Neutral Citation Number: [2014] EWCOP 9

Case No: COP12514588

THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/06/2014

Before :

MR JUSTICE COBB

- -

Between :

County Durham & Darlington NHS Foundation Trust	**Applicant**
- and -	
PP	**Respondents**
(By her litigation Friend, the Official Solicitor)	
H, D & S	

- -

Mr. Sam Karim (instructed by **Ward Hadaway**) for the Applicant
Mr. Angus Moon QC & Ms Susanna Rickard (instructed by **Langleys Solicitors LLP**, as agent for the Official Solicitor) for P
H and D were neither present nor represented
Ms Victoria Butler-Cole (instructed by **Irwin Mitchell**) for S

Hearing dates: 25-26 June 2014

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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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MR JUSTICE COBB

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 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.

The Honourable Mr. Justice Cobb :

1. These Court of Protection proceedings are being heard in public, pursuant to the provisions of *rule 92(1)(a)* of the *Court of Protection Rules 2007* and, having regard to the subject matter, under *§16* of *PD9E* to the *Court of Protection Rules 2007*. A Reporting Restriction Order pursuant to *rule 92(2) Court of Protection Rules 2007* was made on 19 June 2014 by Roderic Wood J, and (subject to a minor amendment), that order subsists as originally drawn, restricting the public identification of the subject of the proceedings.

2. By application dated 12 June 2014, County Durham and Darlington NHS Foundation Trust (hereafter The Trust) seek declarations in relation to PP ('P'). P was born on 17 May 1929, and is therefore 85 years old. P is currently at the Darlington Memorial Hospital, Hollyhurst Road, Darlington, where she was taken on 9 April 2014 following a gradual decline in her functional status as observed by those providing care for her at her care home, which I shall refer to as Ivy Dene Nursing Home.

3. P has a complex medical history, most notably having suffered a left posterior acute circulation stroke some years ago; she currently suffers from atrial fibrillation and "*stroke disease*". Her current diagnosis further includes (a) vascular dementia and possible Alzheimer's with diminished consciousness, (b) ischaemic encephalopathy, (c) and cerebro-vascular disease. She is described by a number of the medical professionals as being "*very frail*", has no eye contact, appears unconscious, and is unable to communicate or respond to any requests or commands. She is acknowledged by the clinical and forensic experts to be in a terminal phase of her life.

4. The Trust seeks the Courts authority, and corresponding declarations, as to P's treatment, in particular the possible withdrawal, or non-escalation of, life-sustaining treatment as part of an end of life care package. The Trust contends (and interim declarations have been made to this effect already) that P lacks the capacity to litigate, and to make decisions in relation to the serious medical treatment in issue in this application. Specifically the Trust seeks the following declarations pursuant to *section 15(1)(c)* of the *Mental Capacity Act 2005*:

    a. That it is lawful and in P's best interests to continue to receive artificial hydration via subcutaneous injection.

    b. That it is lawful and in P's best interests that the Trust's treating clinicians shall be permitted:-

        i. Not to provide artificial nutrition by a percutaneous endoscopic gastrostomy tube or via an alternative artificial feeding regime; and

        ii. Not to resuscitate her in the event of either a cardiac or respiratory arrest.

5. The Respondents to the application are P herself, represented by the Official Solicitor, P's husband (hereafter 'H') (himself a frail and elderly gentleman who

until recently has been in hospital, and has not attended this hearing), P's daughter ('D') and P's son-in-law ('S').

6. This hearing, which commenced yesterday on 25 June 2014, had been set up by direction given by Roderic Wood J on 19 June 2014. The case has been prepared at great speed and with considerable assiduousness on all sides. I am grateful to all – in particular Dr. Dominic Bell, Consultant Intensivist and Anaesthetist to whom I shall make further reference shortly – for co-operating with the logistics to achieve this effective hearing. I deliver this *ex tempore* judgment at the conclusion of the hearing (26 June 2014).

7. For the purposes of making the determinations, I received statements and reports from a number of clinical professionals, and a forensic expert's report from Dr. Dominic Bell. I read the statements and reports with care, and heard the oral evidence of Dr. Bell. I received helpful submissions from counsel.

8. At this hearing the position of the Respondent parties is as follows:

   a. The Official Solicitor, on behalf of P herself, does not oppose the making of the declarations, his final position clarifying once the court had heard the oral evidence of Dr. Bell. Insofar as I am able to ascertain P's likely views at all, they are said to emerge from a discussion between the Official Solicitor's agent, Ms. McKendry, and H on Tuesday 24 June; H thought that if one could ask P now what her wishes would be, he thought she would say that "*probably when it came to the last*" she "*should be allowed to sink into death*". It is not, in fairness, entirely clear from the context whether H was expressing his own views, or the views of P;

   b. I am told that H does not oppose the making of the declarations;

   c. D, at one time (notably at the 16 May 2014 'Best Interests' meeting – see §12 below) was believed actively to be supportive of the application, or part of it (namely in relation to the withholding of resuscitation); in an e-mail to S's solicitor following that meeting dated 6 June, she stated that she would have supported the 'DNR' (Do Not Resuscitate) status being applied, but felt that the hospital had been too hasty to withdraw food and fluid, and she had therefore lost confidence in the overall treatment regime; she said that she felt pressured at the meeting, and (by the time of the e-mail) did not support the DNR. By the time of the hearing, her position had modified again; it appears (from a discussion with Dr. Bell on 22 June 2014, which I am told is accurate) that she recognised that her mother is in a terminal phase of her life, and would want her mother's last days to be spent in "*a nice environment*"; she accepted that physical resuscitation manoeuvres would be inappropriate but would want her mother to have relief from discomfort or distress.

   d. S has been, until the morning of this final hearing, the main opponent of the Trust's application, and the apparent spokesperson for the family. He is angry at what he perceives to be sub-standard care delivered to his mother-in-law in Ivy Dene Nursing Home and Darlington Memorial Hospital; he has filed a statement in which he bluntly accuses the care staff of failing to discharge their professional duty. It appears from the totality of the documents filed

(including limited *inter partes* correspondence) that he and his solicitor have devoted significant time and energy into collating evidence for a potential civil action, which I cannot but observe has detracted a little from the key issues engaged in these proceedings. No one doubts S's love and concern for P; it is not said that he is otherwise than sincerely and genuinely trying to do what is best for P. As the hearing began yesterday, I was advised that he would no longer oppose the application.

9. In the event, therefore, although D and S have expressed considerable concerns about the care which P has received at Ivy Dene and in the Darlington Memorial Hospital, there was no material opposition to the relief sought.

Background

10. The salient background chronology can be summarised thus. On 9 April 2014 P was admitted to Hospital in Darlington from the Ivy Dene Nursing Home with raised sodium levels and infected pressure ulcers on her feet. She was unable to communicate verbally and was believed to be suffering osteomyelitis, the effects of dehydration, and fixed flexion deformity. Later that evening P was transferred onto a ward, where she was treated over the following weeks. The records show that P had fluctuating levels of consciousness with increased periods of sleepiness. S considers that P showed higher levels of consciousness and responsiveness in this period than the records or the clinicians attest to.

11. On 7 May 2014, Dr Nini (Consultant Geriatrician) assessed P, identifying her frailty and cognitive and functional decline over the previous few years. Dr Nini advised that cardiopulmonary resuscitation would not be in P's best interests in the event of a continuing decline in her health, and opined that should such treatment be successful it would be more detrimental than beneficial for her given the likelihood of ongoing vascular incidences to the brain and worsening life quality.

12. A little over a week later, P appeared to suffer a decline. Following a CT scan, it was believed that a further cerebral vascular event had occurred. P became less responsive. Dr. Bell confirmed that he concurred with the view that P had suffered a further stroke. On the following day, 16 May 2014, a 'Best Interest' meeting took place at the hospital involving Dr Cowie, Consultant Respiratory Physician with General Medicine, Peter Duffy the charge nurse, other representatives from the hospital and the nursing home together with P's husband, daughter and son-in-law. The family were keen for P to return to Ivy Dene Nursing Home. Dr Cowie states (in his written evidence) that the clinicians advised at that meeting that resuscitation in the event of cardiac or respiratory arrest would not be in P's best interests "*and indeed would be detrimental should she survive, given her overall cognitive and physical decline*". As indicated above, D indicated her consent to the DNR procedure at the meeting, a view which she subsequently retracted.

13. Predictably, perhaps, P's overall cognition and level of consciousness did not improve. On 20th May 2014, on review by a dietician, it was noted that P had not been able to take safely oral nutrition since 15th May.

14. I note that on 2 June 2014, D and S sent a joint 'letter before claim' to the Applicant, setting out in some detail six complaints about P's treatment at Darlington Memorial Hospital.

15. On 3 June 2014, P was assessed by Dr. Jordan a Consultant Gastroenterologist; he was asked to advise on whether a PEG (Percutaneous Endoscopic Gastrostomy) or another artificial feeding regime might be appropriate to sustain her life.

16. On 4 June, perhaps provoked by the family's letter, a further 'Best Interests' meeting was convened. The clinical team expressed the candid view that P would not benefit from artificial feeding and that the insertion of the PEG tube would be almost impossible. The clinicians further indicated that resuscitation would be futile with negligible chances of success. S continued to oppose the clinicians approach to P's treatment, and it was therefore agreed that the DNR status would be suspended pending further assessment.

17. Dr. Desai (Consultant Gastro-enterologist) and Dr. Bruce (Consultant Physician and Chief of Service in Elderly Care) further assessed P over the following days which led to the re-instatement of the DNR status on 9 June, followed shortly thereafter, and appropriately, by these proceedings.

18. P currently gives the appearance of being asleep for most of the time; she receives subcutaneous hydration and intravenous medication, and appears to be stable.

Capacity

19. I deal first with the issue of capacity. This has to be determined in accordance with statute on the balance of probabilities (*section 2(4) MCA 2005*), assessing P's decision-making capacity relevant to the specific 'matter' under discussion (*section 2(1) MCA 2005*).

20. I have received expert view as to P's capacity from Dr. Bruce and Dr. Bell. Dr. Bruce opines:

> "*she had a vascular demented process with diminished consciousness, most probably a Binswanger type ischaemic encephalopathy. I felt her prognosis was and remains very poor with a negligible prospect of recovery. She clearly did not have mental capacity…*"

Dr. Bell adds:

> "*[P] is extremely unlikely to make any progress along the spectrum of the minimally conscious state before death supervenes, and any such progress will not be associated with restoration of capacity*".

21. In short, both are clear that P lacks capacity in relation to the various specific issues in relation to which declarations are sought.

22. I have applied the statutory assumption of capacity (*section 1(2) MCA 2005*), and have had regard to the obligation to assist P to make the decision (*section 1(3)* ibid); I note the distinction between incapacity and unwise decision-making

(*section 1(4)* ibid), and the further statutory guidance on this determination contained in *section 2* and *section 3* (ibid.).

23. There is no dispute between the parties but that P lacks relevant capacity. Having regard to the materials which I have read, an extract of which is set out above, I am wholly satisfied that P lacks capacity in relation to the decisions on which I have been invited to adjudicate.

The views of the treating clinicians on the key decisions

24. A number of treating clinicians have expressed a view on the central issues. I have received statements and/or reports from:

    a. Dr Manas Desai, Consultant Gastro-enterologist;

    b. Dr. Lucy Nicholson, Palliative care consultant;

    c. Dr. David Bruce, Consultant Physician and Chief of Service in Elderly Care;

    d. Dr. Sarah Jordan, Consultant Gastro-enterologist;

    e. Dr. Pradip De, Associate Specialist in Respiratory Medicine;

    f. Dr. Stephen Cowie, Consultant in Respiratory Medicine.

25. I can summarise their views. These clinicians support the continuation of artificial hydration via subcutaneous injection, and oppose the provision of artificial nutrition by a PEG tube or via an alternative artificial feeding regime; they further oppose steps taken to resuscitate P in the event of either a cardiac or respiratory arrest.

26. The clinicians maintain a consistent and uniform opposition to the insertion of a PEG; it is said that it would be "*pointless*" (per Dr. Bruce), and would not achieve the objective of improving her palliation (Nicholson); Dr. Desai considers that it would be actually "*inappropriate*" to insert the PEG, and Dr. Jordan considered that such a procedure would "*hasten P's demise*". Dr. Cowie concludes that having regard to P's end-stage dementia, artificial nutrition (non-oral) would pose a significant burden to P, would offer no quality of life improvement, no palliation and would not improve her survival prospects.

27. As for CPR, Dr. Nicholson considered that such an exercise would be futile in light of P's underlying diagnosis, current condition and progressive deterioration, and that it would be burdensome. The prospects of success are less than 1%. Furthers she states that:

> "*There would be significant chance of causing harm and distress even if cardiac output is successfully restored (significant chance of hypoxic brain damage and risk of rib fractures and internal organ damage)*"

Dr. Bruce was of the view that CPR would be "*unpleasant*", and of no benefit.

28. Dr. Jordan's evidence is to the effect that cardiopulmonary resuscitation would be of no benefit to P as there is no realistic prospect of success given her "*extremely frail condition*". She states that this would "*therefore constitute a further overly burdensome pointless intervention.*"

29. The use of a bag and mask has been considered as a less invasive form of resuscitation; the doctors opine that this would not provide any sustained resuscitation for P, or long-term benefit to her.

Dr. Dominic Bell

30. Further to the hearing on 19 June 2014, Dr. Dominic Bell was instructed by the Official Solicitor to report to the court. Dr. Bell is a consultant in Intensive Care and Anaesthesia at the General Infirmary in Leeds.

31. Dr. Bell saw P and the family on Sunday 22 June, met staff on the same day, and provided his report for the first morning of the hearing. He helpfully set aside two hours to assist me in answering counsel's questions yesterday afternoon (25 June).

32. He described P as positioned with fixed flexion deformity of the lower limbs and spasticity of her upper limbs in her bed – a presentation which seriously impedes ordinary attention to personal hygiene and mobilisation, and substantially compromises the proposed treatments under discussion. This posture is the consequence of previous strokes and progressive brain injury.

33. His view was that P is "*somewhere on the spectrum between the vegetative state and an extremely low position on the minimally conscious / minimally responsive state*" with no real prospect of a change in that condition. He felt that P had entered a "*terminal*" phase of her life, which he described as "*pre-terminal hibernation*" with survival potentially up to 4 weeks. He felt that her overall management should be directed towards the prevention of, and relief from, discomfort and distress.

34. On the specific issues he commented as follows:

    a. **PEG and the provision/withholding of nutrition**: He opined that the technical hurdles to the safe placement of a feeding gastrostomy tube, together with the difficulties in subsequently monitoring for complications and the ongoing functionality of such a device created by the patient's abnormal posture, outweigh any potential benefits in restoring or maintaining a meaningful quality-of-life. The alternative option of attempting to re-establish enteral nutrition via a nasogastric tube is likely to precipitate pulmonary aspiration or the 're-feeding syndrome' (i.e. re-introducing foods to those who have been significantly starved for any period of time) or both, if delivered in the amounts required to limit any further nutritional 'slippage',

        "*regardless of the technical difficulties in insertion and requirements for imaging, potential for patient discomfort and lack of benefit for the same in restoring or maintaining a meaningful quality-of-life as perceived by the patient*".

In his conclusions, he confirmed that the 'anatomical configuration' of P would represent a technical barrier to PEG insertion and to evaluating her for the development of post-operative complications.

> "*Her current frailty and nutritional status as defined by her low albumin levels would create a risk of compromised wound healing and associated risk of leakage of bowel content into the abdominal cavity and sepsis from peritonitis. Given her current status it is unlikely that the feed will be tolerated, creating a risk of nausea and vomiting, aspiration of gastric contents, and diarrhoea causing the discomfort associated with already problematical personal hygiene. It is highly likely that given the length of time since nutritional supplementation and the current lower than normal phosphate levels that P would also be at risk of the re-feeding syndrome*."

He added:

> "*I have also considered the option of feeding via a nasogastric tube within the body of this report and do not believe that the potential benefits outweigh the feasibility or associated complications*."

b. In oral evidence he helpfully explained some of that terminology and the processes described above, discussing fairly and with care the potential benefits of, and contra-indicators to (indeed the dangers of) the procedure and its potential adverse consequence. He further expressed the view that the administration of a general anaesthetic which would be necessary in order to achieve insertion of the PEG would in itself carry significant and unacceptable risks to P's welfare.

c. **Resuscitation**: Dr. Bell told me that resuscitation manoeuvres of either an electrical or mechanical nature would be technically difficult due to the patient's body habitus. Such a procedure would be likely to be associated with physical harm to P given her frailty. He felt that it would be highly unlikely to be successful in restoring life due to a cardiac arrest representing the end stage of the dying process, and would in any event be incapable of restoring or maintaining a meaningful quality-of-life. He concluded his report by advising that:

> "*Given the 'anatomical configuration' of [P], there are practical barriers to the effective conduct of cardiopulmonary resuscitation, and given her overall frailty it is inevitable that these manoeuvres would be associated with chest wall damage and secondary injury to the internal structures. Given that any cardiac arrest requiring such manoeuvres would represent the end stage of the dying process, the chance of restoring a spontaneous circulation sufficient to maintain life for any sustainable period is virtually non-existent. Furthermore, for the reasons set out within the body of this report such manoeuvres would not in any regard be associated with the restoration of a meaningful quality-of-life*."

d. In his oral evidence he described the physical impact of resuscitation involving compression of the chest wall; my note of his evidence reads:

> "*the chest wall becomes less resilient the older the patient, and the ribs are less robust. To apply a force necessary to compress a heart involves forcing the anterior chest wall almost to meet the posterior chest wall.*"

He described the *"near certainty"* of fracturing P's rib in the CPR procedure, with the effect of causing haemorrhaging within the chest cavity; adding that "*the fractured ribs may well perforate the heart, lung or other organs in the abdominal cavity*."

Transfer to The Elms

35. P is currently in a side room at the Darlington Memorial hospital, having recently been moved off the ward.

36. The family wish P to move from Darlington Memorial Hospital to another residential resource, which I have referred to (a pseudonym for the purposes of this judgment) as 'The Elms'. I am told that the CCG will fund such a placement. There are potent arguments for and against such a move. Dr. Bell discusses these at §6.3 and 6.4 of his report, indicating that in his view such a move would be "*not ideal*"; he amplified his reasoning in his oral evidence yesterday highlighting two particular reasons for not moving P:

    a. That it may well cause P pain discomfort and distress at this point at the end of her life (though that rather depends on the view one takes of her conscious state); he points to the difficulty in making her safe during the journey given her posture and anatomical limitations;

    b. The break in continuity of staff; first, P would lose the benefit of the familiarity of voices and environment. Secondly, the benefits to P of being cared for by staff who have accumulated a repository of knowledge and experience of her will be lost; there is a risk that subtle indicators of P's comfort/discomfort may be lost at a critical stage of her life.

37. The family wish to be able to visit P in a setting which they find more welcoming and accommodating. They say, understandably, that this would benefit P herself. Dr. Bell recognised the force of this contrary argument; Dr. Bell wished to emphasise that he was not being "*absolutist*" about his view, though felt that ideally she should not be moved.

38. There are, or may well be, other argument for and against moving P at this stage of her life, but (as I indicated to the parties at the hearing) I do not propose to make a declaration about the issue of a move. Now that the two key decisions on which the court's adjudication was sought have been resolved, a decision should now be taken by the clinicians in consultation with the family; I encourage those making the decision to do so swiftly, taking account of the points raised above. Dr. Bell encourages the involvement of a palliative care specialist in any transfer, and as a lead in any follow-up post-transfer. In this respect, Dr. Nicholson would be the obvious candidate. Dr. Bell further recommends a palliative care package at §6.5 and §6.6 which should be respected in the event of transfer. The Trust acknowledges all of these points.

My approach on the law

39. The issues which fall for consideration must be determined by reference to the relevant provisions of the *Mental Capacity Act 2005*.

40. Having identified the powerful evidence in support of the conclusion that P lacks capacity (see §19-23 above), *section 1(5)* now requires me to make a decision under the *MCA 2005* for or on behalf P "*in [her] best interests*".

41. *Section 4(5)* provides that:

> *"Where the determination relates to life-sustaining treatment [the person making the determination] 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*."

42. The *Mental Capacity Act Code of Practice*, prepared and issued by the Lord Chancellor under *section 42(1)(b)*, and to be taken into account by the court under *section 42(5)* as relevant to the question arising in these proceedings, provides relevant guidance at paragraph 5.31:

> "*All reasonable steps which are in a 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…*"

43. In determining this application, I resolutely adhere to the best interests principles rather than applying a "*substituted judgment*" test; that said my application of the best interests principle is one "*which accepts that the preferences of the person concerned are an important component in deciding where his best his interests lie*".

44. That principle, in §43 above, emerges from the judgment of Lady Hale in the Aintree case (*Aintree University Hospital NHS Foundation Trust –v- James* [2013] 3 WLR 1299). The Supreme Court there considered the issue of withholding further life sustaining treatment in the context of a patient lacking capacity holding that the fundamental question is whether it would be in the patient's best interests, and therefore lawful, to have the treatment, and if the treatment was not in the patient's best interests the Court would not be able to give consent on the patient's behalf. Whilst "*the starting point is a strong presumption that it is in a person's best interests to stay alive … this is not absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment*" (*per* Lady Hale at para 35).

45. I further follow the guidance offered at paragraph 39 by Lady Hale:

> "*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 to put themselves in the place of the individual patient and ask what his attitude 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.*"

46. The issues have been considered in at least two recent first-instance decisions, but do not consider that they take this jurisprudence further.

Conclusion

47. I do not for one moment underestimate the upset to P's family at seeing P's life ebb away; they doubtless all struggle with the exquisitely painful and conflicting emotions and beliefs about the preservation of her life, even if it is for a matter of moments, as against allowing P the freedom to slip away into death. From the little I know about P, she obviously had a rich and happy life, valuing and valued by her close family, and it is all too understandable that they wish to cling on to her, and to extend that life, for as long as possible.

48. The decision which I am enjoined to make in respect of P engages her *article 8* rights, and the *article 8* rights of her family; in accordance with *section 1, 2 and 6* of the *HRA 1998*. I must (and do) interpret the provisions of the *MCA 2005* having regard to those convention rights.

49. I have weighed carefully the arguments for and against the declarations, canvassed in the argument and in the evidence. I have had regard to the views of the family and – so far as it is possible to ascertain them – of P herself. I have had regard to the uniform medical views as to her realistic prognosis, and the probability that she will not regain any or any significantly enhanced consciousness, let alone capacity.

50. The evidence in support of the Trust's applications has, in the end, been overwhelmingly clear.

51. It follows that I am satisfied from all that I have read and heard that P lacks capacity to make the decisions which I am considering in this application. I further consider it to be in P's best interests to declare that:

    a. The risks of providing artificial nutrition by a Percutaneous Endoscopic Gastrostomy tube or via an alternative artificial feeding regime significantly outweigh the potential benefits to P;

    b. That attempts at resuscitation in the event of either a cardiac or respiratory arrest are likely to cause harm to P, which may have terminal or other deleterious consequences, such that it would not now be in her interests that they be attempted.

52. I therefore make the declarations sought by the Trust.

53. That is my judgment.