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Case No: 13587747

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/06/2022

Before:

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

- -

Between:

Imperial College Healthcare NHS Trust — **Applicant**

- and –

Mrs C
(by her Litigation Friend, the Official Solicitor) — **First Respondent**

-and-

CC — **Second Respondent**

-and-

GC — **Third Respondent**

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Mr David Lawson (instructed by **Capsticks**) for the **Applicant**
Mr Michael Horne QC (instructed by **Official Solicitor**) for **Mrs C**
Mr Abid Mahmood (instructed by **Irwin Mitchell**) for **CC**
GC was unrepresented and appeared **in person**

Hearing dates: 15th-16th June 2022

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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

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 HAYDEN:

1. This is an application made by the Imperial College NHS Health Care Trust concerning Mrs C, who is 77 years of age. The application requires identification of her best interests, in the context of medical treatment. As I deliver this judgment, Mrs C is in the Intensive Care Unit (ICU) of the Charing Cross Hospital in London. Mrs C has dedicated her life to working for the NHS. At one stage in a busy career she was employed, in a managerial capacity, by a company which supplies machinery and equipment to Charing Cross Hospital. The family have told me that this company supplied the equipment that Mrs C is now dependent upon.

2. Mrs C has been voluble and enthusiastic in her support for the NHS. She has worked in various London Hospitals. I was told that she was actively involved in campaigning for Charing Cross hospital to be kept open at a time when it was under threat. During the hearing, I have heard from three of her sons and one of her daughters. Two sons gave evidence in court before me, one gave evidence by video link. The daughter was able to join us by telephone. Each of them made a significant impression upon me. Instinctively, and in their different ways, they all recognised that the court wanted to understand who their mother is, who she has been, and how she approached life. Each family member was determined to take their mother, metaphorically, out of ICU and bring her into this court room. They achieved that with great insight, unfailing respect to her, and with good humour.

3. Yesterday, the atmosphere in the court room was tense and anxious, characterised by antipathy, rather than collaboration. Today saw, in my assessment, a sea change. The concentration was not upon disappointed hopes and expectations or on perceived failures on the hospital's part, but focused instead on presenting to me a full, three-dimensional portrait of the fireball of energy that is Mrs C. She is, well known in her community, where I am told, everybody calls her 'mum'. Many within that community have been enquiring about her and have been genuinely concerned for her health and welfare.

4. As her children have related to me, Mrs C's life has been a life full of song, music, people, food and football. She is eclectic in her musical taste, ranging from Gospel through to Calypso and including modern contemporary music. She is a very good cook and a green-fingered gardener. She also knows how to enjoy herself. She is at her happiest when she is with her family and friends.

5. As her life has become more circumscribed in recent years and as her health deteriorated, none of her enthusiasm evaporated. In the afternoons, she would enjoy old episodes of Ms Marple, classic repeats of well-known soap operas *"like Eastenders or Home and Away"*, and insofar as she could continue to get out, she went to see her friends and to her church. For Mrs C, her church has been central to her life. Much of the evidence that I have heard from the family has concentrated upon their mother's faith and its place in her world. Identifying Mrs C's best interests in the invidious circumstances in which she now finds herself, requires a thorough understanding and evaluation of the part faith has played in her life. Paradigmatically, the Judeo-Christian tradition emphasises the simplicity of faith, characterising it as childlike, and emphasising its unquestioning nature. As I have listened to the family, they have identified their mother's faith as simple, constant and disciplined. If they will forgive me for saying, something of Mrs C emerges in this court, not only by what her children

say about her, but by what they reveal of their own personalities. They are kind, they have clear ethical principles, they are articulate, and hardworking. Faith is important in different ways to each of them but, something of their mother's faith percolates through their lives too. I have been told that she is very proud of her children. From what I have heard, she would have been too modest to claim her own achievement in this, but that she has brought her children up well is plain for all to see.

6. The life of Mrs C, as I have been describing it, has been focusing on her later years, but her early years were very different. Money was short, times were hard, she had 5 children and as M, her son, alluded to, she faced the many challenges common to her generation of West Indians building a life in the United Kingdom. M was referring to the particular ignorance and racism of that period. I noted that he did so without anger or bitterness. I sensed that he had adopted some of his mother's approach to that period. Her faith would not have fed bitterness or resentment, it would have focused on forgiveness. In their different ways, each of the children has chosen a career which is dedicated to people and to public service. It is not difficult to identify where this philosophy springs from. Mrs C's life was entirely dedicated to others.

7. As the medical evidence has unfolded, it has created a very challenging dichotomy which cannot be resolved by medicine alone. Mrs C's best interests can only be identified by a thorough survey of the broad canvas of evidence that the family has offered me in their account of their mother. They have opened up their life and hers, for me to scrutinise in order that I might fully understand the woman in respect of whom I now have to make very challenging decisions.

The medical background

8. It is necessary, because this ex-tempore judgment will be a public record, for me to summarise the medical background. Much of it relates to the past, as I have emphasised to the family. It cannot be changed, it requires to be accommodated, absorbed, and understood. I am satisfied that all those involved in Mrs C's life are committed to doing the right thing for her and have given of their best. J, her daughter, had prepared and read to me a quotation from the former Archbishop of Westminster, Cardinal Basil Hume… *"all human life matters, no life is ever redundant"*. I am entirely clear that this perspective is not only shared by the family but by the doctors and nurses responsible for Mrs C's care. There may have been differing views as to what is best for Mrs C in terms of her medical treatment but, the integrity of the investigations and treatment are plain to see. Mrs C would have expected nothing less from the NHS.

9. Mrs C's recent medical history reveals a raft of health issues. She had a background of hypertension, diabetes, and transient ischemic attacks. She had enjoyed a little bit too much of the good food she had prepared and that had also taken its toll. She had gallstones, arthritis and was awaiting tests for anaemia. She was admitted firstly to the Charing Cross hospital on 16th January 2022, following a fall at her home. At that time, she was also suffering from a chest infection. Mrs C's daughter, who is also her carer, was unable to lift her from the floor and she remained on the floor for 3 hours awaiting the arrival of an ambulance. On admission to the Emergency Department, Mrs C tested positive for COVID-19. She had a raised heart rate, her blood tests confirmed that she had an acute kidney injury with significant raised creatinine levels, which indicated that her kidneys were not functioning efficiently. Her glucose and sodium levels were high. The suspected anaemia was also confirmed.

10. The ECG showed no evidence of myocardial infarction, i.e., no apparent blockage of blood supply to the heart. Mrs C was given intravenous fluids to improve kidney function, which were effective. She was prescribed prophylaxis for thrombosis. However, she remained persistently tachycardic i.e., her heart rate was too fast. The ECG was repeated, and the opinion of a cardiac specialist was sought. A discussion followed which centred upon whether the heart itself was normal and whether anticoagulation was required. It isn't necessary to burden the judgement with any further details of this aspect of the investigation.

11. On 21st January 2022, Mrs C was noted to have reduced oxygen saturations and identified as being less alert. She underwent a CT scan of the brain. The brain at that time was entirely normal. She was then reviewed by the medical and critical care team on the 23rd January 2022, by which day she was more alert but still manifestly displaying ongoing tachycardia. This time, her blood pressure was lower, there was concern that she had not been taking food or drink and that she might be dehydrated. Accordingly, fluids and magnesium replacements were given, and were effective. The blood pressure recovered; the heart rate returned to normal.

12. At 12:45am on 24th January 2022, Mrs C suffered a cardiac arrest. The rhythm was pulseless electrical activity. 8 cycles of CPR were given and a return to spontaneous circulation was achieved at 1:04am. The delay, referred to in evidence as *'down time'*, was therefore within the region of 20-25 minutes. In many ways, it is remarkable that Mrs C survived at all. In other ways, it is not. She has, as her children have told me, in colourful terms and in patois argot, *"been a fighter all her life"*.

13. It is perhaps relevant that the blood gases taken at the time of arrest showed two respiratory failures, with a remarkably raised CO_2 level. Dr Danbury told me that it is, in many ways, CO_2 rather than O_2 that the body most requires to regulate breathing. CO_2 plays various roles in the human body including regulation of blood pH, respiratory drive, and affinity of haemoglobin for oxygen (O_2). Fluctuations in CO_2 levels are highly regulated and can cause disturbances in the human body if normal levels are not maintained. That may have been a factor in causing the cardiac arrest. Mrs C was transferred to the ICU on 24th January 2022. She was obviously and manifestly, grossly clinically unstable, with what is described as *"Type 2 respiratory failure and very poor urine output"*. Mrs C had a collapsed left lung which was treated at that time with ventilation, physiotherapy, antibiotics and bronchoscopy. Her family were informed and updated and told that she was in a very bad way and that having been deprived of blood and oxygen for such an extensive period, prognosis was poor.

14. Although it has been contentious in the family, a 'Do Not Attempt Resuscitation' notice (DNR) was placed on the bed. This reflected the parlous nature of Mrs C's situation. It requires to be stated, with absolute clarity, that the insult to the brain was a profound, catastrophic hypoxic ischemic injury. From 24th January 2022, there was no way back for Mrs C to the life she had lived or to the woman she had been. On the 1st February 2022, an MRI scan was undertaken, it revealed *"features suggestive of profound hypoxic ischaemic injury"*. Mrs C's family were informed of the gravity of the clinical situation and the bleakness of the prognosis.

15. The multidisciplinary team at the ICU was of the clear view that, from a medical perspective, it would be in Mrs C's best interests to undergo extubation without tracheostomy, and for a care plan to be put in place, providing palliative care at the end

of her life. The family struggled to absorb the shock of this prognosis. They requested transfer to the St George's ICU team, but that was declined by St George's, who were not able to provide any alternative options or additional services. The family has kept what they have described as a "vigil" by their mother's bedside throughout this whole process.

16. There has been much discussion as to how best to describe Mrs C's level of consciousness and awareness. In exchange with Mr Horne QC, acting for the Official Solicitor, I suggested that the description or label did not matter. What is clear, is that she is in a prolonged disorder of consciousness. Dr Danbury emphasised that in any event, brain injury should always be regarding as existing in a continuum. It may be, for example, that Mrs C evolves from what is termed a *"vegetative state"* to the *"lower end of minimal consciousness"*. Dr Danbury emphasises that this should not be regarded as progression, indeed many might regard it as the opposite. He told me that in a minimally conscious state it is likely that Mrs C will experience pain as a predominant experience of her life. That may be assuaged by the touch, care, presence, and love from her family, but it does not alter the balance of her experience.

17. It is important to emphasise that Mrs C has been reviewed by two independent doctors i.e., external to the hospital. Dr Danbury, Consultant Intensivist at Southampton University Hospital and Dr Gerry Christofi, Consultant in Neurology and Neurorehabilitation. Both considered that there had been no substantial neurological change between 17th March 2022 and 1st June 2022, when they reviewed the evidence. There was no level of arousal noticed.

18. Dr Danbury was asked to view a video made by the family, which I did not see and did not consider it necessary to do so. Dr Danbury watched it and was prepared to accept that what he saw on that video may have been indicative of a move to a more minimally conscious state and away from chronic vegetative state. The family will recall that Dr Danbury asked for some peace and quiet to watch the video on his own in a conference room, in order properly and carefully to evaluate it. The care and time Dr Danbury took to do this ought, in my judgement, to signal to the family his real commitment both to them and to his patient. When an expert of Dr Danbury's experience is prepared to reconsider and permit of the possibility of a change in state of consciousness, it carries real weight. There may well have been some evolution towards a minimally conscious state. The preponderant evidence points to chronic vegetative state, but just as Dr Danbury was prepared to admit of a possible change, so must I. I am not going to determine the issue one way or the other. My findings reflect Dr Danbury's opinion. It is not necessary to make a determination on the balance of probabilities. Here, forensic and clinical medicine should not be permitted needlessly to become divorced.

19. It is important to record that the family and each of the doctors agree that it is not in Mrs C's best interests to remain mechanically ventilated on ICU with the endotracheal tube in place. Mrs C has remained in this situation now, for nearly 6 months and without any limitations of supportive treatment. The present situation is highly intrusive, profoundly burdensome and medically futile. To continue it further would, I have been told, put Mrs C *"at a great deal of suffering"*. Dr D, a Consultant Intensive Care Specialist, working at Charing Cross Hospital, discounts it as *"not a clinically available option"*.

20. The clinical options have become distilled to two distinct and alternative care plans. The ICU team have made efforts "*to wean"* Mrs C off respiratory support by instituting a spontaneous mode of ventilation and reducing her pressure support. Some of these efforts have been compromised by intercurrent infection or respiratory distress which have required increases in ventilatory support. Dr Danbury suggested in his report that there is a lower than 10% likelihood of Mrs C being successfully weaned from a ventilator. In his oral evidence, he considered that might more realistically be expressed as *"somewhere between 5 and 10% chance"*. This rather precise calibration of the prospects of successful weaning is better articulated, in my view, as a very small prospect of success.

21. There has been some discussion as to whether the weaning process would stand a greater prospect of success with a tracheostomy in situ. The family have told me that Mrs C had a family friend with a tracheostomy and said, on a number of occasions, that would be the last thing she would want for herself. As her son properly recognised, that statement should not be interpreted as complete resistance to it but understood as an option of last resort. In his oral evidence, Dr Danbury cited recent, well regarded peer reviewed research which concluded that the prospects of successful weaning were broadly the same with or without a tracheostomy in situ. Happily, therefore, if I approve the weaning plan, I can respect Mrs C's wishes.

22. The hospital make two important points in respect of the weaning plan. Firstly, they agree with Dr Danbury that it has a low prospect of success. Secondly, they consider that even if Mrs C were effectively weaned and extubated her neurological damage would compromise her ability to maintain her airway or breathe adequately over a prolonged period of time. Medically, they assess her best interest as requiring a removal from ventilation, supported by an end-of-life care pathway. If Mrs C were to be extubated, in the absence of an attempt to wean her, the medical consensus is that she would die very quickly, possibly within a few hours or even within minutes. There would be palliative care and pain relief to ensure that she would be free from pain or distress. This would necessarily include a determination that replacing intubation and restarting ventilation, would not be in Mrs C's best interests. It follows, logically, that those are of suppressive support and renal replacement therapy would also be irreconcilable with Mrs C's best interests.

23. Identification of Mrs C's best interests is not confined to what might objectively be seen as the best course medically. As everybody has recognised, Mrs C's own wishes have to be woven into the analysis. She is no longer in a position to articulate what she would want. That requires me to listen carefully to what her family say about her, to seek to understand the code by which she has lived her life and ultimately to assess the weight this should be given, alongside the medical evidence.

24. Mrs C, I was told, did not talk very much about death, even as her health declined, her focus has been on life, which she has embraced fulsomely and energetically. She had passion for the causes she engaged in and was faithful to those causes throughout her life. I was told that she liked to talk, which I saw reflected to differing degrees in her family. I evaluate these characteristics alongside the reality of the weaning plan. The plan would strike many as distressing, perhaps even horrific. It involves engaging with a struggle against the ventilator to see if she can manage without it. To confront the awful reality, she will be fighting to breathe.

25. I am very clear that Mrs C would think it her duty to fight for as long and as hard as possible, to hold on to a life that she regards as a gift from God. She would, as the family conveyed to me, wish to put her life in God's hands. All this said, the battle that she contemplates must be time limited. Dr Danbury thought it should be a maximum of 14 days. Any longer would be unethical. All, including the family, accept this. 14 days is a very long time to struggle to breathe.

The Legal Framework

26. The law in this area is relatively easy to state though often, as here, intensely difficult to apply to the facts. Mrs C's best interests fall to be determined in accordance with section 4 of the MCA 2005 which provides:

> *"(2) The person making the determination [for the purposes of this Act what is in a person's best interests] must consider all the relevant circumstances and, in particular, take the following steps.*
>
> *(3) He must consider—*
>
> *(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and*
>
> *(b) if it appears likely that he will, when that is likely to be.…*
>
> *(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*
>
> *(6) He 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) the other factors that he would be likely to consider if he were able to do so.*
>
> *(7) He must take into account, if it is practicable and appropriate to consult them, the views of— . . .*
>
> *(b) anyone engaged in caring for the person or interested in his welfare, . . .as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)."*

27. The Code of Practice states:

> *"5.31 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 interests 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. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment."*

28. As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.

Importantly, section 4(5) cannot be interpreted to mean that doctors are under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen. Doctors must apply the best interests' checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests. If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide what is in the person's best interests."

29. The ultimate and clearest iteration of the law remains that in *Aintree University Hospital NHS Trust v James [2013] UKSC 67*:

> *"[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 towards 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.*
>
> *"[45] Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again*

> *I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being." (per Baroness Hale)*

30. Mrs C's rights protected by the European Convention on Human Rights are engaged. In the present context, the relevant rights are established by 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). As the ECtHR recognised in Burke v UK [2006] (App 19807/06), [2006] ECHR 1212:

> *"the presumption of domestic law is strongly in favour of prolonging life where possible, which accords with the spirit of the Convention (see also its findings as to the compatibility of domestic law with Article 2 in Glass v. the United Kingdom, no. 61827/00, § 75, ECHR 2004-II)."*

31. In this context in **Aintree University Hospitals NHS Foundation Trust v James** (supra) at [22], per Baroness Hale highlighted the following, which seems to me to be particularly apposite in this case:

> *"Hence 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."*

32. These sentiments were re-stated in ***An NHS Trust v Y [2018] UKSC 46*** at [92], Lady Black delivering the judgment of the court:

> "Permeating the determination of the issue that arises in this case must be a full recognition of the value of human life, and of the respect in which it must be held. No life is to be relinquished easily."

33. For Mrs C her faith has been utterly intrinsic to her day-to-day life. It is clear that the family hope that their mother will recover to an extent that restores something of her vitality and enthusiasm. That hope, simply cannot be supported by the evidence. Should the weaning be successful, Mrs C's neurological damage will continue to compromise her level of awareness and ability to experience life around her. I am however, entirely satisfied, that Mrs C would "be up for the fight", as the family have termed it. It is not for me to stand in her way. The treating clinicians have listened very carefully to the evidence and are content to pursue the weaning plan if the Court considers it to be in her best interests. For the reasons I have set out above, I consider that it is. Mrs C is a courageous woman with a similarly courageous family. That courage will be needed in the weeks ahead and they will all be in my thoughts.