This judgment was delivered in public. 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

This Transcript is Crown Copyright. It may not be reproduced in whole or in part other than in accordance with relevant licence or with the express consent of the Authority. All rights are reserved

IN THE HIGH COURT OF JUSTICE
COURT OF PROTECTION
[2021] EWCOP 42

No. COP13748444

Royal Courts of Justice
Strand
London, WC2A 2LL

Monday, 10 May 2021

IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF KM

Before:
THE HONOURABLE MR JUSTICE KEEHAN

(**In Public, subject to a Transparency Order**)

B E T W E E N :

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
(WYTHENSHAWE, TRAFFORD, WITHINGTON, ALTRINCHAM SITE)

Applicant

\- and -

(1) KM (by his litigation friend, the Official Solicitor)
(2) TM

Respondents

\- and -

(1) KWM
(2) CA

Interested Parties

____

J U D G M E N T

MISS E. SUTTON appeared on behalf of the Applicant.

MR M. HORNE QC appeared on behalf of the First Respondent.

MR S. KARIM QC and MISS S. HURST appeared on behalf of the Second Respondent.

FIRST and SECOND INTERESTED PARTIES appeared in Person.

____

THE HONOURABLE MR JUSTICE KEEHAN:

INTRODUCTION

1 In this Court of Protection matter, I am concerned with one man, KM, who is 52 years of age. He was admitted to Hospital A on 19 January this year with shortness of breath and pleuritic chest pain. He had, it was understood, returned to Manchester following a long-haul flight from the Togolese Republic.

2 On 24 January, he was transferred to the cardiothoracic intensive care unit at Hospital B. He has remained an inpatient in that hospital since that date. Unfortunately, his condition has deteriorated over the course of the last three and a half months, or thereabouts, to the circumstance where it is said by the treating clinicians that his condition is irrecoverable and irreversible, and that the continued treatment would be futile and overly burdensome.

3 Accordingly, on 28 April, this application was made by the relevant Trust seeking orders by which permission would be granted by the court to withdraw the life-sustaining treatment that KM currently receives. That application is now, as a result of hearing evidence today, supported by the Official Solicitor who acts as KM's litigation friend, but the application is very strongly opposed by KM's wife TM, by his son KWM, and by his brother-in-law KA.

4 It is agreed by the parties on the basis of expert evidence previously submitted that KM lacks the capacity to conduct this litigation as a result of his presenting clinical condition and he also lacks capacity to consent to his medical treatment. The one issue for me to determine, in essence, is whether the Trust should be permitted to withdraw the life-sustaining treatment that KM currently receives which will, sadly but inevitably, lead to his death.

THE BACKGROUND

5 KM and his wife have been married for some twenty-three years and have lived in this country for a considerable part of that time. They have three children, one of whom is an interested party in these proceedings KWM. They are, it is clear and I accept, a deeply religious family of the Pentecostal Christian faith. Prior to 19 January 2021, KM had no significant medical history and he was otherwise a fit and well man.

6 He, as I have said, was admitted to Hospital A on 19 January and he was transferred to Hospital B on 24 January when he was placed on an extracorporeal membrane oxygenation machine ("ECMO"). This effectively replaces the function of his heart and his lungs. He also receives mechanical ventilation and treatments for various infections. On the day following his admission to Hospital B, he was diagnosed as suffering from COVID-19. I am told by Ms Sutton, and accept, that had it been known that he was suffering from COVID-19 prior to being placed on the ECMO machine, he would not have been so placed.

7 During the course of February and March, there were various attempts made on at least eight occasions to wean KM off the ECMO machine, the last of which occurred on 25 March 2021. All of them were ultimately unsuccessful. There were varying periods of some hours when he was able to just about manage to breathe and survive without being on the ECMO machine but, ultimately, the decision was made to restore his connection to it. After the last occasion, it was considered by the clinicians to simply be unsafe for there to be any further trials of weaning him off.

8 Through the early part of his admission in Hospital B, he underwent a series of CT scans of his lungs. In the early part of January and February, these were reported as not showing a great deal of damage to his lungs. The final scan, on or about 24 February, showed a very significant deterioration in the condition of KM's lungs. His clinical presentation since that time has sadly been one of progressive deterioration and a worsening generally of his condition. His treating clinicians, represented at this hearing today by Dr A, a consultant in cardiothoracic intensive care, anaesthesia and ECMO, advised that the clinical picture did not merit or warrant further CT scans being taken, in particular for the purposes of clinical treatment and that taking a patient from intensive care to a CT scan is a risky procedure for many but would have been an especially risky procedure for KM given the perilous state of his health.

THE LAW

9 The law is agreed between all of the parties and has been helpfully summarised by counsel for the Trust Miss Sutton in a legal framework document. I have had regard to all of those authorities in reaching my decision. In particular, I have had regard to the provisions of sections 1 - 4 of the Mental Capacity Act 2005. I also taken account of the presumption in favour of sustaining life wherever that is possible to do so and I give great weight to and have the greatest respect for the wishes and feelings of KM, as best as they can be ascertained, and the wishes and feelings of his family and those who have had care of him.

THE EVIDENCE

10 I heard moving evidence from KM's wife, his son, his brother-in-law and the pastor of his church. They spoke of KM as being a deeply religious man, attending church services in his Pentecostal church each Sunday, and the role that he played in the services.

11 The evidence of those four witnesses, as they say and I accept, reflected the wishes and feelings of KM, can be summarised as follows. The Bible contains the word of God. It is for God alone to make decisions in matters of life and death. They all have a deep belief in divine healing and the intervention of God to cure those who are ill. One must never give up hope with prayer. There is always a chance of recovery and gaining good health. There are never any circumstances in which it would be, in religious terms, right to consent to the withdrawal of life sustaining medical treatment. As KM's wife said to me in her evidence when asked about any pain or distress that KM is suffering, she told me that they believed that that was what God had provided for them and it was for the individual, in this case KM, to live with and accept that pain and that discomfort.

12 I have been urged by all counsel, in particular by Mr Horne on behalf of the Official Solicitor, to give great credit to and great weight to those religious views and beliefs of KM and of his family, and I most surely and assuredly do. The wishes and feelings of KM are, as the authorities have made clear, to be given great weight and great respect but they are not necessarily determinative of the outcome of an application such as this.

13 I heard evidence from Dr A who, as I have said, is one of KM's senior treating clinicians, and from Dr Danbury, the expert instructed by the Official Solicitor for a second independent opinion. Dr Danbury is one of the country's leading experts in COVID-19 and intensive care treatment. Dr Danbury had the benefit of hearing the evidence of Dr A and Dr A had had the benefit of reading the report of Dr Danbury. Both were in agreement with each other and there were no points of disagreement or contention between them.

14 One hugely difficult issue for the family is no doubt the fact that prior to 19 January this year, KM was a perfectly healthy and well man, and yet now they are being told that he is desperately ill and close to death. Dr Danbury gave a very clear explanation in his evidence of how that has come to be. It is clear that KM has suffered a form of deep vein thrombosis as a result of the long-haul flight from the Togolese Republic. Part of that clot broke away and entered his heart and, in particular, into the left ventricle. In consequence, KM suffered a pulmonary embolism which resulted in him suffering a cardiac arrest. He was able to be restored and was treated for his pulmonary embolism. If matters had remained with the pulmonary embolism, the outcome, say the doctors, would have been very different. Unfortunately, KM contracted COVID-19. That greatly exacerbated the damage to his lungs and it quickly became the dominant pathology in KM. The onset of COVID-19 was consistent, said Dr Danbury, with the initial ability for short periods for KM to be weaned off ECMO in February and was consistent with the early relatively benign CT scans of the damage to KM's lungs. However, the onset and ravages of COVID-19 are, as Dr Danbury said, very fast and once they had taken hold, KM deteriorated rapidly. The damage to his lungs had increased. The pulmonary fibrosis worsened and became more extensive.

15 Both doctors are agreed that treatment can be offered to halt the progress of pulmonary fibrosis but once the lungs have been damaged, that damage is irreversible and the position has been reached now, despite two different forms of treatment, that to all intents and purposes, KM's lungs have ceased to function. There is no chance or hope of recovery from that condition. There is no chance that KM would ever be able to lead a life free of ECMO. Dr A has huge experience in the use of ECMO machines on intensive care units. The upper limit for a patient to be connected to an ECMO machine is some three to four weeks. It is beyond the experience of Hospital B for a patient to be on ECMO for as long as KM, namely some fifteen weeks.

16 What are the adverse consequences for KM? What have they been and what are they? He has suffered very considerable weight loss over the last few months, some 20 kg in total. He has suffered massive muscle loss as the body consumes its muscles to provide sustenance. He has necrosis of his lower extremities, namely in his fingers and toes. Dr A said that the necrosis would be extremely painful. If his time on the ECMO machine is prolonged, that necrosis will only worsen. He suffers from severe pressure sores to his perineum and to the back of his right ear. These too are getting worse. If KM remains on the ECMO machine, those pressure sores will only worsen and become more extensive. The one that concerned Dr A most was the one behind KM's right ear which has gone down to his skull and is the worst, or just about the worst, Dr A has ever seen. These sores will also be the source of very real pain and discomfort for KM.

17 Mr Karim, in cross-examination of Dr A, referred to some parts of the medical notes where it appeared that it was reported that KM was comfortable. Dr A responded that that might well have been the case, but he had experienced signs of KM suffering pain and discomfort by grimacing. He spoke of how it was, in the best of circumstances, challenging to maintain pain relief for necrosis and/or for pressure sores. This was increasingly challenging in a patient like KM who has been receiving analgesia and other treatment for such a prolonged period of time that it becomes more difficult for his body to absorb the analgesia and for it to have effect. Although he is sedated, he is not unconscious and KM will be aware of, in some ways consumed by, the pain and the distress that he suffers. Of particular note for Dr A and for me, was Dr A description of the views of the nursing staff who are constantly, on a rota, of course, with KM providing his care. They are distressed that KM is plainly suffering pain and in distress despite their very best endeavours to alleviate the same.

18 Dr A advised, with which Dr Danbury agreed, that if the court gave permission as sought, tomorrow afternoon, after KM's family have been given an opportunity to visit him, the ECMO machine would be removed and death would, Dr A opined, occur in minutes. Both were agreed that because of the increase in sedation that would follow on a palliative care plan that KM would not be aware that the ECMO machine was being removed or that his care plan had changed.

ANALYSIS

19 The views of KM's family have to be accorded, as I have said, very special and considerable weight. Further, KM's deeply held religious views have to be afforded great respect and also carry great weight but, as I have said, they are not determinative of the decision that I should make in his best interests. All counsel agree that there are factors which point in favour of continuing KM on the ECMO machine, namely that it would prolong his life. Secondly, it would be in accordance with his wishes, feelings, and beliefs and those of others.

20 On the contrary, against continuing on the ECMO machine, first the ongoing treatment is, on the evidence of the doctors, futile. It is, as I have just described, burdensome. There are no other alternative treatment options because both of the doctors were clear that because he has been on ventilation on ITU, KM would not be a candidate for a lung transplant which he would not have any prospect of surviving in any event. Withdrawing treatment on ECMO would allow KM to have a dignified death and ongoing treatment is contrary to the unanimous view of all of KM's treating clinicians, to the second independent expert's advice sought, Professor B, and also contrary to the views of Dr Danbury.

21 In all of the circumstances, I am entirely satisfied on the overwhelming medical evidence that continuing treatment for KM on the ECMO machine is futile. There is no prospect of him achieving a recovery. There is no prospect of continued use of the ECMO machine or any other treatment reversing the extensive end-stage damage to KM's lungs. As Mr Horne put it, although it might prolong life, the reality is the continued use of the ECMO machine is simply prolonging his death. Dr A and Dr Danbury were agreed that though it is difficult to be definitive in terms of timescales, even if KM remained on the ECMO machine, death from one cause or another would be likely to follow within two months or, Dr A thought, even sooner. That further time, which would be futile, would be at the cost of enormous great pain and distress for KM. He will continue to lose weight. He will continue to lose muscle mass. His necrosis will become more extensive and so will his pressure sores. He is also at risk, as he has been in the recent past, of suffering yet further infections for which treatment is required.

22 Balancing all matters together, I am in no doubt whatsoever that in this very tragic and very sad case, it is in the best interests of KM that the ECMO machine and life-sustaining treatment is withdrawn and that the care of KM moves to the palliative care plan as set out in the bundle. I approve the course proposed by the hospital that after there has been an opportunity for KM's family to visit him tomorrow, steps should be taken to remove him from the ECMO machine, which I accept will quickly and inevitably lead to his death.