Case No: COP13276568

Neutral Citation Number: [2018] EWCOP 32

IN THE COURT OF PROTECTION

Courtroom No. 10
Nottingham District Registry

Date Friday, 20th July 2018

Before:
THE HONOURABLE MR JUSTICE COHEN

B E T W E E N:

LEEDS TEACHING HOSPITALS NHS TRUST

and

JF (By her Litigation Friend, the Official Solicitor) and CH

MS C WATSON and A KETZER (Solicitor) appeared on behalf of the Applicant
MS K GOLLOP QC and MS R DAVIS (Solicitor) appeared on behalf of the First Respondent
MS N KHALIQUE QC and MS S MCKENDRY and S KUMAR (Solicitor) appeared on behalf of the Second Respondent

JUDGMENT (Approved)

WARNING: The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

MR JUSTICE COHEN:

1. This case concerns a 46-year-old lady, JF, normally known as N as I will call her henceforth.

2. I have read reports on N from Dr Oram, Dr Smith and Dr Kumar and I have read written material from N's sister, CH. I have had the benefit of hearing from Dr Oram and from Ms H and also from her brother, Mr DF.

3. The reason why this case has come about is because of the sad circumstances that have arisen over the course of the last three months or so. N has a history of breast cancer. It is long-standing, certainly since 1998 when she was initially treated in Jamaica, and she first came to the attention of Leeds Teaching Hospitals NHS Trust in 2002 when she was treated at St James's Hospital oncology department. There was treatment and endocrine therapy, but the cancer kept recurring and she developed a metastatic disease in 2012. Her cancer progressed and in April 2018 there were further scans which confirmed its spread.

4. She had been on a full dose of chemotherapy but following the discovery of the spread of the illness and a discussion about the treatment options, N decided that to preserve a better quality of life she would rather take oral medication. I will turn to her in more detail to say what I know of her and what plainly are many admirable qualities. N did not tolerate the oral medication very well and on about 4 May, following excessive vomiting, she went into hospital for a couple of days. When she came out she ceased taking the medication but later started taking a still significant but reduced dose compared to what she had been taking before.

5. She began to feel ill and on 26 May she asked her sister to drive her to hospital. They went in a taxi and, in what must have been an extremely traumatic event, N suffered a cardiac arrest in the taxi as she was arriving at Leeds General Infirmary and as a result for some 20 minutes or so ceased breathing and suffered a severe hypoxic injury. In consequence she has suffered a very significant and severe brain injury.

6. The position now and since then has remained that she is essentially unconscious. She cannot speak or make any sound; she can make spontaneous movements which are felt to be non-deliberate, and until early July she made some responses to painful stimuli but that then ceased. The result now is that she remains in a position where there is no anticipation of any significant improvement in her neurological condition, certainly within the life expectancy of her cancer which is some six to eight months.

7. That is not to say that there might not be some minor change in her neurological condition and over the last few days it is thought that N has been able to feel or respond to some physiotherapy that has been carried out on her arms and hand. That is considered not to be surprising but the medical evidence is that the chance of any significant recovery within the lifespan of her illness is not one that can be regarded as anything other than exceptionally remote.

8. I want to say something about N. I have seen some photographs of her and two video recordings, which her sister had made. She plainly had a huge zest for life. I have seen a video of her attacking her garden with shears just a day or two after coming out of hospital in May. I have seen her singing and dancing. Her dignity and way of life mattered to her considerably. One of the reasons that she stopped the chemotherapy that she had been having and went on to oral medication was that she did not want to lose her fine head of hair. Her job mattered to her, she enjoyed being with her work colleagues, and she enjoyed working and if she had had to attend hospital for chemotherapy she would not have been able to do her job.

9. N's Christian faith was very important to her, as it has been to the rest of her family. She attended church every Sunday; she had a firm belief that each person has an allotted time, a natural span, and that the Lord will decide when her time is up.

10. Bravely, she did not burden her family with her medical worries and did not discuss her health in detail with them. She wanted to enjoy life, rather than worry about the future. However, I am told and accept that notwithstanding that she did not discuss her health in a significant way with her family, she and other members of her family did have a fixed objection to morphine. That comes from the fact that two members of the family had died at a time that they were taking morphine which had been prescribed for them as a result of very serious health difficulties which they themselves had. The family formed the view, I cannot say whether it is correct or not, but it was an understandable view, that morphine had played some part in the demise of those two relatives.

11. I accept the point made by Ms Watson, on behalf of the Trust, that those are the views of people who were not actually in pain at the time and it may be that if they were in pain their views might be different, but nevertheless they were her and their views.

12. I turn next to the law and I start with the Mental Capacity Act, it being common ground of course that N has no capacity to conduct litigation or make any decisions about her care and health. Section 1(5) of the Act states that an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done or made in his, in this case her, best interests.

13. Section 4 of the Act sets out how best interests are to be determined. I am going to refer only to the matters, that seem to me to be particularly material bearing. Subsection 6 provides that I must consider, so far as is reasonably ascertainable (a) N's past and present wishes and feelings; (b) the beliefs and values that would be likely to influence her decision if she did have capacity and (c) other factors that she would likely to consider if she was able to do so. I must, by subsection 7, take into account the views of anyone engaged in caring for N, or interested in her welfare.

14. I bear in mind the Code of Practice, in particular paragraphs 5.18 and 19 and 5.29-5.36, which I am not going to read out but incorporate it into this judgment. I, of course, also bear in mind Articles 2 and 8 ECHR.

15. It is, of course, quite impossible to overestimate the value of life. The starting point is, or the strong presumption is, in favour of life. That is not now, and never has been, irrebuttable and I am referred to the seminal decision of *Re J* [1991] FAM 33 from which I extract from the judgment of Lord Donaldson MR the following:

> 'There is, without doubt, a very strong presumption in favour of a course of action which will prolong life, but it is not irrebuttable. Account has to be taken of the pain and suffering, and quality of life which the patient will experience if life is prolonged.

> Account also has to be taken of the pain and suffering involved in the proposed treatment….
>
> We all believe in and assert the sanctity of human life. Even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable…. but in the end, there will be cases in which the answer must be that it is not in the best interests of the patient to subject the patient to treatment which will cause increased suffering and produce commensurate benefit'.

16. That is echoed at paragraph 5.31 of the Code of Practice, which says:

> '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 interest 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'.

17. The view of the treating team is clear. It was put this way by Ms Watson in opening, that N is essentially unconscious, she cannot speak or make any sound and, as I have already referred to, cannot make deliberate movements. There is a prolonged disorder of consciousness, which has not yet been subcategorised. The cancer remains terminal and progressive; there is going to be no further treatment nor reintroduction of chemotherapy. Life expectancy is extremely limited.

18. The matter came before the court a week ago today before Mr Justice Newton. I am told it was a fairly short hearing and he ordered as follows: that it is in N's best interests, on an interim basis (a) that she should undergo a tracheostomy as her treating clinicians consider that it is clinically indicated before a final decision can be made in this case; (b) that she should not receive an escalation of invasive care or treatment, in particular vasoactive drugs, renal replacement therapy, ventilation treatment that requires central venous action or CPR, and that it was in her best interest (c) to receive pain-relieving medication, such as morphine, and or sedation such as midazolam as is considered by her treating team to be clinically indicated with the purpose of relieving her potential for suffering and or distress, even though such medication might reduce her respiratory drive and in an end of life situation may thereby shorten her life.

19. Those issues now come before me for final determination.

20. The issues before me have been threefold. First, whether or not the tracheostomy tube should be removed. This was inserted, as I understand it, later in the day of 13 July after the court hearing and has been in place since then. It was put in place because the previous tube, an oral tube, was causing N increasing discomfort and was deteriorating and causing irritation in a way that is not uncommon with such tubes and therefore, a tracheostomy was duly inserted.

21. The Trust see no benefit in the continuation of the treatment. They say that if she is making any neurological recovery that is likely to be short-lived and will only be likely to result in an increase of pain. They, therefore, seek that there should be a removal of the endotracheal tube where, as a result, one of two things would happen. Less likely is that her airway will collapse and she will pass away quickly. More likely is that she will accumulate secretions

and will develop a chest infection and she will deteriorate over a period of days to weeks, and eventually pass away. That passing away would be likely to take place significantly more soon than is likely as a result of her cancer.

22. At the moment the secretions are removed every four hours in a process that lasts about 90 seconds-2 minutes, and the contents fill three catheter bags. Ms Gollop QC put it inelegantly, but accurately, that the consequence of removal of the tube would be that N would die either by infection of the secretions or would drown. Of course, if the tube was removed the Trust would do everything possible to minimise the pain, or discomfort, that might be felt by N.

23. The family want to keep the tracheostomy in place. They say that they do not want N's death to be hurried. The tube is life-sustaining and it would be wrong to remove it. That view is supported by the Official Solicitor acting in N's best interests. N is breathing herself. She does not need artificial aids to achieve that albeit she is being given a small amount of humidified oxygen. N wants a natural death and it seems to me that it would need a very good reason to hasten it in this way. I have drawn up, as have counsel, the balance sheet. On the one side, of course, is life and with it in this particular case the ending of life, when it comes, in a natural rather than an imposed or hurried way. Against that is the fact that there will be no recovery; the prospect that there may be discomfort at the end and the end would of course come sooner than it otherwise would.

24. It is said on behalf of the Trust that there also is the question of N's dignity to be taken into account. I think, in this case, that adds little. She is being well looked after; there is not any significant amount of invasive nursing treatment, she is turned, and she is obviously cleaned after bowel movements. Dr Oram, who gave evidence on this particular subject among others was that although it was the team's clear view that nothing more should be done to extend or prolong N's life he, and I am sure that he was speaking for his team too, would not have a problem in continuing with the tracheostomy tube in place, if that was the view that I took as being in N's best interests.

25. The tube has only been put in place some seven days ago and it was done by the hospital in N's best interest, which seems to me, can arguably said, to have been a change of direction from that which was anticipated in the statements that were put before Mr Justice Newton. My clear view on that is that the tube should remain in place for the reasons advanced by the family and the Official Solicitor.

26. The second issue has rather retreated in significance. I have to consider whether or not N should receive an escalation of invasive care or treatment, in particular vasoactive drugs, renal replacement therapy, ventilation treatment that requires central venous action or CPR.

27. The family agree that she should receive none of those except antibiotics if they are required. The health trust takes the same view as it does in relation to the tracheostomy. They say that nothing should be done that would extend life. The family say that all that is being asked for is for treatment for what was described by Ms Khalique QC as treatment for a super-imposed condition which would not cause her natural death if treated.

28. The Official Solicitor has in the forefront of his mind that N wants a natural death, but if N gets an infection and it overwhelms her, that is a natural death and antibiotics should not be provided to prolong a life which has what can only be described as no quality or pleasure for N.

29. I have to balance all these matters and take a holistic view, as I do, in relation to every aspect of this case, but in my judgment it is appropriate for me to declare that antibiotics do not need

to be provided in the event of there being an infection and that it would not be in N's best interests to provide treatment to seek to avert what would be a natural death.

30. That brings me on to morphine, and that is a difficult issue. Dr Oram, in one of his statements, sets out at C34 what he describes as the analgesic ladder which is used by doctors dealing with pain relief. The first rung of the ladder consists of simple agents, such as paracetamol and Ibuprofen. The second rung of the ladder are weak opiates, to which he gave as an example codeine, or codeine related medications. The third rung are stronger opiates such as morphine. I need, in considering this, to bear in mind that N is not even on the ladder at all. She has in the past had paracetamol but is not on paracetamol now. I think it inevitable that as the end of life approaches she will suffer more pain, but it is not possible to say how far up the ladder she will go or when.

31. Dr Oram says there is no better substitute to morphine. There are other drugs, such as gabapentin and ketamine, but they have other side effects and indeed sometimes the same side-effects as morphine and may depress breathing themselves, but the family do not have those rooted objections and indeed I have been told by Ms H that she does, herself, take gabapentin albeit in small doses.

32. I agree with Ms Gollop QC, that there does not seem an urgency in the making of this decision. I bear in mind that it is possible that N will never go further up the ladder, or so far up the ladder that she becomes in need of morphine. Dr Oram accepted that if a conscious patient had been able to make a balanced decision that he or she did not want morphine he would not seek to impose it upon the patient. I, of course, have to take the decision for others, but I bear in mind the strong family opposition shared by N to the use of morphine.

33. I therefore authorise other medications, but not morphine, but I give the Trust permission to apply in respect of morphine in the event of an increase in N's pain level, making morphine in the view of the treating team desirable within the imminent future.

34. I do not think it would be right for me to say that there are no circumstances in which morphine ought to be prescribed if it transpires that there is no alternative that might be able to do the job. Therefore, I wish to keep that open as a possibility. Whether the court will order it will depend on the circumstances at that time, but if all other avenues have been exhausted it seems to me that it would be quite wrong for me to bar the treating team from a position of being able to apply for permission to use morphine in circumstances where their conscience makes this, not only highly desirable, but something that should be imminently implemented.

35. Those are my rulings on all the matters on which I am being asked to rule.

End of Judgment

(This judgment has been approved) Transcript from a recording by Ubiqus

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