Neutral Citation no. [2007] NIFam 13 | *Ref:* **MOR7026**

Judgment: approved by the Court for handing down | *Delivered:* **21/12/07**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION

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OFFICE OF CARE AND PROTECTION

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IN THE MATTER OF PM

BETWEEN:

A HEALTH AND SOCIAL SERVICES TRUST

PLAINTIFF;

-and-

PM

-and-

THE OFFICIAL SOLICITOR

DEFENDANTS.

_____

MORGAN J

[1] This is an application for a declaratory judgment in respect of medical treatment which the plaintiff proposes to carry out on the first named defendant. The first named defendant objects to the carrying out of the treatment. The issues in this case concern the capacity of the first named defendant to consent and the approach that the court should take if it finds that he does not have that capacity. Nothing should be published which would identify the patient the subject of this judgment.

Physical illness

[2] PM is a 26-year-old man who developed acute renal failure at the age of 4 requiring dialysis support in the form of peritoneal dialysis. His mother came forward as a live donor and he received a successful renal transplant three years later in November 1988. He subsequently suffered acute rejection which only partly responded to an increase in treatment and he needed to return to peritoneal dialysis in May 1993. He received a donor transplant in December 1994 and thereafter he had normal renal function over a number of years.

[3] From in or about 1999/2000 there have been increasingly frequent non-attendances at the transplant clinic with deterioration in kidney function. His erratic attendance made adjustment in treatment and monitoring of his condition difficult. He had a period of inpatient care in a psychiatric ward during which his renal function remained stable. After discharge it became increasingly difficult to monitor his function because of his lack of co-operation. A blood sample taken in August 2005 showed substantial deterioration in kidney function. He agreed to an admission for a renal biopsy which showed acute rejection as well as chronic changes. He received a high dose of steroids over the next few months before he stopped attending reviews. In July 2006 there was substantial further deterioration and his blood sample in January 2007 showed only marginal improvement on that situation.

[4] He is at present an inpatient in a psychiatric ward. He agreed to blood sampling which showed the effects of very advanced kidney failure. He has a build-up of waste with a serum creatinine corresponding to 2% of normal kidney function. His urea corresponds to more than twice the levels seen in patients with end stage kidney failure attending for regular dialysis. There is a build-up of acidosis, low calcium, very high levels of phosphate accumulation and profound renal anaemia. He has a pale sallow appearance. There is some enlargement of his heart in keeping with his anaemia, high blood pressure and fluid accumulation. All of these features reflect his advanced kidney failure. I have heard evidence from Dr Nelson, consultant nephrologist, that unless he is treated by urgently commencing regular haemodialysis he will die within a period of weeks or months with slow deterioration. PM has refused that treatment.

Mental illness

[5] PM first presented with symptoms of a psychotic illness in September 2000. He has been under the care of a professor of psychiatry since then. He was initially treated as an inpatient and a diagnosis of schizophrenia was made. The psychiatrist, who also gave evidence before me, comments that PM never fully accepted this diagnosis and in particular would not accept the

diagnosis or the need for treatment during the first two years of his care. He eventually agreed to take a depot antipsychotic drug which he took regularly for around four years and was managed as an outpatient in supported accommodation. Recently he began to refuse this treatment and there was a deterioration in his mental state and his ability to properly care for himself.

PM's views

[6] The deterioration in his renal state was discussed with him during his psychiatric care. He refused to accept that he was developing renal failure stating that his kidney would last him for 40 years. This appeared to be a delusional idea and in view of the deterioration of his mental state and evidence of significant risk to his life as a result of this he was admitted as a detained patient to a psychiatric ward. He eventually agreed to permit blood tests which were necessary to monitor of his renal function and the safety of antipsychotic drug prescription. These blood tests indicated a significant degree of renal failure.

[7] The psychiatrist's evidence is that PM does not fully understand the nature of his kidney illness. He has some completely different view about his kidney as a result of which he does not believe that he is at risk of death. Although he can understand fairly complex information he has no comprehension of this issue. It is part of his neurosis that he does not accept that he has a problem with his kidney.

[8] I have been assisted by a report from the Official Solicitor who has been appointed Guardian ad Litem to represent the interests of PM. That report discloses that PM asserted categorically that he does not believe that he is going to die. He said that this was just something that he knew. He denied feeling ill at all. Although he asserted that he had been taking his medication he agreed that he had not attended outpatients in relation to his kidney for the last year. He indicated that he had agreed to blood tests, injections and being weighed since he had arrived in hospital on the basis that he would be given periods of leave to see his parents. He described how he had absolutely hated dialysis in the past although he noted that the doctors were now referring to a different type of dialysis. He asserted his belief that his tablets were sufficient to treat his condition and that he was not going to die. The Official Solicitor also interviewed his parents who have encouraged him to take the treatment. The naturally find themselves in a difficult situation because they also want to respect PM's views.

Capacity

[9] The relevant principles in relation to capacity or helpfully set out in Re MB [1997] 2 FLR 426. That dealing with lack of capacity provides as follows:

> " *A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when:*
> *(a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;*
> *(b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.* "

On the evidence before me the psychiatrist has demonstrated to a high standard that PM is unable to comprehend or retain the information communicated to him as to his present condition and the likely consequences of his not having the treatment proposed. It follows that PM is unable to use the information and weigh it in the balance as part of the process of arriving at a decision whether to accept the treatment. Accordingly I consider that PM is incapable of making the decision as to whether or not to consent to the proposed treatment.

The proposed treatment

[10] The treatment which the Trust proposes is set out in an amended schedule 1 to the Originating Summons herein.

> *" 1. The carrying out of assessments on the first named defendant by servants or agents of the plaintiff, including clinical assessments and the taking of blood and urine samples for testing and analysis and the performance of x-rays and ultrasound scans, such procedures being necessary to assess the first-named defendant's renal function and haematological condition.*
> *2. The insertion and maintenance of a central venous dialysis catheter which is required to facilitate regular haemodialysis.*
> *3. The administration of a local anaesthetic and/or sedation in order to facilitate the insertion of the central venous dialysis catheter.*
> *4. The insertion and maintenance of IV canulae which are required to facilitate the administration of such IV fluids, blood, blood products and drugs as are necessary for the purposes of carrying out regular haemodialysis and the insertion of the central venous haemodialysis catheter.*
> *5. The provision of pre-procedure care including the administration of IV fluids, blood, blood products and*

drugs and oral medication necessary for preparing the first named defendant for regular haemodialysis and the insertion of a central venous haemodialysis catheter.

6. The administration of sedation for the purposes of facilitating haemodialysis.

7. The performance of regular haemodialysis initially on a daily basis to stabilise the first-named defendant's condition and thereafter on a thrice weekly basis or with such regularity as is necessary to provide effective haemodialysis.

8. The provision of post-procedure care including the administration of IV fluids, blood, blood products and drugs and oral medication necessary to facilitate the first named defendant's stabilisation following regular haemodialysis and the insertion of a central venous haemodialysis catheter.

9. The administration of Erythropoietin (EPO) treatment. In a normal kidney, the hormone EPO is produced which stimulates bone marrow to produce red blood cells. Due to the first named defendants very advanced kidney failure, this hormone is not being produced in sufficient quantities and as a result he is suffering from anaemia. In order to combat anaemia, the first named defendant requires EPO treatment administered in the form of intravenous injections.

10. Vitamin D replacement therapy and phosphate binders administered in the form of oral medication to combat hypertension. "

[11] Dr Nelson indicated that PM's advanced kidney failure would best be treated by urgently commencing regular haemodialysis. He explained that the first step was to place a plastic tube in a large carotid vein, preferably the jugular. In order to do this the patient was required to lie flat on a couch. The vein would then be scanned with ultrasound. Local anaesthetic would then be applied and a needle through which a wire is passed would be inserted and a plastic tube placed over the wire. The procedure would take approximately 20 to 30 minutes. It would produce discomfort which he described as relatively minor typical of that sustained at the dentist. He explained that anyone undergoing this procedure might be anxious and a degree of sedation might be appropriate. The sedation would have to be carefully monitored to ensure that it did not interfere with breathing and the patient at all times could move if he wanted to.

[12] Once the catheter was in place it would be held in place with sutures and a dressing at the exit site. This is a temporary solution. In the longer term Dr Nelson would prefer provide a fistula usually in the arm or leg although half of patients use a catheter under the skin which runs less risk of

infection. This can be used for years if necessary. The procedure for a permanent catheter is slightly longer and more complicated than the insertion of the temporary catheter.

[13] After insertion of the catheter the next step would be the provision of dialysis initially every day for three to four days for a period of 4 hours. Dialysis would then continue for approximately 3 times per week averaging 4 hours per day. The patient would not be sedated during dialysis. All of the above procedures require the cooperation of the patient.

The risks associated with the treatment and its effect

[14] If the patient did not co-operate with the insertion of the catheter it would be dangerous to attempt to proceed and the Trust would not do so without further order. The reason for requiring the patient to lie flat is to prevent air getting into the vein. Once in place the temporary catheter exits outside the skin by 2 to 3 inches. It would be uncomfortable but possible for the patient to pull the catheter off taking the stitches out. If that happened there was a danger of bleeding and air entering the vein. Dr Nelson explained that this has happened accidentally and a fatal outcome is very rare. If in those circumstances it was necessary to renew the catheter one would need to establish if there was infection before reusing that site. One would usually use of a vein on the other side of the body.

[15] The use of any catheter always gives rise to the possibility of infection. In this case infection would raise the possibility of septicaemia and endocarditis. Dr Nelson also recorded that if the catheter was disconnected during dialysis at the exit point large amounts of blood might still be pumped out onto the floor causing risk to the patient.

[16] If PM undergoes the treatment Dr Nelson indicates that his kidney problems can be controlled. His father is anxious to give him a kidney by way of transplant. Dr Nelson anticipates that PM has the prospect of a long and healthy life in respect of his kidney difficulties if this occurs. I am satisfied on the basis of the evidence that the treatment proposed by Dr Nelson is the appropriate treatment for a person in PM's condition.

Article 3 and 8 of the convention

[17] Article 3 of the ECHR prohibits torture or inhuman or degrading treatment or punishment. A minimum level of severity must be obtained and relevant factors include the nature of the treatment, the manner of its execution, its duration, its physical and mental effects and the objective of the conduct. Many of these issues were considered by the European Court in Herczegfalvy v Austria (1993) 15 EHRR 432. The court set out the relevant legal principles at paragraph 82 of the judgment.

> *"82. The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.*
>
> *The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist."*

I am satisfied that in this case the treatment proposed for PM is a therapeutic or medical necessity. Without the treatment he will die. Although the treatment will be invasive and endure over a long period I am satisfied on the evidence that this is the least invasive method of preserving PM's life in the long term.

[19] Article 8 of the ECHR is concerned with private and family life.

> *"1 Everyone has the right to respect for his private and family life, his home and his correspondence.*
>
> *2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."*

Although I have found that PM lacks capacity to consent to the proposed treatment I must take into account his strident objection to it. That objection is of considerable importance in relation to his private life. I also recognise that the proposed treatment will be markedly invasive and that it constitutes a breach of article 8 (1).

19. In respect of this article the issue is whether the interference was in accordance with law, for a legitimate aim and necessary in a democratic society. I am satisfied that the application before me is made in accordance with precedent and that the legitimate aim is the preservation of PM's life. Since I am further satisfied in this case that without treatment PM will soon die I am clear that the treatment is in his best interests and, therefore, necessary in a democratic society.

Conclusion

[20] In this case I am satisfied to a high standard in relation to each of the Convention issues and also in relation to the issue of what is in PM's best interests.

[21] Accordingly I make the following declarations:

(a) that the first named defendant lacks the capacity to consent to medical treatment for very advanced kidney failure; and
(b) that the proposed course of treatment set out in paragraph 10 above can be lawfully carried out by the plaintiff's servants or agents upon the first named defendant, being, in the existing circumstances, in the best interests of the first named defendant, notwithstanding the inability of the first named defendant to consent thereto.