TRANSCRIPT OF PROCEEDINGS

Ref. 13376434

IN THE CIVIL AND FAMILY JUSTICE CENTRE AT BIRMINGHAM

33 Bull Street
Birmingham

NCN: [2019] EWCOP 21

Before MR JUSTICE COHEN

IN THE MATTER OF

ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

-v-

TG & OG

MS KATIE SCOTT instructed by DAC Beachcroft LLP on behalf of the applicant

MS SOPHIA ROPER instructed by the Official Solicitor on behalf of TG

MS DEBRA POWELL QC instructed by Bindmans LLP on behalf of OG

JUDGMENT
14th FEBRUARY 2019, 16.49-17.28
(AS APPROVED)

JUDGE'S NOTE: THIS JUDGMENT MAY BE REPORTED SUBJECT TO ANONYMISATION BY COUNSEL AND JUDICIAL APPROVAL OF IT

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MR JUSTICE COHEN:

1. I want to thank all three counsel for their contribution today and the excellence of their submissions, both written and oral. I want to thank the family who have shown enormous dignity throughout these proceedings and have participated fully in them and I am very grateful to them. I thank also Dr White and Dr Newman for their presence throughout today, Dr Newman for his evidence and Dr White for his reports.

2. It is agreed that the question I have to answer is whether or not it is in the best interests that intubation should continue or should not continue to be provided to a patient TG, who is an inpatient in the critical care unit of the Royal Bournemouth Hospital.

3. The background to the case is as follows. TG was attending church on 16th December 2018 when she collapsed, having suffered a massive subarachnoid haemorrhage. There were no indications that she had been in anything other than good health prior to this event. She then had a secondary cardiac arrest. For about five to seven minutes the seriousness of her collapse was not appreciated and thus only after that time was resuscitation started, initially by some nurses who were in the congregation and subsequently paramedics. It took about 15 minutes before the paramedics arrived, having been called only when the seriousness of the situation was appreciated and there was another 20 minutes or so of resuscitation in the course of which an endotracheal tube to maintain her airways was put in place.

4. Dr Newman has told the Court that brain damage normally starts after about four minutes from when the heart ceases to work, and it is plain that this lady suffered a far longer period than that. She was taken to hospital where the scans showed very extensive damage to her brain.

5. There is a host of medical evidence before me in the form of reports from Dr White, who is a consultant anaesthetist and he has provided two lengthy reports to the court; additional evidence has been provided by Dr Cossburn who is a consultant neurologist at Poole Hospital, by Dr Burn who is a consultant in rehabilitation and brain injury at Poole Hospital, and from Dr Wang and Mr Duffill who are members of the Wessex Neurological Centre at University Hospital Southampton. The medical evidence is now agreed as between them and Dr Newman, consultant neurologist, who was instructed pursuant to my direction, as a joint expert and who has both reported in writing and has given oral evidence today.

6. TG still has her endotracheal tube in place. She is attached to a ventilator but receives little support from it in the sense that it is not something that appears to be an important part of keeping her alive and it is anticipated that she will be likely to be

removed from it within the near future. The scans which have taken place and the EEG sequences show that TG has suffered severe cerebral dysfunction and that there is very extensive damage to the cerebral cortex. There are no wave patterns which suggest sentience. She is in a vegetative state at the moment. She has eye opening and blinking and has some movements to her right shoulder and neck area. It does not appear that her level of consciousness or the degree of responsiveness have changed significantly over the course of the eight weeks since her arrest.

7. Dr Newman says the clinical situation is very grim. It is now nearly two months since the insult to the brain and scans show a very gross abnormality. The chances of meaningful improvement are very small and there is no chance of meaningful recovery. By that he explained that there is a small chance of recovery to MCS minus which would be the best outcome. If that happened, she may be able to have awareness of pain but nothing more than minimal consciousness at a very low level.

8. There is, he says, no chance of her recovering to a stage of MCS plus, a level which might permit very simple vocalisation and answers to basic questions and the ability to recognise someone who was close to her. That would, at best, enable her to follow with her eyes or respond to pain or touch but he says, in this case there is no chance of that degree of recovery being reached. He says her memory will almost certainly completely have disappeared and her previous personality will not emerge.

9. His view, shared by the other professionals who have expressed their opinion, is that it is not in her best interests to continue with intubation and that nature should be allowed to take its course with the likely result of an early death.

10. Dr Newman expressed the view that if, contrary to his advice, intubation continued it would be preferable in the near future for discussions to take place with the family with a view to a tracheostomy, so that the breathing tube which she currently has, which as he described it, is a nine inch tube that goes from the mouth, down the larynx and into the trachea would be replaced by a small tube, two to three inches in length, cut into the throat that will go directly in the trachea and bypass the larynx and mouth.

11. If successfully done, that would enable, at least in theory, a range of other options for her care because at the moment she is confined and has been since admission to the critical care unit. If a tracheostomy succeeded then it may be that care in the community, either in a special nursing home or at home might become possible. If the tracheostomy became complicated and caused problems, that may mean that she would have to remain in hospital, albeit in a less acute unit.

12. The family has become persuaded, and I do not put it that way in any critical sense at all, that she is able to respond to people who are close to her and to prayers. That was tested so far as practicable by Dr Newman who saw her, not only on his own on two occasions but also for several minutes in the presence of her husband and later with two other members of family.

13. TG did indeed respond to a squeeze of a knuckle by Dr Newman but not to pressure on her temple and her eyes did open from time to time. Dr Newman's view was that

these were simply reflex actions rather than any form of conscious response. He says that if she did recover to a minimally conscious state minus, the only responses available to her would be likely to be to painful stimuli, which is another way of saying that she may possibly and only possibly regain an appreciation of pain or an ability to respond to environmental stimuli. Thus, says the health Trust, there is no benefit in the continuation of treatment except the fact that she will remain alive.

14. In assessing best interests I have to apply the provisions of section 4 of the Mental Capacity Act 2005 and the statute sets out various matters which the court must consider so far as reasonably ascertainable.

15. Those include under sub-section 6 (a) the person's past and present wishes and feelings and in particular any relevant written statement (but there is no written statement in this case); (b) the beliefs and values that would be likely to influence the decision if the patient had capacity and (c) the other factors that he/she would be likely to consider if able so to do. By sub-section 7 I must take into account, if it is practical and appropriate to consult them, the views of (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind and (b) anyone engaged in caring for the person or interested in the person's welfare.

16. The fundamental principle of the sanctity of life and so the very strong but not absolute presumption in favour of continuing TG's life is engaged. I must apply the best interests test which is widely defined going far beyond simply clinical best interests.

17. The starting point by way of authority was of course the case of Bland, reported as Airedale NHS Trust v Bland [1993] AC 789. I have been referred to many passages but that case needs to be seen in its context. It took place many years before the passing of the Mental Capacity Act. It concerned a young man who had suffered catastrophic damage three to four years before the case came to court. He was described as being at the extreme end of the persistent vegetative state. His father made it clear to the court that his son would not in the circumstances wish to have stayed alive.

18. There was no prospect of any improvement at all in his state and by analogy the Trust sought to persuade me that medical treatment should not be persisted with when it is futile and secondly, that the patient in this case, as in Bland, would be completely indifferent to the medical treatment, whether it continued or not and whether she remained alive or not. But that case needs to be seen on its facts. It was, of course, a case decided before the arrival of section 4 of the Mental Capacity Act, to which the individuals wishes, feelings, beliefs and values are central feature. Certainly, in the Court of Appeal judgments in Bland, Butler-Sloss LJ as a starting point, put at the centre self-determination, and I return to that in a moment.

19. The law has moved on since Bland and there are two other passage of the authorities of particular relevance. The first is paragraph 62 of Briggs (no. 2) [2017] 4WLR 37, where Mr Justice Charles said this:

"But in my view, when the magnetic factors engage the fundamental and intensely personal competing principles of the sanctity of life and of self-determination which an individual with capacity can lawfully resolve and determine by giving or refusing consent to available treatment regimes:

(i) the decision maker and so the judge must be wary of giving weight to what he thinks is prudent or what he would want for himself or his family, or what he thinks most people would or should want, and

(ii) if the decision that P would have made, and so their 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."

20. These matters were also considered in the case of Lambert v France [2000] 30 EHRR 346 (application number 46043/14), a judgment delivered by the European Court of Human Rights in June 2015. At paragraph 142 the court said this:

"In a case such as the present one, reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses. In Pretty the Court was not prepared to exclude that preventing the applicant by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life constituted an interference with her right to respect for private life as guaranteed under Article 8 of the Convention. In Haas it asserted that an individual's right to decide in which way and at which time his or her life should end was one of the aspects of the right to respect for private life."

21. The individual's wishes are a central feature in what I have to consider. But, before I turn to them, I want to deal with one or two further points in respect of the medical evidence. I accept the professional views and reject the family's suggestion that the movement of the patient's eyes or twitching of the shoulder were symptomatic of any emergence from her vegetative state and likewise that it was anything other than a reflex response, unconnected to external stimuli such as prayers or recognition of the family and I accept the medical evidence that any improvement in her state will be at best minimal.

22. I am satisfied that the issue of indignity is not one that features large in this case. I arrive at that conclusion for a number of reasons, first of all it is quite clear from the statements made by the family and friends that personal dignity is not something that featured large in TG's life or thoughts. Secondly, I am satisfied that the issue of pain is not one that impacts in this case as it is not felt by the patient. If pain does emerge, as it might if she were to regain a minimal degree of consciousness, that should be amenable to treatment with medication.

23. I turn now to the evidence filed on behalf of the family and what it tells me about TG's wishes and feelings and beliefs and values and I want to pay tribute to the drafting of the statements filed on behalf of the family which are extremely helpful and well set out.

24. I start, of course, with her husband and I have been struck particularly by paragraphs 25 - 31 of his statement, paragraphs 8 and 11 of her daughter's statement and paragraphs 9- 10 of that of her son. I am not going to repeat them verbatim in a published judgment but they are much in my mind. They have two principal strands: first, that if her presence was a comfort to others (as I find it to be) she would want to be there whatever the cost to her. Family was central to her and she would want to remain a part of the family no matter what form it would take for as long as possible. Secondly, she had the utmost respect for life because of its intrinsic value and that it was for no-one other than the Lord to take away. It is for Him alone to end and she would never accept anyone else facilitating death. I also take into account the statement of her friend M who had a discussion with her about Dignitas in the context of a programme on television and she recalls TG saying, "Why do people want to go?" before adding something like "They're not God and they don't know what will happen in the future." It is absolutely clear from everything that I have read that her Catholic faith and her belief in God were and are a crucial part of her life.

25. I agree with what Miss Roper on behalf of the Official Solicitor has said at paragraph 10 of her position statement that "This is compelling evidence that TG would not have consented to the endotracheal tube being removed and that she would have wanted to benefit from the opportunity to live and take whatever chance is offered, however small, of improvement in her condition. It also suggests that TG would not perceive the intensive care she is currently receiving as a loss of dignity but would accept it as part of God's plan and that she would not wish her doctors to take any active step to terminate that plan." I am satisfied that her wishes and feelings and beliefs and values are plainly for the continuance of life.

26. I am being asked to take today an irreversible decision that will lead inevitably to death sooner rather than later and probably within minutes or seconds of the tube being removed. I am being asked to do so in the face of what I find are the wishes and feelings of TG. I asked counsel if they were aware of any case in which the court has terminated life support against the wishes of the patient and they were unable to tell me that there ever was one; with the quality of expertise before me I am sure that there must therefore not have been such a reported case.

27. I also remind myself that I am being asked to make this decision just two months after the injury and I am referred to the Royal College of Physicians' guidelines and that in the case of a non-traumatic injury such as this, six months is required before a vegetative state is regarded as being permanent. In America a rather shorter period is allowed but it is still only two months into this six-month period and the Court is being asked to take this course when it is possible that TG might make some recovery and be able to return to live at home even if she would be unaware of the fact.

28. I have had to do what is sometimes called a balance sheet exercise. What on the one hand is the benefit of removal of the tube? First, it would be the end of the process which brings, or is likely to bring no significant benefit to TG. Secondly, it removes the possibility of indignity and/or pain. I do not think there is more to be put in that column.

29. On the other side there is the continuation of life; there is the recognition of her wishes for herself and for her family; thirdly, it enables her life to progress and be ended in accordance with the will of God; fourthly, it permits the possibility, faint though it may be, of some improvement in her state and fifthly, although this may be repetitious, it provides the ability for her to play a part in her family as she and they would wish, even though she would be unaware of it.

30. I have come to the clear decision that it is in the patient's best interests that intubation should continue. I recognise that this places a huge burden on the treating team. It is against their advice and their wishes and of course also those of Dr Newman but I remind myself constantly, this is her life and her wishes as I have found them to be and nobody else's. It may be that if the position were to remain the same in six months' time or no successful tracheostomy had been carried out that different considerations might apply but I am not looking at the future, I am looking at things as they are now and for those reasons I reach my decision and refuse the application.

We hereby certify that the above is an accurate and complete record of the proceedings or part thereof.

This transcript has been approved by the Judge