Neutral Citation Number: [2019] EWCOP 19

Case No: COP13423167

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/04/2019

Before :

MRS JUSTICE LIEVEN DBE

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Between :

MANCHESTER UNIVERSTITY NHS FOUNDATION TRUST	**Applicant**
- and -	
DE (by her proposed litigation friend, the Official Solicitor)	**Respondent**

- -
- -

Mr Wenman Smith (instructed by **Hill Dickinson LLP**) for the **Applicant**
Mr Hallin (instructed by **the Official Solicitor**) for the **Respondent**

Hearing dates: 18 April 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE LIEVEN DBE

This judgment was delivered in private. 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 children 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.

Mrs Justice Lieven DBE :

1. This is an application by Manchester University NHS Trust for a declaration that DE lacks capacity to conduct proceedings, and to consent to treatment on her left leg, and that it is lawful and in DE's best interests for her to be given blood products if it becomes clinically necessary during an operation on her left leg. This application came before me on an urgent basis during the vacation. I heard Mr Wenman Smith of counsel for the Applicant, and Mr Hallin of counsel instructed by the Official Solicitor on behalf of DE over the telephone. As I explain in more detail below I adjourned the hearing overnight so that the OS's representative Mr Beck could visit DE and discuss the operation with her. I then made the order the next morning, the OS consenting to my doing so. I am now giving my written judgment some time later.

2. During the hearing I heard oral evidence from Mr Wheelton, the consultant orthopaedic surgeon and Dr Chernik who had carried out the capacity assessment. I was told at the hearing that DE's Mother (KE) had said that she did not wish to join in on the telephone hearing.

3. The background to this matter is that DE is a 49 year old woman who suffers from autism and mild learning difficulties. Mr Wheelton said that she functioned on a fairly high level and I believe that she lives independently, with some level of support. DE and her mother are Jehovah's witnesses, and I will set out below in more detail the evidence in respect of DE's religious observance and the strength of her beliefs. The application was made because the Trust was concerned that as a Jehovah's Witness DE's religious beliefs would mean that she would not wish to have blood products, but she did not have capacity to consent.

4. On 11 April 2019 DE had an accident by falling down the stairs of a bus. She suffered a serious break to her left femur and tibia. She was admitted to the Applicant's hospital. The medical evidence is that she requires surgical fixation of the femur and possibly the tibia. This will involve an operation cutting into her skin and applying a plate and screw to the bones. There is a risk that during the operation DE will require blood transfusion or blood products, I will below refer to these interchangeably as which it is makes no difference to the issues in the case. According to Mr Wheelton the risk of blood products being needed is difficult to quantify but something in the region of a 50% likelihood.

5. If DE did not have the operation at all then her mobility would be impaired and potentially seriously impaired. The longer that she cannot mobilise the greater the risks to her of having an embolism, but also in the longer term, of reduced mobility.

6. Mr Wheelton gave evidence that the operation was urgent, with a window of opportunity of about two weeks before the bone started to reform and therefore the effectiveness of the operation being reduced. He said that if the operation was delayed it became more complex and potentially less successful, he also said that a delay would increase the likelihood of DE needing a transfusion. The evidence was quite clear that the sooner the operation was carried out the better, both in terms of reducing risks of serious consequences but also for the long-term success of the operation.

7. The other factor in respect of urgency was that the specialist orthopaedic surgeon at the hospital was available to do the operation over the weekend (the hearing was on Thursday). However he was not available after Monday, and therefore either the operation would have to be carried out by someone with less specialism or it would have to wait for another week. Mr Wheelton explained that this was quite a complex fracture

into the joint in a difficult location and therefore there was a strong preference for a specialist surgeon.

8. Mr Wheelton also gave evidence on alternatives to a blood transfusion. He explained that there were alternatives if there was initial blood loss, however if these were ineffective then a blood transfusion could become necessary and extremely urgent. Ultimately if DE did need a transfusion during the operation, and she did not receive one, then she could die through the loss of blood.

9. During the period of her admission to hospital two capacity assessments have been carried out. On 13 April Dr Chernick spoke to DE and assessed her capacity. His evidence was that she told him she was a Jehovah's Witness and that they do not have blood transfusions. She understood that her leg was broken and that she needed surgery. She said that she wanted surgery and she wanted to go home. However, she did not appear to understand that she might need a blood transfusion and that she could die if it was clinically necessary and she did not have one. Dr Chernick's view was that she could not process the information that she was given. He concluded that DE did not have capacity to decide whether or not to have a blood transfusion.

10. Dr Chernik's oral evidence slightly expanded what is set out above. He said that he had met DE initially with her mother and brother and then on her own. She was quite tearful when with the family members, but he had an easier conversation when she was on her own. He was clear that she was not impeded in her understanding by the medication she was on. She had told him proudly that she was a Jehovah's Witness, and that they did not have blood transfusions. When he explained to her that she had a broken leg and might need a transfusion she did not appear to understand that she might need a transfusion. He said to me that he did not think she could link the need for the operation with the potential for needing a transfusion. He concluded that she did not have capacity to decide whether or not to have a transfusion if clinically needed.

11. On 17 April Dr Ahluwalia reached the same conclusion.

12. DE's Mother's position was that she was a committed Jehovah's Witness and she did not believe that it was in DE's best interests to have a blood transfusion because it was contrary to the beliefs of Jehovah's Witnesses. Dr Chernik told me that KE had told him DE would not accept blood products.

13. In terms of DE's wishes and feelings Mr Wheelton had asked her about the operation and she had said that she wanted the operation. When he asked her about having a blood transfusion she said that she was a Jehovah's Witness. She had expressly said to him that she did not want to die.

14. The evidence at the oral hearing on DE's beliefs and her commitment to the Jehovah's Witness religion was fairly scant. She attends services, but her mother described her as not being a practising Jehovah's Witness. She can recite the scriptures, but I got no sense of the degree to which she understood them or believed them or the degree to which they played an important part in her life.

15. This matter came before me very urgently, and as I have explained above the position of the Applicant was that the operation was needed urgently. At the time of the telephone hearing the OS had not been able to meet DE, as he had only been instructed I believe the

day before. The OS's position at the hearing was that DE was a woman who had practised her faith for many years and that she had said she did not want a blood transfusion. The OS questioned the level of the urgency for the operation, and suggested that DE's wishes and feelings needed to be further investigated. After some discussion towards the end of the oral hearing I agreed to adjourn my decision overnight in order to give Mr Beck time to visit DE. I am extremely grateful to Mr Beck for his efforts on DE's behalf, and making the time to visit her in the evening.

16. I indicated at the end of the telephone hearing that I was minded to make the order, but I would adjourn for Mr Beck to visit DE. I agreed that we would reconvene the oral hearing the next day if the OS wished.

17. In the event I received an email with an attendance note from Mr Beck the following morning. He recorded that he had visited DE and that the OS was now supporting the application. He had met DE and her mother and brother. His attendance note records that DE said that she was a Jehovah's Witness but made it very clear that she wanted the operation to happen as soon as possible. She could not explain why blood transfusions were prohibited under the religion, and the evidence is clear that she herself was not too concerned about having a transfusion.

18. DE's mother said to Mr Beck that she could not consent to a transfusion because of her religion, but she was not objecting to DE having the operation or a transfusion if necessary, indeed she supported her having the operation.

The law

19. I have to consider two issues under the Mental Capacity Act 2005: firstly, does DE have capacity to make the decision in question; and secondly, is it in her best interests to have the operation.

20. The principles to be applied were helpfully summarised by Peter Jackson J (as he then was) in *Wye Valley NHS Trust v* B 2015 COPLR 843 at [5] relying on the decision of the Supreme Court in *Aintree University Hospital NHS Trust v James* [2014] 1 AC 591:

> *"(1) Every adult capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent any invasion of the body, however well-meaning or therapeutic, will be a criminal assault.*
> *(2) Where there is an issue about capacity:*
> *• A person must be assumed to have capacity unless it is established that he lacks capacity: s.1(2) .*
> *• A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain: s.2(1)*
> *• The question of whether a person lacks capacity must be decided on the balance of probabilities: s.2(4) .*
> *• A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success: s.1(3)*
> *• A person is not to be treated as unable to make a decision merely because he makes an unwise decision: s.1(4) .*
> *• A lack of capacity cannot be established merely by reference to—*
> *(a) a person's age or appearance, or*

> *(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity: s.2(3) .*
> *(3) A person is unable to make a decision for himself if he is unable to understand the information relevant to the decision, to retain, use and weigh that information, and to communicate his decision: s.3(1) .*
> *(4) Where a person is unable to make a decision for himself, there is an obligation to act in his best interests: s. 1(5) .*
> *(5) Where a decision relates to life-sustaining treatment, the person making the decision must not be motivated by a desire to bring about death: 4(5).*
> *(6) When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence his decision if he had capacity, and to the other factors that he would be likely to consider if he were able to do so: s.4(6) .*
> *(7) So far as reasonably practicable, the person must be permitted and encouraged to participate as fully as possible in any decision affecting him: s.4(4) . "*

21. A person does not have to be able to comprehend every detail of the decision to be decided, but just the salient points *LBL v RYJ* [2010] EWHC 2664.

22. In terms of the approach to best interests, Baroness Hale in *Aintree v James* at [35] said:

> "*The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be.*"

23. Where a patient lacks capacity it is of great importance to give proper weight to their wishes and feelings and to the patient's own beliefs and values. Mr Hallin referred me to *Wye Valley NHS Trust v* B, that being a case where Peter Jackson J found that the individual did not have capacity but it was not in his best interests to have the operation. referred to above, because that case had some similarities with the present. B was a 73-year-old man with a severely infected leg, without an amputation the inevitable outcome would be that he would shortly die. B had schizoaffective disorder and strongly objected to undergoing the operation. Peter Jackson J found at [34] that B did not have capacity and said that he did not understand the reality of his injury and thought he would get better with proper care. B was having auditory hallucinations and he had said that the Lord did not want him to have his leg amputated.

24. Peter Jackson J found that B did not have capacity because he had a clear inability to weigh the relevant information as part of the process of reaching a decision. The Official Solicitor had argued that weight should be given to B's wishes and feelings, and value given to his religious beliefs. The Judge found that it would not be in B's best interests to force him to have the operation against his wishes [45]. The reason for this conclusion was that B's religious beliefs were deeply meaningful to him, and that to force him to have the operation would be to take away his little independence and dignity to replace it with a future he had little appetite for [45]. B had said that he was not afraid of dying.

Conclusions

25. The first issue I need to decide is whether DE has capacity in respect of litigation, and the decision as to whether to accept blood transfusion if clinically necessary. I accept Dr Chernick's evidence that DE does not have capacity in these regards. It appears from the evidence that although she understands that she needs an operation she cannot understand that one possible consequence of the operation may be that she needs a transfusion, and that if she does not have the transfusion she would die. The evidence clearly suggests that DE cannot retain, use and weigh the information that she is being given about the consequences of refusing a transfusion. This is not an example of somebody making a poor decision, but of not understanding the decision that she is making.

26. In terms of her best interests, to some degree in the light of Mr Beck's conversation with DE the concerns have largely fallen away. There is no doubt that it is in DE's best interests to have the operation. Without it her long term mobility will probably be impaired and there could be very serious consequences in terms of the risk of pulmonary embolism from her inability to mobilise over a prolonged period.

27. It is also plainly in her clinical best interests for the doctors to be able to give her a blood transfusion if needed during the operation. In the worst case if the clinical team do not have this option then DE could die during the operation.

28. The only issue during the hearing was the degree to which DE's wishes and feelings would be overborne by a decision to allow a blood transfusion, in the light of her being a Jehovah's Witness; and therefore whether there was a disproportionate interference in DE's article 8 rights. However, the evidence even at the oral hearing was that although DE described herself as a Jehovah's Witness she was not someone for whom those beliefs were central to her personality or sense of identity. During the oral hearing I did not get any sense that she would feel deeply upset if an order was made in the form sought, or that she would feel a deep conflict with her religious beliefs. As such she was someone who was in a quite different decision from B in Jackson J's decision, where his religious beliefs were fundamental to B's sense of who he was. The other stark contrast with that case is that DE had been completely clear that she did not want to die. She is also significantly younger than was B.

29. My view in regard to DE's best interests was further strengthened by the evidence from Mr Beck's visit. It appeared from that visit that DE was not strongly identifying herself with the beliefs of Jehovah's Witnesses, and indeed her mother supported the operation going ahead. In those circumstances I have no hesitation in finding that it in DE's best interests to have the operation.