with the person or his friends, family or carers (see chapter 3 for guidance on helping communication. "
>
> 5.51 Decision-makers must show they have thought carefully about who to speak to. If it is practical and appropriate to speak to the above people they must do so and must take their views into account. They must be able to explain why they did not speak to a particular person – it is good practice to have a clear record of their reasons. It is also good practice to give careful consideration to the views of family carers, if it is possible to do so.

Discussion

38. Section 4(7) MCA has assumed central importance in the trial. The claimant was clearly someone engaged in caring for Carl and interested in his welfare, even if she was not a court appointed deputy or the holder of a lasting power of attorney who could formally grant or refuse consent to medical treatment.

39. The decision maker must take her views into account if it was practicable and appropriate to do so. She submits that given the significant nature of the decision; her life-long care of Carl; her travelling with him in the ambulance and her communication with the nursing staff on 2 January, it was both appropriate and practicable for Dr Swarbrick to consult with her either by telephone or invitation for a meeting in person in the early hours of the morning, to discuss the proposed DNACPR notice.

40. Alternatively, she contends that it was both practical and appropriate and the least intrusive means of respecting Carl's rights to have deferred a decision in respect of DNACPR until later in the morning of 3 November when the claimant could attend at a face to face meeting and the ultimate decision could have had the benefit of the input of the other members of the clinical team.

41. The defendant submits that s.5 (2) MCA provides a defence to any form of liability in respect of a decision relating to a person who lacks mental capacity as long as the

court is satisfied that in reaching the decision the maker 'reasonably believes that it will be on the best interests for the act to be done'. (see s.5 (1)(b)).

42. Whilst there is no dispute that Dr Swarbrick took the decision he did on clinical grounds that he believed was in Carl's best interests, the issue is whether he took it in accordance with the procedure set out in s.4. As Lord Justice Ryder has pointed out in the passages cited above and as reflected in the references to human dignity inherent in the ECHR, in guidance and elsewhere, 'best interests' means something broader than clinical judgment. A 'best interests' decision normally requires consultation.

43. If there has been consultation, or a s.4(7) compliant reason to dispense with it, then section 5 MCA protects the doctor and through him the defendant from liability for a breach of s.6 HRA 1998 through breach of the procedural obligation in Article 8. The provisions of s.4 MCA set out with specificity the procedural obligations to consult before important medical decisions are taken. There is nothing in Tracey or the developing Strasbourg case law to suggest that a higher standard is required in DNACPR decisions.

44. However, if the procedure set by s.4 (7) has not been met, the issue is whether s5 MCA operates to prevent liability for a breach of Carl's human rights. I note that a similar submission that was advanced in the case of H v Commissioner of Police for the Metropolis [2013] EWCA Civ 69; [2013] 1 WLR 3021 at [51] was considered by Lord Dyson MR to have force, albeit that it was not decisive of the outcome. In that case police officers had been called to a swimming pool where a 16 year old boy with severe autistic disorder had been visiting accompanied by a carer. The officers restrained the boy believing that he would be in danger of falling into the water. They did so without first consulting the carer nearby who could have advised them of the risks in so doing. The trial judge had had the benefit of the hearing the decision makers give evidence and concluded that any belief that the police officers may have held that there was an emergency requiring them to act before consulting the carers was not a reasonable one within the meaning of s.5 (1) of the Act.

Conclusions

45. There is nothing in the case of Tracey or the Strasbourg case law to suggest that the concept of human dignity applies any the less in the case of a patient without capacity. I accept the claimant's case that the core principle of prior consultation before a DNACPR decision is put into place on the case file applies in cases both of capacity and absence of capacity. The fact that there was no cardiac arrest before the notice was cancelled is not decisive, as its existence is itself an interference with private life; it is an important decision about medical treatment of a potentially life saving nature.

46. I also accept the defendant's submission that the practical exigencies relating to communication differ if the patient who is being treated by a doctor cannot communicate his wishes and beliefs. In my view, those considerations go to the question whether there is a convincing reason to proceed to implement a DNACPR decision without prior consultation. In the case of persons who lack capacity, the MCA spells out when and with whom a decision taker must consult; if it is not 'practicable or appropriate' to consult a person identified in s.4 (7) before the decision is made or acted on, then there would be a convincing reason to proceed without consultation.

47. If, on the other hand, it is both practicable and appropriate to consult then in the absence of some other compelling reason against consultation, the decision to file the DNACPR notice on the patient's medical records would be procedurally flawed. It would not meet the requirements of s.4(7) MCA; it would accordingly not be in accordance with the law. It would be an interference with Article 8(1) that is not justified under Article 8(2) for two reasons:-

    i) a decision that is not taken 'in accordance with law' cannot justify an interference with the right to respect afforded under Article 8(1) ;

    ii) if consultation was appropriate and practicable there is no convincing reason to depart from it as an important part of the procedural obligations inherent in Article 8.

48. The discharge of this procedural obligation is not a matter of challenging a clinical judgment as to the appropriate treatment for a patient. The formation of such a judgment is a necessary first step in the decision making process before a DNACPR notice is placed on file but not generally a sufficient one.

49. One of the difficulties here is that nowhere in the clinical notes is it indicated has Dr Swarbrick considered his duty to contact Carl's carer under s.4 (7) of the MCA. The reasons for not contacting Carl's carer are not recorded in the clinical notes or the notice giving effect to the decision. A minor point is that the language used in the form DNAR (do not attempt resuscitation) was contrary to defendant's then guidance :

> "The terminology not to attempt Cardio Pulmonary Resuscitation DNA CPR supersedes any other terminology which may be in use such as DNR DNAR or Not for CPR".

The specific language required by the policy makes clear that it is only CPR that is covered by the notice and not other means of resuscitation.

50. Dr Swarbrick has subsequently given two reasons for not attempting consultation before the decision was taken (see above at [9]). Neither reason addresses in terms either the practicality or the propriety of doing so. I can see every reason why a telephone call at 3.00am may be less than convenient or desirable than a meeting in working hours, but that is not the same as whether it is practicable.

51. The first reason given by Dr Swarbrick is that he did not think that Carl was at high risk of a sudden deterioration over the next five hours (that is until 8.00am). There are three observations to be made on this reason. First, by inference, if there had been a high risk of deterioration leading to cardiac arrest, the decision would be or might well have been different; that is to say an attempt would have been made to communicate despite the unattractive hour for such a discussion. If so, an attempted communication could be said to be practicable. Second, if the decision was not considered so urgent as to merit communication, it might have been possible to defer it to 8.00 when it could benefit from the input both of the carer's views and that of the relevant consultants. Third, a review at a meeting at 8.00am was considerably shorter than the 48 hour period spelt out in the notice. No action was in fact taken to enable Dr Swarbrick to communicate with Ms Winspear around 8.00am.

52. The second reason that Dr Swarbrick gives for not contacting Ms Winspear is the clinical nature of the judgment rather than a discussion as to the quality of life. This seems to evidence a misunderstanding as to the purpose of the consultation. It is not a debate about clinical judgment, although one consequence of consultation may be to afford the family to obtain a second opinion if they did not accept it. Rather it is to communicate the decision to the patient or in the event of incapacity without any other appointed representative, the patient's carer, so that important medical decisions about treatment are taken with relevant input into the decision making process, the principle of dignity and best interests is respected in the widest sense and the family can take on board and respond to the news. Ms. Winspear as carer does not have a veto over the treatment plan but she is entitled to be consulted, and it is best practice to consult any other relevant family members.

53. Although Dr Swarbrick may have considered that CPR would have been futile in Carl's case, the decision in Tracey makes plain that this does not obviate the need for consultation for patients with capacity and s.4(7) MCA makes plain that consultation about such a decision is necessary with the carer of an incapacitated patient unless not practicable. Further, such consultation was obviously not futile. When Ms Winspear made her views known to Dr Farrer he cancelled the notice, as he considered that Carl's best interests were not served by its continued existence as it was a barrier to their participation in a discussion of the future treatment plan, following which Carl was transferred to the ICU.

54. I acknowledge that the joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing 'Decisions relating to cardiopulmonary resuscitation' applicable in January 2011, recommends advance decisions on CPR where there is something more significant than a small risk of respiratory failure. However, the section of this guidance that deals with communication with patients at section 6.1 was drafted without the benefit of the decision of Tracey.

55. The first sentence states:

> 'When a clinical decision is made that CPR should not be attempted because it will not be successful and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate the discussion with the patient to explore their wishes".

I do not consider that this is compatible with Tracey.

56. In other respects the Joint Statement suggests that Dr Swarbrick's decision was flawed. Section 7.1 deals with communication and discussion with patients or those close to patients who lack capacity. It states that consultation is not only good practice but is likely to be a requirement of the Human Rights Act (Article 8). The guidance goes on to consider the Mental Capacity Act, in a case where no welfare attorney or court appointed guardian has been appointed. At section 9.2 it states:

> "…the decision as to whether CPR is appropriate must be made on the basis of the patient's best interests. In order to assess best interests, the views of those close to the patient should be sought unless this is impossible"

57. The statutory test is practicability, but if Dr Swarbrick had this advice in mind, the reference to impossibility should have alerted him to the need for compelling obstacles to consultation before implementing his clinical decision, and the duration of any obstacles should be for the least period practicable.

58. In the light of all the evidence, I am not satisfied that it was other than practicable and appropriate to have attempted to contact Ms Winspear before the DNACPR notice was affixed to Carl's records. Although her willingness to be woken in the small hours was not known to the clinicians at the time, the fact that she had a telephone, had been Carl's carer from birth, had been in the hospital the previous day and had kept in touch with nursing staff would or should have been known.

59. Accordingly I am satisfied that there was a breach of the s.4(7) duty; no s.5(2) defence exists to this claim,;there has been a violation of the procedural duty under Art 8(2). I find for the claimant on her claim for a declaration.

Other issues

60. In the pleadings and skeleton argument there were supplementary submissions to the effect that the defendant's 2008 guidance on consultation:

    i) Was flawed for not spelling out the necessity of consultation under s.4(7) MCA;

    ii) Was not sufficiently accessible to the claimant;

    iii) Should have been referred to in the consultation with Dr Farrer.

61. I am not persuaded by any of these arguments in so far as they arise at all on the facts of this case. A challenge to the policy should normally be way of judicial review. There are many references to consultation in the policy. Read as a whole there are sufficient to identify the need for consultation, the need to have regard to the MCA and the ECHR. The policy has now been revised and replaced in the light of the detailed guidance in Tracey.

62. Here consultation with Dr Farrer was successful in achieving the claimant's wish for no DNACPR notice being in place and he cancelled the existing one. There was no need to introduce policy into an urgent discussion about a treatment plan for an unwell patient. In the event of a rejection of the family's wishes, there might have been some need to explain the policy context in which it was made and how the policy is to be found. It is not necessary to determine this issue.

63. The claimant seeks just satisfaction by way of an award of damages both personally and in her capacity as personal representative of Carl's estate. I am not persuaded that she has any personal claim for damages. Her legitimate interest was as Carl's carer, it is his best interests and right to respect for private life that is under consideration. In Glass v United Kingdom (Application 61827/00) 9 March 2004, the court was concerned with a dispute about consent to treatment with respect to a 12 year old child where the child's mother was his legal proxy. It concluded at [72] that it was only required to consider the case from the position of the child. That case is a

stronger one than the present where Carl is over age and the claimant's relevant status was as carer.

64. I consider that the grant of a declaration reflecting the procedural breach of Article 8 is sufficient satisfaction for the claimant on the facts of this case:

i) The decision was made before the clarification of the law in Tracey.

ii) The good faith of Dr Swarbrick's clinical judgment is not in dispute.

iii) Consultation was always foreseen as part of the treatment plan.

iv) The notice only subsisted for 9-10 hours.

v) The notice had no impact on Carl's actual treatment or the timing and manner of his death.