IN THE HIGH COURT OF JUSTICE
COURT OF PROTECTION
[2020] EWCOP 70

No. COP13684602

Royal Courts of Justice
Strand
London
WC2A 2LL

Tuesday, 15 December 2020

Before:

MR JUSTICE COHEN

B E T W E E N :

UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST — Applicant

- and -

(1) RS (by his litigation friend, the Official Solicitor)
(2) Z — Respondents

REPORTING RESTRICTIONS APPLY

MR V. SACHDEVA QC appeared on behalf of the Applicant.

MR A. HOCKTON appeared on behalf of the First Respondent.

MS B. DOLAN QC appeared on behalf of the Second Respondent.

J U D G M E N T

MR JUSTICE COHEN:

1 The University Hospitals Plymouth NHS Trust apply for a declaration that RS, as I shall call him, and as the title of the case should be corrected, lacks capacity to consent or refuse medical treatment, including ventilation and CANH (that is, feeding and hydration) and for an order that it is lawful and in his best interests for ventilation and for food and hydration to be withdrawn and for such palliative care as is appropriate to be provided in order to maximise his dignity and ensure he does not suffer unnecessarily.

2 The application is supported by RS's wife, but is opposed by his mother, two sisters and niece. For ease of reference, I shall refer to them as "the birth family". RS is in his middle age. On 6 November 2020 at home he suffered a cardiac arrest. In the course of it his heart stopped for at least 45 minutes before cardiac rhythm was restored. In the absence of blood flow, irreversible brain damage becomes progressive from around five minutes at normal temperatures.

3 It was, therefore, inevitable that RS has suffered significant brain damage as a result of lack of oxygen. Now, over five weeks later, RS remains in a coma in hospital. It is, therefore, self-evident that he lacks capacity to make a decision for himself. It is common ground amongst all the medical professionals and accepted by all the family that he at best will never recover beyond a low level minimally conscious state which I shall shorten to "MCS". He will, therefore, not regain capacity at any time.

4 It thus falls to the Court to make a decision in the best interests of RS as set out at s.1(5) of the Mental Capacity Act 2005 and in making a best interests decision the matters that the Court shall take into account are set out at s.4 of the Act and I will refer now just to some of the subsections.

5 The court making the determination must consider all the relevant circumstances and, in particular, by subsection (5):

> "Where the determination relates to life-sustaining treatment [the court] 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".

By subsection (6):

> "[The court] must consider, so far as is reasonably ascertainable"

and I stress those words "reasonably ascertainable"-

> (a) the person's past and present wishes and feelings …
>
> (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".

Then at subsection (7):

> "[The court] must take into account, if it is practicable and appropriate to consult them, the views of –
>
> (a) anyone named by the person as someone to be consulted on the matter in question …
>
> (b) anyone engaged in caring for the person or interested in his welfare".

6 It is unnecessary in this case for me to enter into a lengthy review of the law. The leading authority is the Supreme Court case of *Aintree University Hospitals NHS Foundation Trust v James & Others* [2013] UKSC 67 and I shall refer to several paragraphs that are particularly important. At paragraph 35:

> "The authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive. As Sir Thomas Bingham MR said in the Court of Appeal in *Bland*, 'A profound respect for the sanctity of human life is embedded in our law and our moral philosophy'. Nevertheless, they are also all agreed that this is not an absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment".

Paragraph 36 starts with these sentences:

> "The courts have been most reluctant to lay down general principles which might guide the decision. Every patient, and every case, is different and must be decided on its own facts".

Then at paragraph 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".

Finally, paragraph 45:

> "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".

7 In *Salford Royal NHS Foundation Trust v P* [2017] EWCOP 23 where Mr Justice Hayden at paragraph 29 summarised the applicable principles which include

> "(v) It is incumbent on the court fully to investigate and consider the values and beliefs of the patient as well as any views the patient expressed when she had capacity that cast light on the likely choice the patient would have made and the factors that the patient would have considered relevant or important".
>
> (vi) "Where the patient's views can be ascertained with sufficient certainty, they should generally be followed … or afforded great respect … though they are not automatically determinative. '… if the decision that P would have made, and so [his] wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life. … the "sanctity of life" or the "intrinsic value of life", can be rebutted … on the basis of a competent adult's cogently expressed wish".

8 Against that legal background I turn to the undisputed evidence as to the condition and prognosis of RS. RS remains in a coma. He was examined on 5 December 2020 by Dr Bell, Consultant in Intensive Care and Anaesthesia at Leeds General Infirmary. Dr Bell was instructed by the Official Solicitor and his assessment was carried out by way of a 45 minute video assisted by Dr W to whom I shall return. Apart from short lived phases of partial eye opening, RS made no spontaneous movement. There was no response when his name was called or to loud hand claps. When his eyes did open there was no evidence of focusing or tracking and no blink reflex to a visual threat. There were no characteristic facial features of discomfort or distress during what would to a feeling person be a painful stimulation. Extreme flexion of RS's limbs did not generate any resistance or features of discomfort. The treating team have not been able to identify any features of discomfort or distress or pleasure at any time during his admission to hospital.

9 Dr Bell's analysis of more frequent eye opening than before is that it is suggestive of a potential conversion from coma to a vegetative state, but, says Dr Bell, and it is undisputed, he has not yet reached a vegetative state. At the best, says Dr Bell, RS might progress to the lower end of MCS. The fact that after one month there has been such limited emergence from coma means that there is likely to be very little more by way of recovery.

10 Dr Bell thought that at best there was a 10 to 20 per cent chance that in his MCS RS would be able to acknowledge the presence of a human being, being part of a base test to which his wife refers and to which I will return, but there would be no means of knowing whether (1) it is a response to a particular person or simply to someone, anyone, for example, holding his hand and (2) whether the response was meant to signify any particular emotion, whether it be distress or pleasure or something else. Dr Bell was dubious that this state would be reached as his low prognosis indicates. He said that nothing will restore any level of functionality to RS.

11 Dr W, the treating Consultant in Intensive Care Medicine, did not significantly disagree with Dr Bell, but thought that Dr Bell was being optimistic in suggesting that there was a 10 to 20 per cent chance of either reaching MCS or that the reaction indicated above might be

achieved. He predicted that RS will reach a vegetative state and is in the process of transition to that now from his state of coma, but that his chances of reaching a low level MCS were not as high as Dr Bell put them.

12 It is important to stress at this stage that moving from a vegetative state to a minimally conscious state is not a dramatic event. They are part of a spectrum. So far as life expectancy is concerned, if preserved with his current treatment RS could survive up to five years or more. With the removal of a ventilator he would be likely to be able to breathe unassisted, but in the event of the removal of nutrition and hydration he will die within a matter of a couple of weeks.

13 Both Dr Bell and Dr W referred me to a couple of matters which I think are not of particular relevance. Dr Bell referred to the test that he applies to define a "meaningful quality of life" at para.4.9 of his report which I shall read. He says:

> "I define the threshold of a 'meaningful quality of life' as requiring three elements to be satisfied; namely (1) for the individual to have an awareness of the environment and their own existence or the realistic prospect of regaining such awareness; (2) for that individual to derive pleasure from some aspects of their life to a degree that was not overshadowed by obvious discomfort or distress; and (3) for that person to be able to consistently communicate feelings of pleasure or discomfort in some way".

Applying those tests, he concludes that RS will never achieve a meaningful quality of life. I accept that RS will not satisfy any of the three tests, but I question where they get the court. That Dr Bell or the treating team or the court might regard a life as lacking a meaningful quality does not determine the outcome.

14 Likewise, I do not think that Dr W's expression of view of the distress at keeping alive a patient with no prospect of meaningful recovery causes to the treating team is one that can influence my decision.

15 The focus of this case has very much been as to whether RS has expressed an ascertainable view as to how he would wish to be treated in his current situation and, if so, what it is. Everyone agrees that he has never said how he would like to be treated if he were to find himself in his exact current situation and, indeed, I have been told very few patients do express such a detailed wish in advance. His views have to be inferred from what he said to others about situations which bear relevance to his predicament.

16 This has been an acutely uncomfortable situation for everyone as they try to come to terms with the fact that a much loved family member, even if kept alive, will never be anything remotely like the one they knew just over a month ago and this very sad situation has been exacerbated by what is plainly a deep family rift which has emerged over the last decade and, indeed, probably since before RS's marriage to his wife some 17 years ago. The issue is focused around RS's religious faith, his adherence to the tenets of the Catholic religion and their application in these circumstances.

<u>The birth family</u>

17 I heard oral evidence from RS's niece, but I have also read statements and attendance notes of conversations with his mother and two sisters. They describe RS's devotion to his birth family, his compassion for his grandmother when she had Alzheimer's disease and for his

father with cancer. He was clear that they should be cared for and have a chance of life. He expressed his disagreement with a widely reported case in England where the decision was to terminate the medical treatment for a very small child born with serious abnormalities. They say that he was religiously conservative, opposed to abortion, even for an unborn child likely to be medically compromised and opposed to euthanasia.

18 It was a matter of upset to him that he and his wife were unable to obtain an annulment of her previous marriage and thus marry in church and that thereafter he was unable to take Holy Communion. That many Catholics would not stop taking Communion in such circumstances shows, they say, his adherence to his religion. Taking all these factors together, they say, would show that he would not want his life terminated if it could be sustained. The preservation of life would outweigh all other factors in his thinking.

19 As an adjunct to this, they add that it is too early to take a decision and I have been referred to the guidelines issued both by the Resuscitation Council and by the Royal College of Physicians to Prolonged Disorders of Consciousness (PDOC) following sudden onset of brain injury. I have read the relevant passages of both documents, well-known as they were to the medical professionals. The guidelines are just that. They are guidelines, but each case is case specific.

20 The Royal College Guidelines are for use for those who have, or may have, a capacity for recovery. For the subset of patients for whom there is uncertainty about the nature of their injury they set out a valuable template, but for the vast majority of those with a catastrophic brain injury and who show no evidence of progress within five days, let alone no meaningful recovery within what is now more than five weeks, a confident prognosis can be made as the Resuscitation Council guidelines make clear. Doctors would not and do not commit patients to a range of intrusive tests when they are making no improvement after such a catastrophic injury. In this case the nature of the prognosis is such that no further investigations are needed and I accept entirely the evidence of Dr Bell and Dr W to that effect. The Royal College guidelines are not for those who are still in a coma over a month after the event.

21 There has been relatively little contact in recent times between RS and his birth family. It is not necessary to go into any reasoning. RS has not seen his sister and her children who live in England since about 2011 and he has had little contact with his mother and sister in Poland, speaking to them on the phone from time to time, the frequency of which is in dispute, and seeing them for brief periods only on his relatively infrequent holiday trips to Poland.

His wife

22 RS's wife gave evidence to me and has subsequently written to the court, as I told the parties she had. Unsurprisingly, it has been an immense strain for her. RS and she had been married for 17 years. She described how much of a family man her husband was. He loved nothing more than to be with his family and they were the most important people in his life.

23 He was a religious man, going to church at least once a month and would have gone more often if his shift work permitted it. But, as his wife said, it did not mean that he, certainly by 2020, adhered strictly to all aspects of the doctrine of his faith. He had married her, a divorcee. He pursued their relationship in the full knowledge of her status and they began their family life before marrying in a registry office. It was particularly hard for her to read and to listen to what the birth family were saying, because their involvement in his life over the last decade had been so limited.

24 She told me how he had said that he never wanted to be a burden if he was seriously ill and she felt also that he would not want his children to see him in his current condition, but they should remember him as an able bodied person. She recalled him saying that every life is precious and that you must hold on to life and also that if anything happened to him he would want all steps to be taken to save him, but that if he was beyond saving he did not want to be kept alive. She believed that he would not regard removing treatment as removing life.

25 She said that she and the children said goodbye to him after a week when it became clear that no improvement was at all likely and it has caused them great anguish that this situation has endured and the children could not comprehend why it was continuing. She said that the bare minimum recovery that could justify keeping RS alive would be one where he could interact with her and the children even if just to squeeze their hands or move a finger to acknowledge their presence. This was said to the Official Solicitor's representative before she had heard the doctor's evidence that the very best recovery that might be achieved was one where her husband might be able to respond to her touch but not in a way that could indicate whether or not he knew who she or the children were. She says that she knows in her heart that he would never want to be kept in his current condition and that he would want his children to remember him not as he is now, but as he was before his accident.

26 I have considered whether or not I can ascertain RS's wishes. I have reached the view that they can be ascertained from what his wife reports him as having said and I am satisfied when he said to her, as I accept he did, that he did not want to be kept alive if he could not be saved and that he never wanted to be a burden if seriously ill he was expressing a wish that he would not want to be kept alive in a state which provides him with no capacity to obtain any pleasure and which is so upsetting to his wife and children.

27 I place much greater weight on what his wife says, because over the last decade and probably the previous decade before that she has known him so much better than anyone else. I do not accept that his religious beliefs make him unlikely to have said what his wife says that he said, and nor do I feel that she was putting any form of impermissible gloss on what he said.

28 Having religious beliefs does not answer the question in this case. The fact of his beliefs does not mean that he would regard his current situation as acceptable or that he would wish to be kept alive whether in a coma, vegetative state or a minimally conscious state minus.

29 I, of course, give strong weight to the sanctity of life, but it is not the deciding factor. I give weight to what I find his views to have been, but on their own they too are not conclusive. I have to ask myself what is in RS's best interests in the light of his wishes as I found them to be. I am sure he would have taken into account the views of his family but especially those of his wife and children and the impact that his condition has on them, namely a situation which brings them huge sadness and a memory of RS so very different to that which he would have wished.

30 I much regret that the court has to make this decision for the family and I regret the stress that it has caused to its members. I fully appreciate that everything people have said to the court has been said out of love for RS and wishing the best for him and an outcome which would meet what they would believe his wishes to be.

31 I have had to weigh a range of divergent and competing factors. In this case, and not putting them in order of importance, I have particularly considered:

i) The prospects of obtaining a life that could bring RS any semblance of pleasure and quite how low those prospects are.

ii) The sanctity of life encompassing with it religious beliefs.

iii) The balance between pleasure and distress and the evidence of Dr Bell that patients with very limited ability to show any emotion more often show distress than pleasure.

iv) The views of others near and dear to him and in particular those nearest and dearest to him, his wife and children.

v) His views so far as I have been able to ascertain them, which is the most important factor of all.

32 All these weigh in the balance of best interests. What other people might wish for themselves in such cases is completely immaterial. If RS were able to make decision for himself in his current predicament, I am satisfied that he would not wish his life to be preserved.

33 I find that the course that he would want to be taken is the course which in this case is that which is in his best interests. I therefore grant the declaration. It is for the Trust and RS's wife to decide between themselves whether hydration is to be withdrawn. In respect of that my order is permissive rather than mandatory.

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CERTIFICATE

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Official Court Reporters and Audio Transcribers
5 New Street Square, London, EC4A 3BF
Tel: 020 7831 5627 Fax: 020 7831 7737
civil@opus2.digital

This transcript has been approved by the Judge.