Neutral Citation Number: [2021] EWCOP 13

Case No: 13712297

IN THE COURT OF PROTECTION
IN THE MENTAL CAPACITY ACT 2005
IN THE MATTER OF TW

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/02/2021

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	**Applicant**
- and -	
TW (by his litigation friend, the Official Solicitor)	**1st Respondent**
- and -	
FY	**2nd Respondent**

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Miss Nageena Khalique QC (instructed by **Capsticks Solicitors LLP**) for the **Applicant**
Ms Bridget Dolan QC (instructed by **TW's litigation friend, the Official Solicitor**) for the **1st Respondent**
Mr Ian P Brownhill (instructed by **Irwin Mitchell**) for the **2nd Respondent**
Hearing dates: 10th & 12th February 2021

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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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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered following a remote hearing conducted on a video conferencing platform and was attended by members of the public and the press. 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 respondent and members of his 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 Hayden :

1. This is an application brought by the Sandwell and West Birmingham NHS Trust. It concerns TW, who suffered catastrophic brain injury, arising from a stroke. The court has been asked to declare whether it would be in TW's best interests to continue to receive life sustaining treatment, ventilation and blood pressure medication or alternatively, whether it would be lawful to withdraw it.

2. Over the course of the day, I have heard extensive medical evidence. In summary, on 12th December last year, in the early hours of the morning, TW was admitted to hospital complaining of general dizziness, blurring of vision, a headache, and sensory changes on the left side of his face and in his legs. Having regard to the wider canvas of the evidence that has been made available to me, I suspect that TW had recognised that he was in trouble. He did not, however, communicate his anxieties to the doctors. Indeed, he explained to them that he had recently had dental work to *"fix cracked teeth"*, he speculated as to whether that might be the problem. A medical record made by a nurse at the time, noted TW was unsteady on his feet and that this might be due to the blood pressure medication he was receiving. His medical records reveal a reasonably long-standing concern about TW's blood pressure. He was assessed by a consultant and discharged with medication. Because he had come into a hospital, he was also advised to self-isolate, having regard to the challenges presented by the pandemic.

3. On the 17th December, TW became unwell and telephoned his brother asking for help. When his brother went to the flat, there was no response, so it was necessary to force entry and ultimately to call an ambulance. When TW was admitted to hospital, he was in a very agitated state. He was unable to respond to directions and commands from hospital staff, but he was able to be roused by voice. The degree of his general agitation was such that it was not possible to assess his neurological status with any accuracy. He was treated for a general encephalitis. There was some concern that his drinking in the past might have been a factor, and initially, it was felt by the treating clinicians, that his presentation might be related to this. A CT scan was arranged and appeared to be normal.

4. With this history, and in different times, TW may very well have been admitted to a specialist stroke hospital. But I have been told, given the significant clinical pressures consequent on the 2019 Covid-19 pandemic, it was not possible. It is important to note, that TW has, nonetheless, received care and attention of the highest quality and from those specialised in treating stroke patients.

5. On 18th December, i.e. the following day, TW's treating clinicians noted that, whilst his level of consciousness had not changed, he was moving his left limb less frequently than the right side, a significant indicator of stroke. He had also developed involuntary eye movements, known as nystagmus. Nystagmus, I have been told, can be caused by central nervous system abnormalities, or by problems associated with drugs or alcohol. Additionally, TW was seen to be experiencing altered speech. An MRI scan was commissioned, and he was started on the basic medication for a stroke.

6. An MRI scan indicates neurological abnormalities which may not be perceptible on a CT scan. Sadly, the MRI brain scan of 23rd December 2020 indicated that the tissue in multiple areas of TW's brain had been severely damaged due to deprivation of blood.

More particularly, the scan revealed multiple infarcts, i.e. seriously damaged brain tissue, present in the cerebellar hemisphere, the right middle hemisphere, the peduncle, the pons and the midbrain. The cerebellum, pons and the midbrain are responsible for the brain's core functions.

7. Manifestly, the neuroradiology presented an alarming and dispiriting picture. The following day, 24th December 2020, TW tested positive for Covid-19. Whilst he had a significantly raised temperature, he did not have cardiopulmonary problems. He also appeared to have improved a little since being admitted, and at times he became less agitated, and was able to follow some of the commands that had previously escaped him. He was able to communicate his basic needs by way of pointing and gesture. He was not able to speak.

8. Tragically, on the morning of 29th December, TW suddenly and dramatically deteriorated, with a high temperature. He fell into a severe coma, on the Glasgow Coma Scale he scored 3 (the most serious level), he became unable to clear his saliva, he had no cough or swallow reflex. He was quickly admitted to the ICU where he had a breathing tube inserted into his windpipe. A further CT scan was taken, revealing that TW had suffered a major stroke. His scan also revealed, what is termed, a *'slight uncal herniation'* which is a slumping of the brain as a result of the impact of the stroke on the brain stem. Those indicators in relation to the brain stem were sadly going to prove to be catastrophic in terms of TW's neurological status.

9. Dr A, a consultant neurologist employed by the applicant Trust, has explained that TW's injuries to the brain stem are not only irrevocable, but that there is no prospect of any recovery. The slumping of the brain, he noted, had caused further damage to those parts of the brain which regulate respiration, as well as more general awareness. Notwithstanding the pressures that have been on the NHS and intensive care generally, it is obvious that TW received scrupulous and attentive treatment. On 2nd January 2021, there was a yet further CT scan, which once again, showed deterioration and worsening of the injuries, most specifically, to the brain stem. There were further EEG's, on 7th and 12th January 2021, for prognostic purposes, without sedation. The consensus revealed that TW had suffered a brain injury so significant that the electrical waves generated by the normal, healthy brain at the most basic level of human functioning, were no longer present. In the intervening weeks, that has not changed, other than perhaps, to deteriorate further.

10. It is important to highlight that in addition to the assessments of the treating clinicians, there has been a wide range of second opinions. Ultimately, there has been complete unanimity both as to the extent of the brain damage and in respect of the prognosis. Mr E was asked for a further opinion, he confirmed that TW had suffered a devastating or catastrophic stroke in his brain stem from which he will not recover in any meaningful way. Mr E's view was that treatment aimed at prolonging TW's survival was futile and as such, could not, any longer, be described as being in his best interests.

11. On 13th January, Dr A further assessed TW. By this time, TW had been in a coma for in excess of two weeks. He noted that TW's pupils remained fixed and dilated, and entirely unresponsive. He observed that he no longer blinked reflexively, he tested his awareness to light to find that he had no response to it. He concluded that TW had no voluntary eye movements and exhibited no response to pain. His only responses were

involuntary. It is self-evident that the assessment indicated a tragically poor prognosis. TW is only 50 years of age. It is a level of coma at the most serious end of the spectrum of gravity and there is damage to the brain stem which, though not amounting to brain stem death, is also at the most serious end of the spectrum of gravity.

12. The multidisciplinary team treating TW considered that ventilation and other life sustaining treatment was irreconcilable with his best interests, and that those best interests might more effectively be promoted by a palliative regime. On the 30th January, TW's heart rate fell to levels that were regarded as dangerous, triggered by an episode of coughing, which itself was an involuntary reflex. On that occasion, CPR was administered, and TW's heart rate was restored.

13. On 1st February 2021, Dr B, an Intensive Care Medicine and Anaesthesia consultant who, along with Dr A, has given evidence before me today, said he observed signs of further neurological deterioration in TW as he became more unconscious. TW's condition later returned to what is assessed as his baseline. Dr B recognised this clinical pattern as indicating temporary changes which signalled the instability of TW's condition, arising from the severity of his brain injury.

14. It was thought appropriate to seek a further independent expert opinion. On 28th January this year, Prof D, a professor of intensive care medicine, assessed TW with the objective of focusing on prognosis. Professor D's conclusions, both in his report and in his evidence to me, can accurately be described as bleak. He told me that TW's brain stem infarction had destroyed the key functions that are intrinsic to supporting life. This included conscious awareness of his surroundings, voluntary movements, protective reflexes, normal heart function and the ability to breathe without support. He was clear in his assessment and in his report that TW will never recover. By this Professor D explained that TW *"would never recover a life that was worth living"* in the most basic sense of being aware of his surroundings or recognising whether people were with him or not.

15. Mr Brownhill, who appears on behalf of TW's brother, pressed Professor D on the prospects of recovery. Professor D engaged with the questions to a degree that indicated both his level of experience and his integrity as a doctor. But he did so on the basis that he was addressing what he described as being a *"theoretical counter-factual"*. Even if, on that basis, there was a prospect of any recovery, it would only be to a level of consciousness that could properly be described as minimal and in those circumstances, because it would lead to awareness at some level, might objectively, reflect a deterioration in the quality of TW's life. Professor D was asked whether TW might be able to breathe for himself for a limited period. Though he did not consider this likely, Professor D noted that even if he did, TW might develop pneumonia from his inability to respire, or infection from inhaled gastric contents, causing him to deteriorate, and ultimately to die. Again, the theoretical counter factual posited by Mr Brownhill, only permits of a different trajectory but is similarly bleak. Accordingly, Professor D recommended that supportive treatment should be withdrawn, and that TW should be permitted to die. I think it was Dr B who described TW's care at this stage, as keeping his body alive, but not TW himself. Thus ultimately, as I have foreshadowed, there emerged a unanimous professional consensus.

16. Dr B explained, in his evidence, that in his clinical assessment, the intensive care interventions for TW are not merely futile but have become burdensome and invasive. He emphasises that TW's situation, as the history shows, has become *"precarious"*. Treatment, if indeed it can now properly be called that, involves suctioning of TW's airway and every aspect of his personal care being provided, in order to sustain the *"life of his body"*. What is plain, Dr B explained, is that there is now evidence of deterioration due to the complications associated with this critical, catastrophic injury, and prolonged immobility. Dr B anticipates cardiac, respiratory and urinary infections. He was pressed as to how long he thought TW would survive were he to have his ventilatory support withdrawn. In his report, he outlines three possible outcomes.

17. The first is that if he were to fail to breathe, at all, on cessation of ventilation, which is what is indicated by the clinical history, he would die within minutes.

18. Secondly, if he were able to make some respiratory effort, albeit inadequate, he might die within hours. But if he were to breathe enough to survive beyond 6-12 hours, there might then be a prospect of him lasting for a further few days. Although he did not highlight it in his oral evidence, it is recorded in Dr B's report that TW would be returned to the ward area. The levels of support required would be such that there would be no question of him leaving the hospital, even to transfer to a hospice.

19. It is important that I emphasise, because I know his family will understandably be troubled by it, that any respiratory distress TW suffers is highly unlikely to be recognised by him. In simple terms, it is very unlikely that he has the capacity, any longer, to experience pain. Nonetheless, respiratory distress has the potential to be upsetting to those observing. An extensive care plan providing for the cessation of ventilation has been set out. Within the plan there is provision for video calls from the family, along with directions in respect of palliative care medications designed to achieve as much comfort for TW as possible and to placate symptoms of respiratory distress. It is perhaps the most important feature of the plan that it provides for direct visits from the family, where that is possible, in line with the present Covid-19 infection regulations.

20. It is obvious from all that I have heard about TW that he is a man who had much to offer the world. He has been involved in a number of charitable projects and plainly addressed life with great enthusiasm and energy. I have been told that he had a good sense of humour and liked to entertain others. He visited Canada, aged 20 years, intending to stay with a family member for a short period but he enjoyed it so much that he did not return home and decided to settle there. This reveals courage and independence.

21. TW's catastrophic brain injury, at 50 years of age, is tragically sad. That it has occurred at the height of the second wave of the pandemic when physical contact with the family has simply not been possible (for all but twenty-five minutes in total), is heart breaking. It is impossible not to be moved by the circumstances of this family particularly TW's wife, his brother, his three daughters, as well as his former wife, who has been present at this hearing. The grief of TW's daughters is almost palpable and viscerally painful to witness. I would also add that I was later informed that TW's mother was present in the home of FY (his brother), during the course of the hearing.

22. Although Mr Brownhill represents FY, he has called TW's wife (R) and daughters as witnesses. Following the medical evidence, the family's views appeared to diverge. I do not regard this as a family conflict. FY and R cling to a hope for recovery which cannot be founded in the evidence. The daughters acknowledged the force of the medical reasoning and recognise it as irresistible. Ultimately, the daughters asked for no more than some time to be physically with their father.

23. TW's wife was the first of the lay witnesses to give evidence. She spoke movingly of the strength of her marriage. Her love for her husband was obvious, her commitment to him was equally obvious. Her determination to portray him in the best possible light was clear. She described him as her soulmate. Listening to her, and watching her give her evidence, it struck me that she was, in truth, simply not able to engage with the medical evidence. Her distress, and shock, simply will not permit that. She hopes for a full recovery. She believes a full recovery is possible, she considers that TW's strength of spirit and personality will conquer this catastrophic brain injury.

24. FY, believed it was his responsibility to his much-loved brother, to strain every sinew to *'fight for him'* to be kept on the ventilator; to fight for him to receive treatment, however futile or burdensome the doctors may consider it to be. He is, temperamentally, I suspect, inclined to question the medical profession. There is nothing wrong with that. But ultimately, FY was not able to engage with the detail of the analysis and the extent of the investigation. He was, in my judgment, unable to confront and appreciate the realities of the evidence and its consequences for his brother. I emphasise that this is not in any way a criticism of him. It is reflective of his love for his brother, which is obvious and sincere.

25. At a Directions hearing, earlier this week and in consequence of exchanges with counsel, it was thought appropriate for TW's daughters to give evidence together, rather than to be sworn independently. This process has become known as 'hot tubbing'. It is usually deployed to receive evidence from expert witnesses. It seemed instinctively appropriate here and I am pleased that it was adopted.

26. I was able to see three very impressive young women, combining their different talents and energies, and harnessing their individual skills. They interacted spontaneously and supported each other in giving evidence which was full of care, reflection and maturity. They are aged 22, 20 and 17 years. I have said, during the course of this case, and in other judgments, that the evidence of family members is every bit as important as the medical evidence. This has been strikingly true here. I found the evidence of these three young women to be eloquent and powerful. The eldest daughter (M), who is 22, is, everybody agreed, most like her father. She read a prepared note to me at the beginning of her evidence, which I think she said had been put together over lunchtime, and maybe to some degree the night before. It was a structured, thought-through and powerful statement which represented not only her views, but those of her sisters. In it, she focused upon her profound wish to be with her father when he was at the very end of his life, and to be present, if possible, when he died, or alternatively, just to touch him, to be able to say goodbye.

27. N, her younger sister, was also very distressed. She fought her distress down to tell me that she understood and accepted the force and the logic of the medical evidence, and all that she too wanted was to be able to say goodbye. S, the youngest of the three, also supported her sisters.

28. These three very young women ask only for the chance to say goodbye to a much-loved father. It is the most natural and instinctive request. It is what most families would want. It is what any doctor would want to be able to facilitate, and it is what any judge would want to be able to achieve. I was struck by the way N put it: it was not merely what they wanted, she told me, it is what they knew their father would have wanted. It was, as she described it, a facet of his rights, and his dignity, at the end of his life, that she wanted to be able to deliver. Even in these unbearable circumstances the daughters focused not on their own needs but on what they believe to be their father's needs. I have no doubt that TW would have been immensely proud of his daughters' courage and, if I may add, rightly so.

29. This request was so powerfully and compellingly advanced that I returned to Miss Khalique QC, who appears on behalf of the Trust, to explore whether this position, which had changed from the case advanced by Mr Brownhill on behalf of the brother and the wife, could be put separately to the doctors. Dr B and Dr A gave further evidence.

30. I should mention here that yesterday I visited TW remotely in the hospital. I spoke to Dr C and his colleague, and there were other nursing staff present. There is a record of the meeting. This is an ICU ward in the middle of a pandemic, and it was impossible not to be struck by the exhaustion of all those involved. Their attention to TW, their commitment to their patient, their sensitivity to his welfare and privacy, revealed to me that even in these most distressing of circumstances, they had provided not only for his medical care, but had been vigilant to preserve his dignity as a human being.

31. When he gave his evidence, Dr A became emotional. It was the emotion, in my view, of a senior, dedicated, Consultant who had been working at an extraordinary rate for many months, in the most difficult of circumstances, and who as a human being was genuinely moved at being unable to facilitate a level of contact at the end of life that would have been his instinct as a doctor as well as a human being. His sympathy to the family was manifest. It was equally clear in the evidence of the other doctors, though expressed in different ways. Dr A impressed upon me the extent to which those working in ICU encounter death on a daily basis and in isolated circumstances. He told me that he had seen more deaths in the last twelve months than in the rest of his career put together. I gave a great deal of thought to N's carefully phrased request and to the equally powerful evidence of M and S. I wondered if it might be possible to achieve that which they desired.

32. I cannot imagine a more difficult situation for a doctor than being in the witness box and having to confront this intensely modest and heartfelt request whilst being required to evaluate it against the broader medical context for his patient. The tension between basic human kindness, and professional, ethical responsibility, was exquisitely balanced. Dr B unwaveringly focussed upon his patient, whilst recognising the immensity of the tragedy unfolding. Key for him is the fact that TW has reached a stage where his situation, medically, is properly to be described as *"precarious"*. Despite the best efforts of the team, and the commitment that I have outlined, there have been circumstances, in recent weeks, where even the

professionalism and care of this team has not been wholly able to preserve TW's dignity.

33. On 25th January 2021, it was noted that there had been intermittent nosebleeds due to irritation from the naso-gastric feeding tube. Dr B told me this was rare. TW was also regurgitating food because of the delay in the functioning of his bowel. Additionally, there was bleeding from the mouth due to TW biting his tongue during periods of involuntary movement and muscle seizure. The nutrition team were required to insert a naso-jejunal feeding tube and a mouth guard was recommended. All of this was distressing to watch, and the medical effort achieved only minimal effect given the seriousness of TW's condition. It follows from what I have said that TW cannot feel the pain of that, but for it to occur in circumstances where treatment can achieve nothing, I consider that Dr B is right to recognise this as a compromise to his patient's dignity. The precariousness of TW's situation means that it is likely that he will sustain cardiac arrest and other infection which will require invasive treatment. In gentle and sensitive terms both Dr A and Dr B intimated that to require them to provide treatment in these circumstances, which they assess as contrary to TW's interests, comes perilously close to, if not crossing, an ethical boundary.

34. TW's daughters and his second wife, who is not the children's mother, live in Canada. In consequence of the restrictions presently placed on international travel it was thought impossible to be able to arrange a visit in under three weeks. TW's situation is such that he will likely require invasive intervention in this period. In particular, further cardiac arrest is foreseeable. Cardiopulmonary Resuscitation (CPR) to a patient in TW's circumstances has now become inappropriate, in the sense that it serves only to compromise his dignity whilst achieving nothing by way of treatment. I am ultimately satisfied that any plan artificially to sustain TW's situation to enable his daughters or wife to come over from Canada would be inimical to his best interests at the end of his life. Although I have been deeply moved by the evidence of these three impressive young women, I am ultimately unable to yield to their request, whilst fulfilling my obligations to their father. The medical evidence indicates that he would not know of their presence beside him.

35. As I have referred to above, TW has been a brave and determined man. I have witnessed that same bravery and courage in his daughters at this hearing. They have been able, in their different ways, to bring something of TW's character and personality into this court room. Because TW's best interests and his own timescales require it, the proposal is that the palliative plan should commence this weekend and withdrawal from ventilatory support take place on 15th February 2021. For this reason and because the family are desperate for these issues to be resolved, I have given this judgment ex tempore. It will however be perfected where necessary and be placed in the public domain. For all the reasons I have set out, I consider it would no longer be in TW's interests to provide ventilatory support and, subject to the extension to the time his brother may spend time with him in hospital, I endorse the palliative plan. Ms Dolan QC, instructed on behalf of TW by the Official Solicitor, has also carefully investigated the possibility of trying to accommodate a visit between TW and his

daughters in three weeks' time. At the conclusion of that investigation, the Official Solicitor, concluded that this could not be reconciled with the best interests of TW.

36. I know that this judgment will come as a disappointment to the family. But I would echo Dr B's advice, which is all that can be given: TW should not be remembered in his present parlous condition but celebrated for the huge contribution he made to all around him and more widely.

37. There has been no need for Counsel to address me extensively on the law. Miss Khalique has set out the established framework and case law within her position statement. The law is well established but always challenging to apply in such difficult and highly fact specific cases.

Capacity

38. As a result of his profound brain injury, TW does not have the capacity to make the decision to continue to receive life-sustaining treatment. FY accepts this and does not resist a declaration in this regard. Similarly, it follows that TW lacks capacity to conduct these proceedings.

Best interests in the context of life-sustaining treatment

39. Where lack of capacity has been established, the challenge for the court is to evaluate where best interests lie. The seminal case of **Aintree Univ. Hosp. NHS Foundation Trust v James [2013] UKSC 67** at [22] identifies the ambit of the court's inquiry when making best interests decisions in the context of whether to withdraw life-sustaining treatment:

> . "*….the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it.*"

40. The following passage also requires to be emphasised:

> *"39. 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 the nature of the medical treatment in question, what it involves and its prospects of success; 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 interested in his welfare, in particular for their view of what his attitude would be.*

41. The starting point for this inquiry is that there is a strong presumption that it is in a person's best interests to stay alive in light of their rights under Article 2 (the right to life), Article 3 (protection from inhuman or degrading treatment) and Article 8 (the right to respect for a private and family life) of the ECHR **(Burke v UK [2006] (App 19807/06)**. However, it is well-established that this presumption, whilst "*of the most profound importance"* (per Baker J as he then was in **W v M [2011] EWHC 2443 (Fam)**, at [222]), can be displaced by evidence that it would be contrary to the person's best interests to continue to receive life-sustaining treatment.

42. As I have set out above, I am clear that the continuation of ventilatory support and likely invasive treatment can no longer be reconciled with TW's best interests. In those circumstances I must grant the declaration sought by the Trust.