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

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IN THE COURT OF PROTECTION
[2018] EWCOP 39

No. 13301639

Royal Courts of Justice
Strand, London, WC2A 2LL

Thursday, 30 August 2018

Before:

MR JUSTICE KEEHAN

B E T W E E N :

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST — Applicant

- and -

HB (by her Litigation Friend, the Official Solicitor) — First Respondent

- and -

FB — Second Respondent

REPORTING RESTRICTIONS / ANONYMISATION APPLIES

MR J MCKENDRICK QC (instructed by Bevan Brittan LLP) appeared on behalf of the Applicant.

MR S MATTHEWSON (instructed by the Official Solicitor) appeared on behalf of the First Respondent.

MS N KHALIQUE QC (instructed by Higgs & Sons Solicitors) appeared on behalf of the Second Respondent.

J U D G M E N T

MR JUSTICE KEEHAN:

Introduction

1 This is an application by the University Hospitals Birmingham NHS Foundation Trust, dated 23 August of this year, for an order that it is in the patient's best interests and lawful to receive the treatment set out in Part 1 of the updated treatment plan, dated 28 August 2018, and that it is not in her best interests and not lawful to receive the treatment set out in Part 2 of the plan.

2 The patient is HB. She is the first respondent. She lacks capacity to litigate and is represented in these proceedings by the Official Solicitor. The second respondent is FB, one of HB's eight children. She effectively represents the views and wishes of her brothers and sisters. The Official Solicitor and HB's children consent to the orders sought by the Trust in Part 1 of the updated treated plan but oppose the orders sought in Part 2 of the treatment plan.

Background

3 HB, who is 61 years of age, collapsed at home, having suffered a cardiac arrest, on 17 July 2018. She has a history of diabetes, high blood pressure, high cholesterol and chronic kidney disease. On admission to hospital, her Glasgow Coma Score was assessed as 3 out of 15. She was intubated and transferred to the intensive care unit for supportive care. Over the following 24 hours, she was sedated. An EEG was performed on 20 July to assess the degree of her brain function and demonstrated that HB's brain cortex was not functioning and she had not reacted to external stimulus. These findings were consistent with HB having suffered a severe encephalopathy. There was no evidence of ongoing seizure activity. The prognosis is said to be very poor.

4 By 2 August 2018, HB's Glasgow Coma Score remained at 3 out of 15. Her organ function was preserved but her brain had suffered irreversible hypoxic injury. It is a cortical injury with some evidence of brain stem dysfunction. Her diagnosis is vegetative state. A diagnosis of permanent vegetative state cannot be made until six months have elapsed since the index event. Early on, she was successfully treated for a potential chest infection.

5 In July a clinical decision was made to place a "Do Not Resuscitate" note in HB's medical notes. There is an issue between the Trust and the family whether they were notified of this decision, but it is agreed I do not need to resolve that dispute for the purposes of this application.

6 The treating clinician sought a second opinion from a Professor of Intensive Critical Care Medicine, a Consultant Intensivist, and Professor of Neurology, a consultant neurologist. Both agreed that the prognosis of HB recovering any level of function was extremely limited. The Professor of Neurology, however, noted that 10% of patients did recover some level of awareness, albeit not functionality.

7 A best interests meeting was held on 13 August 2018, attended by members of the clinical team and members of the family. One of the clinicians present at the meeting, Professor of

Critical Care Medicine, is recorded to have said that, "HB values being alive, irrespective of her ability to function physically or not to have any mental capacity." It is noted that the family members present agreed with the Professor of Critical Care Medicine on this issue.

8 The outcome of the best interests meeting was summarised by the Intensivist Doctor as follows,

> "We therefore agree that our main therapeutic goal will be to facilitate her being able to be discharged to a neurological rehabilitation centre, such as Specialist Care Hospital. To this end, she will have a tracheostomy placed followed by a plan to liberate from the ventilator. Following 48 hours of continuous liberation from ventilation, she will be stepped down to HDU and then referrals to Specialist Care Hospital made. It was agreed CPR would not be performed in the event of cardiac arrest and a respect form is in the notes. In terms of escalation of all other forms of organ support, we emphasise this would probably do nothing to help her brain injury but said any decision to offer or not offer this would be fully discussed with them. As such, there is no pre-emptive plan to withhold giving such therapy. It is likely such decisions would require another formal best interests meeting to adopt a consensus."

9 HB subsequently and successfully underwent a tracheostomy and was breathing independently through the same. Overnight of 21/22 August, HB's condition deteriorated and there were indications she had pneumonia. She was commenced on a course of antibiotics to which she responded. The clinical team assert that HB's neurological status remains unchanged, with a Glasgow Coma Score of 3 out of 15.

10 HB receives two-to-one nursing care on the intensive care unit, which includes suctioning and the provision of personal care 24 hours a day. She is fed via a nasogastric tube.

11 A Consultant Intensive Care Medicine and Anaesthesia, HB's Consultant Intensivist, described her current condition in her statement of 28 August as follows:

> "HB has extensive co-morbidities. These include heart failure, diabetes and chronic renal failure. These co-morbidities significantly decrease her resilience and the likelihood of intervention being successful in the long term. Essentially, her body was already compromised prior to her cardiac arrest. Her reserves were already below that of the average person. Her cardiac arrest and subsequent hypoxic brain injury have only worsened this. An admission to critical care increases frailty in all situations. HB is now immobile and bed bound. All her muscle groups are profoundly weak, including respiratory muscles and those used to cough. The combination of these factors makes her particularly prone to infection. Repeated infections and invasive treatments, because of the physical impact that the treatments have on her body, will only worsen this prognosis. She is highly unlikely to survive repeated infections even with the provision of ITU care.
>
> HB's neurological condition remains unchanged. She opens her eyes, occasionally responds to pain. She cannot communicate and there is no evidence she has awareness of her surroundings. I have considered the evidence provided by HB's family of their view as to her response to them. HB has 24/7 nursing care. Having discussed this with the nursing team caring for HB around the clock, they do not

agree with the responses indicated by the family. I have reviewed HB's ICU charts, which monitor, amongst many other factors, her neurological observations and interactions, responses to family and staff. These do not support any level of awareness or responsiveness, as indicated by HB's family.

A small proportion of patients in HB's condition, up to 10%, may go on to gain some awareness by six months post-the index injury. Given her frailty as outlined above, there is a high chance she will not survive to this point. In my view, given these factors, it is highly unlikely that HB will fall within the 10% of patients who do neurologically improve. Any further insult, such as infection leading to multiple organ failure, will reduce the possibility of neurological improvement further due to the further detrimental impact on her brain. Even if HB were to be one of the 10% of patients who experience some improvement in awareness, the level of her neurological insult means that she will be totally dependent for all aspects of living. It is vanishingly unlikely that she will ever be able to live outside of a 24/7 nursing care environment. If she were ever able to be discharged from an acute hospital environment, she will not recover any meaningful level of function to the extent that she would be independently mobile, be able to eat and drink orally or communicate beyond a level of blinking.

HB has a very grave prognosis. It is only expected that HB's frailty and physiological complications will increase over time. In her current condition, she may suddenly and unpredictably succumb to infection, a cardiac arrest or a respiratory arrest, or she may simply soldier on for several weeks. I have described the imminent and medium-term physical risks above. In the long term, even if HB is able to survive for a longer period of time, she will ultimately die of pneumonia or other overwhelming infection due to her described frailty and dependency. This is even if she were to receive all invasive treatments. If she does survive, her physiological condition will remain unchanged, i.e. bed bound and highly dependent, continuing to make invasive ITU care highly likely to be unsuccessful. She has already succumbed to pneumonia and, in my opinion, it is only a matter of time before she suffers a further infection with increasingly serious consequences."

12 On the instruction of the Official Solicitor, Dr Danbury assessed HB on 24 August. In his report of 28 August, he set out his assessment as follows:

> "I consider that HB is frail. I would grade her Clinical Frailty Score as CFS 7. From what the clinical team have told me, I believe they may consider her CFS to be 8. I based my conclusion on her CFS on the clinical response she had made to antibiotics that were commenced for a hospital-acquired pneumonia on 22 August 2018 and my examination of her on 24 August 2018. It is my opinion that, based on my experience, the ICU literature and her CFS, it is more likely than not that she would die if she were to suffer a deterioration that required multi-organ support. For the same reasons, it is my opinion that it is more likely than not that she would not be able to be resuscitated should she suffer another cardiac arrest. Having a high CFS is associated with a reduction in the likelihood of surviving critical illness and of making a good functional recovery, even if survival occurs. Probability of survival is not the same as whether a treatment can be considered to be in an individual's best interests to receive it."

13 A little later, towards the end of his report, Dr Danbury concluded with the following words:

"This is not to say that she will make a full recovery and it is my opinion that she is highly likely to be fully dependent on carers for all activities of daily living for the rest of her life. However, it is my opinion that it is too early to predict the extent of HB's recovery, taking into account the national guidelines on the diagnosis of prolonged disorders of consciousness. In my experience of managing patients similar to HB, I have experience of several making a marked neurological improvement over the course of several months."

14 Part 1 of the updated treatment plan sets out the following:

"(1) The tracheostomy will be downsized within the next 24 to 48 hours, clinical condition permitting.

(2) Her arterial line will be removed. This is accordance with best practice to minimise the risk of infection.

(3) Following the conclusion of her current course of antibiotics, her intravenous line would be removed.

(4) Plans will be make for the transfer to the respiratory ward, with a tracheostomy tube in situ, where she will be under the care of Consultant, Respiratory Medicine.

(5) HB will be referred for a neuro-rehabilitation opinion from Specialist Care Hospital.

(6) Ward-based care will be provided by the medical team. This includes nursing care, continued administration, nutrition, hydration and medication through her NG tube; physiological and neurological monitoring, continued tracheostomy care and monitoring suction for secretions. If she were to develop any condition which required non-invasive treatment, which would be delivered through intravenous lines, such as antibiotics or fluids, this would be provided subject to the clinicians being able to site an intravenous line."

15 Part 2, as I term it, of the treatment plan provides as follows:

"(1) In the event of a further cardiac arrest, no attempts at cardio-pulmonary resuscitation will be undertaken.

(2) In the event that HB's renal function deteriorated, renal replacement therapy will not be initiated.

(3) No invasive monitoring, such as arterial or central venal pressure measurement, will be undertaken.

(4) No vasoactive drugs will be administered to support her blood pressure.

(5) Not for further ventilatory support in the event of deterioration.

(6) Following HB's transfer from ITU, HDU to ward, HB will not be considered for readmission to critical care in the event of deterioration.

In the case of (1) to (6) above, the consensus view in each case is that such interventions would be futile because they will not change, treat, cure or alter her underlying brain injury. They would have no prospect of allowing HB to resume a meaningful quality of life and would, in each case, impose burdens upon her in terms of loss of comfort and dignity that could not be balanced against the benefits they could produce."

16 This matter was originally listed for directions before Moor J on 22 August and again on 24 August when the matter was listed for this hearing.

The Law

17 I am immensely grateful to leading counsel for the Trust, leading counsel for FB, and counsel for the Official Solicitor for their very helpful submissions on the issues of the law to be applied in this case. I have regard as my starting point to the observations of Lady Black at para.92 in the case of *An NHS Trust & Ors v Y* [2018] UKSC 46, where she said as follows:

> "Before turning to the central questions in the case, it is worth restating the basic position with regard to medical treatment, because it is upon this foundation that everything else is built. Although the concentration is upon the withdrawal of CANH, it must be kept in mind that the fundamental question facing a doctor, or a court, considering treatment of a patient who is not able to make his or her own decision is not whether it is lawful to withdraw or withhold treatment, but whether it is lawful to give it. It is lawful to give treatment only if it is in the patient's best interests. Accordingly, if the treatment would not be in the patient's best interests, then it would be unlawful to give it, and therefore lawful, and not a breach of any duty to the patient, to withhold or withdraw it. For a recent authoritative statement to this effect, see the *Aintree* case, although I would add that if a doctor carries out treatment in the reasonable belief that it will be in the patient's best interests, he or she will be entitled to the protection from liability conferred by section 5 of the MCA 2005. It is also important to keep in mind that a patient cannot require a doctor to give any particular form of treatment, and nor can a court."

18 I of course have regard to s.4 of the Mental Capacity Act in determining best interests. By s.4(2), best interests are not confined to best medical interests but the person making the determination must consider all of the relevant circumstances. In the case of *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, the Supreme Court emphasise that, when considering the best interests of this particular patient at this particular time, decision makers had to look at her welfare in the widest sense, not just medical but social and psychological. They had to consider the nature of the medical treatment in question, what it involved and its prospects of success. They had to consider what the outcome of that treatment was likely to be. They had to try to put themselves in the place of the individual patient and ask what her attitude to the treatment was or would be likely to be

and they had to consult others who were looking after him or interested in his welfare, in particular for the view of what their attitude would be.

19 By s.4(6) of the 2005 Act, I have to have regard to the patient's own past or present wishes. I am reminded in relation to the case of *Trust A & Anor v H* [2006] EWHC 1230, which found that the court is not tied to the clinical assessment of what is in a patient's best interests and it will reach its own conclusion on the basis of careful consideration of all the evidence before it. Best interests is an objective test.

20 In determining the best interests of an incapacitated adult, the court will adopt the balance sheet approach, as explained by Thorpe LJ in *Re A (Male Sterilisation)* [2000] 1 FLR 549. When considering the best interests of a patient, the court must assess the advantages and disadvantages of the various treatment management options, the viability of each option and the likely effect that each would have on the patient's way and enjoyment of her life. Any likely benefit of treatment has to be balanced and considered in light of any additional suffering the treatment option would entail. There is a very strong presumption in favour of taking all steps which will prolong life. Save in exceptional circumstances or where the patient is dying, best interests of the patient will normally require such steps to be taken. If there is doubt, it is to be resolved in favour of the preservation of life, *R (Burke) v General Medical Council, Official Solicitor intervening,* [2006] QB 273.

21 I was helpfully referred to the Code of Practice, in particular paras.5.29 to 5.36 and, of particular importance, to para.5.31, which provides:

> "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."

22 I was further referred to various passages of the decision of the Supreme Court in the *Aintree* case and, in particular, to para.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*, at p 808, '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."

23 Later, at paras.39 to 41, the court said as follows:

> "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.

40. In my view, therefore, Peter Jackson J was correct in his approach. Given the genesis of the concepts used in the Code of Practice, he was correct to consider whether the proposed treatments would be futile in the sense of being ineffective or being of no benefit to the patient. Two of the treatments had been tried before and had worked. He was also correct to say that 'recovery does not mean a return to full health, but the resumption of a quality of life which Mr James would regard as worthwhile'. He clearly did consider that the treatments in question were very burdensome. But he considered that those burdens had to be weighed against the benefits of a continued existence. He was also correct to see the assessment of the medical effects of the treatment as only part of the equation. Regard had to be had to the patient's welfare in the widest sense, and great weight to be given to Mr James' family life which was 'of the closest and most meaningful kind'.

41. Perhaps above all, he was right to be cautious about making declarations in circumstances which were not fully predictable or fluctuating. The judge was invited to address the question whether it would be lawful to withhold any or all of these treatments. But if he had been asked the right question, whether it would be in the patient's best interests to give any or all of them should the occasion arise, his answer would clearly have been to the same effect. He would have said, as he was entitled to say that, on the evidence before him, it was too soon to say that it was not. That conclusion is quite consistent with his statement that 'for what it is worth' he thought it unlikely that further CPR would be in the patient's best interests."

24 Finally, at paras.43 and 44, the court said:

"43. Thus it is setting the goal too high to say that treatment is futile unless it has 'a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering'… Given its genesis in *Bland*, this seems the more likely meaning to be attributed to the word as used in the Code of Practice. A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability. The Intensive Care Society and the Faculty of Intensive Medicine, who have helpfully intervened in this appeal, supported the test proposed by Sir Alan Ward. But this was because they believed that it reflected clinical practice in which '"futility" would normally be understood as meaning that the patient cannot benefit from a medical intervention because he or she will not survive with treatment'…

44 I also respectfully disagree with the statement that 'no prospect of recovery' means 'no prospect of recovering such a state of good health as will avert the

looming prospect of death if the life-sustaining treatment is given'. At least on the evidence before the judge, this was not, as Sir Alan Ward put it, a situation in which the patient was 'actively dying'."

Evidence

25 I heard evidence from Consultant, Intensive Care Medicine and Anaesthesia, who is a very experienced consultant in intensive care medicine and anaesthesia and has been the lead of the clinical team caring from HB. Consultant, Intensive Care Medicine and Anaesthesia was at pains to make the point that the Trust were not proposing to withdraw all care from HB – she would receive her nursing care and be looked after – but said the Trust wished to put ceilings on the treatment plan; that is not to provide her, as set out in Part 2 of the updated treatment plan, with treatment which, in the view of the Trust, would necessarily be invasive and would be burdensome. Consultant, Intensive Care Medicine and Anaesthesia was also at pains to make the point that those interventions would have no impact or effect upon the underlying severe brain injury that HB suffers from. She asserted that she and the Trust had had full regard to the wishes and feelings of HB and of the family in coming to their assessment of best interests.

26 I then heard evidence from FB. She gave very moving evidence of discussions that she had had with her mother prior to her admission to hospital on 17 July. This discussion arose because of a previous admission to hospital that HB had had to endure and which brought to her mind that it was time for a lasting power of attorney to be drafted. The lasting power of attorney was in favour of FB and FB in evidence told me that her mother had said to her that were she to become ill again, that she would want all possible steps to be taken to keep her alive. I have no doubt that FB is accurately reflecting the views that her mother conveyed to her. Those views are entirely in keeping with HB's religious and cultural beliefs. She is a practising Muslim.

27 It is also significant, and a matter to which I give weight, that, very sadly, HB's husband died from a heart attack about 12 years ago. His death and the manner of his death had a significant impact not only on HB but upon all of the children of the family.

28 FB and some of her siblings have reported and told Dr Danbury of changes that they have noted in their mother's interaction over the course of the last few weeks. As I have already mentioned, Consultant, Intensive Care Medicine and Anaesthesia and the clinical team do not accept that there has in fact been any change or any improvement in HB's neurological functioning since her admission to hospital.

29 Dr Danbury gave evidence this morning by telephone. He agreed that HB had suffered a very serious brain injury, that her prognosis is poor. The prospect of any effective improvement in her neurological condition is similarly poor, but, importantly, Dr Danbury told me that in his clinical experience it was at this stage too early to determine whether and to what extent HB would make any neurological improvement. He gave the example of two of his patients who suffered similarly as HB. One made no improvement at all. The other, over a period of six months, Dr Danbury met as he was walking through his hospital. Dr Danbury further said in evidence that if ten patients were put before him each suffering from the same brain injury as HB, in this timeframe he would not be able to predict who would make no recovery whatsoever and would die, and which of them would make some recovery from their current condition.

30 In those circumstances, Dr Danbury did not support the application by the Trust to not give the treatment set out in Part 2 of the treatment plan, numbers (1) to (6).

Analysis

31 In my judgment, FB and her siblings have been entirely genuine in what they have reported that they have seen, albeit it has not been noticed or detected by the clinicians. But, as I indicated during the course of submissions, I propose to proceed on the basis that there has been no change or improvement in HB's neurological condition. She is plainly very poorly. She is plainly very fragile. It is clear that she has suffered a very significant and serious encephalopathy which has left her in a poor medical condition, but she has survived thus far two episodes of infection.

32 When considering what is in HB's best interests, I take account of the fact that the balance of medical evidence would support the view that the treatment set out in the second part of the treatment plan would bring about no significant improvement in HB's underlying condition and, to that end, they might be seen as futile. I accept that those treatments set out in part 2 of the treatment plan numbers (1) to (6) would be burdensome treatments for her to receive because they are either invasive or, in the case of cardiopulmonary resuscitation, it is a violent treatment.

33 Against that, I have to balance the very clear wishes, expressed by HB to her daughter, that she would want all steps taken to preserve her life and, as Professor of Critical Care Medicine mentioned at the best interests meeting, even if that meant that further continued physical incapacity, or indeed a lack of mental capacity.

34 I am satisfied, within the meaning of the 2005 Act, that HB does not have the capacity to make decisions about her medical treatment. I accept that the quality of the care given by the Trust staff, both clinicians and nursing staff, has been of an excellent quality. I accept that the Trust, the clinical team, have taken all proper steps in their analysis of HB's needs and, indeed, seeking second opinions from Professor of Intensive Care Medical and Professor of Neurology. However, I accept the evidence of Dr Danbury that it is too early at this stage, just six weeks and two days post the cardiac arrest, to be clear as to whether HB will achieve any improvement in her neurological condition or not.

35 Where it is not clear whether HB will make an improvement in her neurological condition, it is, in my judgment, contrary to her best interests and premature to rule out the treatments set out in Part 2 of the updated treatment plan, numbers (2) to (6). In relation to number (1), that is cardiopulmonary resuscitation, this, Mr McKendrick QC tells me on behalf of the Trust, is the particular treatment that causes most concern to the medical staff. I have carefully reflected and considered whether it would be in her best interests for her not to receive CPR should she suffer a collapse or further cardiac arrest. Mr McKendrick submits that it would not be in HB's best interests that the potentially last moments of her life were lived with her undergoing the violent and invasive procedures necessary in providing CPR, that it would be a traumatic scene for her children to witness in her final moments.

36 I entirely accept those submissions and the force in them, but key to the decision must be the wishes and feelings of HB and it is plain that administering CPR in the event of a further collapse and giving her, albeit a very, very small chance of life, is what she would wish. In my judgment, at the moment, it remains in her best interests for that treatment to be

provided to her. I entirely accept that there will undoubtedly come a time when such treatments would no longer be in her best interests but I am entirely satisfied that that stage has not been reached yet.

CERTIFICATE

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