Neutral Citation Number: [2020] EWCOP 55

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 09/11/2020

Before :

Mr Justice Poole

- -

Between :

AN NHS TRUST	**Applicant**
- and –	
(1) AF **(By his litigation friend, the Official Solicitor)**	
(2) SJ	**Respondent**

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- -

Mr Vikram Sachdeva QC (instructed by an NHS Trust) for the Applicant
Ms Bridget Dolan QC (instructed by The Official Solicitor) for the First Respondent
Mr Peter Mant (instructed by MJC Law) for the Second Respondent

Hearing date: 30 October 2020

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Approved Judgment

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 patient and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Poole:

Introduction

1. AF is an 80-year-old man who suffered a severe stroke on 5 May 2016. A month later he had a Percutaneous Endoscopic Gastrostomy ("PEG") tube inserted which was used to give him Clinically Assisted Nutrition and Hydration ("CANH"). On 27 March 2020 Mostyn J held that AF lacked capacity to decide whether to continue to receive CANH via his PEG, and found that it was in AF's best interests for him to do so.

2. AF's case has come before this court because his PEG tube has fallen out. The Applicant NHS Trust seeks a declaration that it is in AF's best interests to re-insert the PEG tube. The Official Solicitor supports the application but SJ, AF's daughter, opposes it. At the hearing before me Mr Sachdeva QC appeared for the Applicant, Ms Dolan QC for the Official Solicitor, and Mr Mant for SJ. I am grateful to all the participants and representatives for their conduct of this case and wish to record particular thanks to Mr Mant who acted pro bono.

3. I heard this application on 30 October 2020 and gave my decision granting the application that day because of the need for a determination to be made immediately, but reserved this written judgment so that I could give my full reasons.

4. Following Mostyn J's judgment in *A CCG v AF and others* [2020] EWCOP 16, AF continued to live at his care home receiving CANH via his PEG without incident until on 28 August 2020 the PEG tube became blocked. After an overnight admission to hospital the blockage resolved and he was discharged back to the care home. On 9 October 2020 the PEG tube fell out. It is likely that the bumper which helped to keep the tube in place, failed due to wear and tear. AF was taken to the Emergency Department of the Applicant Trust's hospital and was admitted under the care of the gastroenterology team. A feeding tube was inserted, not for the purpose of administering hydration and nutrition, but to maintain the patency of the PEG tract. AF is able to consume food orally and sometimes does so, but with no gastrostomy in place he was not receiving sufficient nutrition to sustain life.

5. By order of the Mr Justice Williams on 16 October 2020, the feeding tube was removed and a balloon gastrostomy ("BG") inserted. AF was discharged back to the care home on 20 October 2020. A BG will typically last for about three months before having to be replaced.

6. On the day of the hearing before me AF was in hospital again. He had been admitted late on 28 October when very unwell with pneumonia. He was administered antibiotics and monitored. I heard evidence from Dr B, a Consultant Gastroenterologist who has assessed him clinically in hospital, that he was responding well to treatment and that it was likely that he would become clinically well enough to undergo re-insertion of a PEG tube towards the end of his current in-patient stay, within a few days. This would avoid the need to re-admit him on a subsequent occasion. Dr B was an impressive witness who gave clear, fair-minded evidence. She told me, under questioning by all parties, that the procedure to reinsert the PEG tube would be more straightforward than

the initial insertion because AF had a patent PEG tract. The procedure would therefore be similar to, and carry no more risk than, an endoscopic examination of the kind routinely undertaken for a biopsy. The risk of significant complications by way of perforation, aspiration or infection would be as low as 1 in 2000. It is a five-minute procedure, and is done under light sedation not general anaesthetic, such that the patient typically has no recollection of the procedure after it has been completed.

7. The advantage of a PEG reinsertion is that it will last usually for two to four years, it can be used both to continue CANH and the administration of medications that AF needs. A BG would need replacing every 3 months and whilst that can usually be done in the care home, it is, like the PEG re-insertion, an unpleasant experience for the individual undergoing it.

8. Dr B's clear evidence was that AF is in a good condition nutritionally and is physiologically robust such that when he recovers from his pneumonia, as she fully expects he will, it is likely that he will be fully restored to his pre-pneumonia condition. She would expect, other things being equal, that with continued CANH he could live for a few more years yet.

9. The PEG tube had been in place since 2016 and, as noted, they usually last for two to four years before requiring replacement. Therefore, in March 2020 it could have been expected that re-insertion would soon be required. However, the Court in March 2020 was not made aware of that expectation and therefore the order made did not expressly cover the need for reinsertion of the PEG tube.

10. The trust now invites the court to declare pursuant to section 15 of the MCA 2005, that

    1. It is lawful and in AF's best interests to undergo (1) insertion of a PEG and (2) any necessary ancillary procedures, and

    2. Such PEG insertion shall not be undertaken until such time as AF is in the opinion of his treating gastroenterology team medically fit to undergo the procedure and that exchanging his present balloon gastrostomy for a PEG is, in the opinion of his treating gastroenterology team, clinically indicated.

11. I should note that shortly after his most recent admission with pneumonia, a junior doctor decided, after consultation with the family, to put AF on an end of life pathway, Dr B told me that she would not have done so, but would usually wait for 24 to 48 hours to determine whether a patient was responding to antibiotics before making a decision of that kind. When she reviewed AF on the morning of 29 October he was responding well and, in consultation with the admitting consultant, but without discussion with the family, AF was taken off the end of life pathway. By the time of the hearing AF had had four to five doses of antibiotics, his C-Reactive Protein and white cell count were falling significantly, and the signs were that he would make a good recovery. Dr B advised that AF's pneumonia was probably unrelated to the failure of his PEG tube or the insertion of the BG. It was coincidental.

12. It is agreed by all, as it was before Mostyn J, that AF lacks capacity to make the decision under consideration.

13. SJ's case is that it is not in AF's best interests to have the PEG re-inserted or to continue to have CANH. She goes further, contending that it is not in AF's interests to receive any active treatment, including antibiotics, or even blood tests for the purpose of monitoring and investigation, and that it is in his best interests to be placed back on an end of life pathway as he briefly was overnight on 28th and 29th October 2020. In her evidence before me JS said that she thought that the balloon gastrostomy should now be removed.

14. By section 4 of the Mental Capacity Act 2005:

> **4 Best interests**
>
> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
>
> (a) the person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
>
> (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
>
> (3) He must consider—
>
> (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
>
> (b) if it appears likely that he will, when that is likely to be.
>
> (4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
>
> (5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
>
> (6) He must consider, so far as is reasonably ascertainable—
>
> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so.
>
> (7) He must take into account, if it is practicable and appropriate to consult them, the views of—
>
> (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
>
> (b) anyone engaged in caring for the person or interested in his welfare,
>
> …
>
> (10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
>
> (11) "Relevant circumstances" are those—
>
> (a) of which the person making the determination is aware, and
>
> (b) which it would be reasonable to regard as relevant.

15. AF did not make an advanced decision when he had capacity. SJ gave evidence as to AF's past wishes and feelings, beliefs and values before Mostyn J. In her evidence before me she made it clear that her evidence on those important matters has not changed.

16. In March 2020 Mostyn J received 929 pages of written evidence and heard oral evidence not only from SJ but from 10 other witnesses including from two experts in Neurological Rehabilitation, a Neuropsychiatrist, and a Palliative Care Consultant. He held that:

> "I am strongly satisfied on the evidence, although it is not all one way, that were CANH to be withdrawn AF would not take sufficient food and drink orally to sustain life and would, sooner or later (probably sooner) expire." [3]

And,

> "In making the best interests evaluation mandated by section 4 of the Mental Capacity Act 2005 I have clearly decided on the evidence it would not be in AF's best interests to discontinue CANH." [5]

17. As to AF's wishes and feelings, beliefs and values, Mostyn J recorded that AF had been described by his family as a "strong and fiercely independent man" whose "experiences in the NHS meant that he was familiar with disease and death" and who "stated on many occasions to those close to him that he would not want to be kept alive as a "body in a bed"." [18]. In evidence before me SJ described AF as doing nothing but lying in bed staring at the ceiling and said "you might as well put him in a cupboard" by which she meant that AF would not notice if that happened because his functioning is so severely compromised. After his stroke in 2016, AF had stated that he longed "to be dead" but Mostyn J found that at that time he did not have capacity [26]. Importantly Mostyn J found that, contrary to his daughter's views, AF "derives pleasure in a number of respects from physical and emotional stimuli" which included having his back washed, interacting with animals and children, listening to music and the radio, watching television, and having poetry read to him. He was capable of limited verbal communication and communicated effectively with eye contact and gestures.

18. Mostyn J concluded that it was unlikely that if AF

> "were granted a brief window of lucidity he would reach the conclusion that he would be better off dead rather than to continue with the limited life that he presently enjoys." [31]
>
> And,
>
> "I have reached the very clear conclusion that it would be categorically contrary to AF's interests for him to be set on the path that will lead to his inevitable death from starvation. This may be a diminished life, but it is a life nonetheless which has, I have said, intrinsic quality and from which AF derives pleasure and satisfaction." [32].

19. The judgment was not appealed. The question now arises as to the extent to which, if at all, my evaluation of AF's best interests should be circumscribed by the findings made by Mostyn J seven months ago. For the Applicant, Mr Sachdeva pointed to what he said was a "compelling analogy" with the approach approved by the House of Lords to a renewed application for readmission to hospital under the Mental Health Act 1983, soon after a mental health tribunal had ordered the discharge of the patient. In such circumstances the House of Lords held in *R(Von Brandenburg) v East London and The City Mental Health NHS Trust* [2003] UKHL 58, [2004] 2 AC 280, that:

- "the rule of law requires that effect should be loyally given to the decision of legally-constituted tribunals in accordance with what is decided." [8]

- "It is not therefore open to the nearest relative of a patient or an ASW [approved social worker] to apply for the admission of the patient … simply because he or she or they disagree with a tribunal's decision to discharge." [8]

- Although a tribunal making the original decision will have taken into account the "foreseeable future consequences of discharge" it is "not called upon to make an

assessment which will remain accurate indefinitely or for any given period of time." [9(3)].

- An ASW "may not lawfully apply for the admission of a patient whose discharge has been ordered by the decision of a mental health review tribunal of which the ASW is aware unless the ASW has formed the reasonable and bona fide opinion that he has information not known to the tribunal which puts a significantly different complexion on the case as compared with that which was before the tribunal." [10].

20. Mr Mant draws on a different analogy from Children Act proceedings. *In Re B (Children Act Proceedings: Issue Estoppel)* [1997] Fam 117, Hale J, as she then was, held that there was no

> "strict rule of issue estoppel which is binding upon any of the parties in children's cases. At the same time the Court undoubtedly has a discretion as to how the enquiry before it is to be conducted."

If a party wished to challenge a finding made in previous proceedings, the court would be anxious to know not only what the previous finding had been, but the evidence on which the finding had been reached.

21. Ms Dolan QC for the Official Solicitor commended an approach which flows from the Court of Protection Rules. The overriding objective within COPR 1.1 requires the court to deal with the current case in a way that is proportionate to the nature, importance and complexity of the issues and allocating to it an appropriate share of the court's resources. As Baroness Hale observed in *N v ACCG* [2017] UKSC 22 at [40]

> "The court's general powers of case management include a power to exclude any issue from consideration and to take any step or give any direction for the purpose of managing the case and furthering the overriding objective (rule 25(j) and (m)). It was held in *KD and LD v Havering London Borough Council* [2010] 1 FLR 1393 that the court may determine a case summarily of its own motion, but their power "must be exercised appropriately and with a modicum of restraint."

22. The parties' submissions overlap, and both principle and good practice point to the same approach to this application in which the court is being asked to make a best interests evaluation only a few months after another court has made a determination of best interests in respect of a similar decision, concerning the same P, and after a full hearing.

    a. There is no strict rule of issue estoppel binding on the court.

    b. Nevertheless, the court should give effect loyally to a previous judicial finding or decision that is relevant to the determinations it has to make, and should avoid re-opening earlier findings that cannot be undermined by subsequent changes in circumstances. An example would be a finding that P lacked capacity at a

particular point in time. Such findings, if not successfully appealed, should generally only be re-opened if new evidence emerges that might reasonably have led the earlier court to reach a different conclusion.

c. Where there has been no material change of circumstances subsequent to a previous judgment, no new evidence that calls for a re-opening of the earlier findings, and the earlier evaluation of best interests clearly covers the decision that the new court is being asked to consider, appropriate case management might involve the court summarily determining the new application.

d. Determinations of capacity and best interests are sensitive to specific decisions and circumstances, therefore the court will exercise appropriate restraint before making any summary determination.

e. If the decision or circumstances that the new court is being asked to consider are not clearly covered by the earlier judgment, or there has been a material change of circumstances or new evidence that calls into question the previous findings, the court should manage the case in a way that is proportionate having regard to the earlier judicial findings and decisions.

f. In dealing with the new application proportionately, the court's focus will be on what has changed since the previous ruling, and any new evidence. It should usually avoid re-hearing evidence that has already been given and scrutinised in the earlier proceedings.

23. In this case all parties pragmatically agreed that the failure of the PEG on 9 October 2020 was a material change in circumstances that had not been expressly contemplated by the court in March 2020, and that therefore the decision to re-insert the PEG was a new decision for the Court to consider. Similarly, there was no argument against approaching AF's recent hospital admission for pneumonia as a change in circumstances that required a best interests evaluation, in particular given SJ's position that treatment for it should cease. It might have been contended, but was not, that it was implicit in Mostyn J's determination that re-insertion of the PEG was in AF's best interests because it was necessary to ensure the continuation of CANH. The focus of the evidence before me was therefore on developments since Mostyn J's judgment and the parties sensibly agreed that I need hear oral evidence from only two witnesses, Dr B and SJ. Hence, I was able to hear this case within one day and to give my determination whilst reserving this judgment for the reasons I have given.

24. Nevertheless, Mostyn J's conclusions are highly material to my evaluation of best interests in relation to these new decisions. Indeed, it would be wrong in my judgment to re-open his findings that (i) AF had lacked capacity in 2016 when he made statements indicating that he wanted to die; (ii) as of March 2020 AF derived "pleasure and satisfaction" from his life; and (iii) AF's statements before his stroke, that he would not want to be kept alive as a "body in a bed", were not applicable to his condition in March 2020. Those findings cannot be altered by subsequent events and there is no new evidence to demonstrate they could now be challenged. I also give significant weight to Mostyn J's very firm conclusion that at the time of his judgment it was in AF's best interests to receive continuing CANH through his PEG.

25. The material changes in circumstances since March 2020 are that the PEG fell out due to wear and tear, a BG has been inserted as a temporary means of continuing CANH, and AF is currently an in-patient receiving treatment for pneumonia.

26. The new evidence I have received includes a statement from Mr James Beck of the Official Solicitor's office. On 27 October 2020, Mr Beck attended on AF by a WhatsApp video call, assisted by the care home manager, and spoke by telephone with five members of the care home staff. Mr Beck had also spoken with AF in February 2020 and found it much easier to engage with him on this occasion. Mr Beck asked him whether he wanted to continue to be looked after at the care home to which he appeared to nod "yes". AF was asked whether he was "OK with [the PEG] in your tummy?" to which he "appeared to nod in the affirmative." It is fair to note that on follow up questioning AF appeared to become confused and no reliable response could be elicited. The accounts of those who see AF daily were that he continues to enjoy listening to music and the radio, and having poetry read to him. He responds to these activities with evident emotion on occasions. He exercises choice, for example about whether to have the radio or television on, and at what volume, by using hand signals such as a thumbs up or thumbs down gesture. He enjoys watching films, especially cowboy films. He appears to remain attentive throughout a film and occasionally makes brief comments about them. On return to the care home from hospital on 20 October he gave fist bumps to members of staff. When Mr-Beck asked AF how he felt about being back at the care home AF responded with what "sounded like a very positive affirmation … I could hear a distinct laugh or chuckle which sounded joyful."

27. Very sadly JS has been unable to share in these kinds of interactions since she last saw her father in December 2019. She lives in Spain and the Covid-19 pandemic has prevented her from visiting him at the care home. She told me that arrangements for a video call, or similar, had been thwarted because the care home would not allow them to be conducted privately (this is not accepted by the care home). She gave powerful evidence to me about events in 2016 and her firm belief that her father had the PEG inserted at that time against his will. As she gave evidence it was painfully evident that she deeply mourns the loss of the man her father once was. However, for the reasons given, she cannot speak to his current condition and apparent wishes and feelings, however difficult they are to discern. The care staff and Mr James Beck were able to give the court up to date evidence. Their accounts add to the evidence that Mostyn J received that AF's situation is far from that of a "body in a bed" – the situation that, prior to his stroke, AF had said he wanted to avoid. AF's life is grossly diminished from the one he enjoyed before his stroke, but even so he has a life which appears to give him some stimulation and some pleasure. He gives no indications of being a man who wants to die or to resist being treated.

28. Taking into account all the relevant circumstances and the views referred to, I am quite satisfied that it is in AF's best interests to undergo re-insertion of a PEG and any necessary ancillary procedures and I declare that such PEG insertion shall not be undertaken until such time as AF is in the opinion of his treating gastroenterology team medically fit to undergo the procedure and that exchanging his present balloon gastrostomy for a PEG is, in the opinion of his treating gastroenterology team, clinically indicated. I am also quite satisfied that it is in AF's best interests to undergo active treatment for his current chest infection which, for avoidance of doubt, includes intravenous antibiotics and repeat blood tests.

29. The active treatment and proposed reinsertion of the PEG tube does not constitute aggressive treatment, it interferes only very modestly with his bodily integrity, it carries an extremely low risk of complications and it is highly likely to succeed in returning him to the condition he was in until 9 October 2020. AF shows no indication of wishing to die and as Mostyn J found, any past views he expressed about not wishing to be a "body in a bed" do not apply to his current condition which is of a man who, notwithstanding his grossly restricted existence, can take pleasure and stimulation from activities, culture, and human interaction.

30. The court cannot predict every treatment decision that may have to be made over the remainder of AF's life. However, all parties agree that there ought to be an ongoing care plan, in accordance with guidance from the BMA at section 2.7 of its document, "*CANH and adults who lack the capacity to consent – guidance for decision-making in England and Wales."* The Trust has agreed to write to the GP and CCG to inform them of this judgment and to ask them to use their best endeavours to ensure advance care planning now takes place, the CCG will be asked to put advance care planning on the agenda for the forthcoming best interests meeting that has been convened to determine whether AF should change GPs.