Key legal developments updated – Healthcare, July 2021

Priority High Medium Low

Area of interest	Title	Significance
End of life / continuing care	Sandwell and West Birmingham Hospitals NHS Trust v TW & Anor [2021] EWCOP 13 And NZ, Re (Mental Capacity Act 2005) [2021] EWCOP16	**TW:** The question was whether a person should be kept alive purely so that his family could have the opportunity to visit and be with him as he died. TW was a 50-year old man who suffered a catastrophic brain injury after a stroke, recovery from which was impossible. Medical professionals were sustaining his body but were unable to do more than that. TW's family lived in Canada and in the Covid-19 Pandemic it would take weeks to organise a "farewell visit", during which time TW was being kept alive to the detriment of his dignity. It was therefore felt that sustaining TW's life this way was no longer in his interests and he should be allowed to die sooner rather than later. The family of TW disagreed between themselves on this approach, with TW's wife and brother feeling keeping him alive was in TW's best interests, but TW's two daughters "acknowledged the force of the medical reasoning" and felt withdrawing care was the correct decision. Hayden J found that the continuation of respiratory support and the potential for invasive treatment was no longer in TW's best interests and gave his support to the palliative pathway put forward by the clinicians. **NZ:** NZ was a Covid-19 patient who was sadly rapidly deteriorating whilst on extracorporeal membrane oxygenation (ECMO) which was described by the Trust as "last resort treatment". Despite the care provided NZ was rapidly deteriorating, with key organs failing and one lung completely necrotic. With the clinical picture increasingly bleak clinicians wished to withdraw treatment and allow NZ a dignified death. There were family concerns based on their, and NZ's, religious belief that one cannot "condone any act that would be seen to bring life to an end". This brought them in to conflict with clinicians who felt it was unethical to sustain NZ's life.

		Hayden J's judgment was that whilst the conflict was appreciated, clinicians can never be compelled to do something that they themselves would find unethical. As he said in his conclusion "the objective here is not to shorten [NZ's] life, but… to avoid the prolongation of her death". In this case it was decided to withdraw treatment to allow NZ to die. The focus of the judgment was balancing the ethical duty of doctors with the strongly held believes the patient held (or was presumed to hold) in relation to end of life treatment. Both cases highlighted here show that courts are incredibly reluctant to intervene and force clinicians to go against their clinical judgment and encourage them to carry out care that they themselves would see as unethical.
Mental health & capacity re treatment	**X NHS Foundation Trust & Anor v Ms A [2021] EWCOP 17**	Ms A was a woman in her thirties who suffered from paranoid schizophrenia. She had been in hospital on more than 5 occasions over the past 14 years and it appeared those admissions were as a result of her ceasing to take medication. There had also been other referrals to mental health services that did not require hospitalisation. In September 2019 Ms A had stopped taking her medication as she felt well in herself and was wanting to try for a third child. By 2020 she was pregnant and off her medication. She voiced a desire for a vaginal birth at home. During a consultation with her obstetrician, the doctor concluded that Ms A lacked capacity in respect of her mental health and was showing no insight into her previous illness. By early 2021 Ms A's mental health deteriorated and she was detained. It also became clear that Ms A's baby was breech, the complications of which could be fatal. Unfortunately Ms A's behaviour restricted clinicians' attempts to turn the baby and with the lives of both mother and child a risk, the clinicians applied to the court for a declaration on Ms A's care. Mrs A wanted to remain at home and the clinicians felt it was safer for mother and child to be transferred to the maternity unit to enable a safer delivery. Cohen J found that it was in the best interests of Ms A to make an order to transfer her to the maternity unit at the local hospital, by restraint if necessary, so that a planned caesarean section could take place.
Vaccination against	**NHS Tameside & Glossop CCG v CR v**	CR was a 31-year old male with lifelong severe learning disability, autism and epilepsy. He lived in a care home and had done since January 2021. Due to his medical conditions

patient's carer's wishes	**SR [2021] EWCOP19 (CP)**	he fell within the priority group for vaccination, but his father SR was against the vaccination of his son. The court accepted that CR was not the in the normal cohort for care home patients as he was young and not frail. The central issue was whether it was in his best interests to have the vaccine when he himself was not frail. It was recognised that whilst CR himself was not particularly vulnerable, he was living in a location that subjected him to an increased "risk of such contagion". The court found that the objections to vaccination by SR held "no clinical evidence base" and indeed found that SR's aversion to vaccination was from his own deeply held belief that there was a link between the MMR injection and the autism of CR. Judge Butler found that the CCG could administer a vaccination if so required against SR's wishes, but he made it very clear he was not authorising physical intervention, be that restraint or otherwise, in order to do so.
Article 2, scope	**R (Morahan) v HM Coroner for West London [2021] EWHC 1603 (Admin)**	Tanya Morahan was a voluntary patient in a psychiatric rehabilitation unit who died whilst on leave in the community. On 30 June 2018 Tanya had left the unit with permission but failed to return when she agreed to but returned the following evening. During this absence she had not failed to comply with her medication plan but remained compliant to it. Two days later in early July Tanya left again with permission and said she was going to spend time at her flat. This time, however, she failed to return and the Metropolitan Police checked her home address the next day. She failed to answer the door. Her flat door was forced by Police and her body was found at her home. Pathology evidence was that she died as a result of an overdose of recreational drugs and she more likely died closer to the time she was known to be alive than when she was eventually found. The Coroner found that these circumstances did not give rise of an automatic duty to conduct an Article 2 Middleton inquest because there was no so clear-cut breaches of a substantive operational duty owed by the Trust to take steps to avert the immediate risk of Tanya's death. The family argued that an automatic duty arose under the Rabone factors of voluntary responsibility and exceptionality of risk. They argued the Trust ought reasonably to have known the real and immediate risk to Tanya's life and should have taken measures to prevent her death. On judicial review, the court found the Trust did not owe a positive operational duty to Tanya. They likened the scenario to that of a psychiatric patient who dies from a road traffic

		accident as being "accidental death", like that of an accidental overdose, and said no duty arose in that situation. Similarly, the risk Tanya would both take recreational drugs and then overdose on them was unforeseeable by the Trust because she had no history of accidental overdose. The court found that it was impossible to argue that whether there was an operational duty and expect the Trust to take steps to prevent it, if the risk itself is unforeseeable. What was key here was that Tanya was a voluntary patient and the risk of death from an overdose was not one that there was any reason to think the Trust should have foreseen. It emphasises the fact someone is an inpatient (whether on a voluntary basis or formally detained) at the time of their death does not automatically engage Article 2. Each case must be assessed on its facts and it must be shown that there is an arguable case that the organisation responsible for the individual's care should have been aware of the specific risk that ultimately led to their death.
End of life – applications to withdraw care	**A London NHS Trust v (1) CD (by her litigation friend, the Official Solicitor, (2) EF, (3) AB [2021] EWHC 727 (COP)**	CD was a young woman who attempted to take her own life by hanging but failed. The unanimous medical opinion is that CD had suffered a catastrophic global brain injury as a result of her failed suicide attempt and she was now in a prolonged vegetative state. CD's parents were separated and her father wanted life support to continue whilst the mother and sister felt it was not in CD's best interests to continue to live in this state. Much attention was focussed on CD's human rights and the opinions/beliefs of not only CD's parents but her sister and close friends. The medical evidence was clear that CD had no awareness of her condition and there was no possibility of her recovering to the level of function where she could undertake any of the activities she used to enjoy. Due to the overwhelming medical opinion and the fact that the only dissenting voice was her father, and even then he accepted that if it was known to be futile keeping CD alive under continuing care, Mr Justice Williams found that transferring CD to a palliative pathway would be in accordance with her wishes.
Autism and indoctrination	**Re EOA [2021] EWCOP 20**	EOA was a 19-year old man who suffered from autism. In 2015, he and his three other siblings had been removed from their parent's care. Their parents had been subjecting them to

		extreme religious indoctrination and keeping them socially isolated, not allowing them to attend school or receive any medical treatment. It should be noted that since 2015 the parents had effectively abandoned their children, playing no role in any care proceedings and never sought to have any contact with them. Anticipating issues when EOA reached maturity, the local authority applied to the Family Division to seek an order restricting EOA's contact with family and where he should live, feeling he was vulnerable to exploitation and did not have capacity to manage his own affairs at this time. Various orders were made from October 2019 to the date of the latest hearing and during one attendance EOA himself stated he wished to be free of court proceedings and make his own choices in relation to where he lived and with whom he spent his time. All parties (including the Official Solicitor) agreed that EOA lacked capacity to make decisions about care and support, about where he should live, and decisions about foreign travel. The court found that EOA's experiences had impacted his functioning and development and that this possibly played a part in his autistic behaviour. In terms of his capacity, the court took each element in turn from foreign travel, contact (with family members who still held the extreme doctrine, those that did not, and strangers), and capacity for internet and social media use. Balancing EOA's deprivation of liberty against these restrictions on his movement, the court found that it was in EOA's best interests to have his access to social media and family restricted, but interestingly found that contact with his brother (who still held to the extreme religious doctrine) was still permitted so long as the contact continued to be "innocuous".
Gillick competence in children re puberty blockers	**AB v CD & Ors [2021] EWHC 741 (Fam)**	AB was the parent of a child experiencing gender dysphoria, waiting for treatment with puberty blockers to prevent male physical characteristics from developing. There was evidence that developing such characteristics would cause her child severe psychological harm and be contrary to her best interests. Whilst the child had been assessed as having capacity and Gillick competent prior to the Bell case, the issue was whether parents could consent to such treatment when the child either could not, or would not, consent. It is well established that a Gillick competent child has capacity to consent to their treatment, but the case highlighted how parents can still consent on behalf of their child in the absence of the child's

		consent but they couldn't provide consent overruling the child's refusal.
Amending proceedings / fundamental dishonesty	**Mustard v Flower [2021] EWHC 846 (QB)**	Following the judgment in 2019 in relation to the legality covert recording (Mustard v Flower [2019] EWHC 2623 (QB)) , the matter before the court this time was concerned with whether or not it was required and/or necessary for a Defendant to reserve the right to apply for fundamental dishonesty if, at trial, it was found that the Claimant had been exaggerating her injuries and down-playing her pre-incident disabilities. The court held that it was well established in case law that it was not necessary for a defendant to make a specific pleading of fundamental dishonesty for a trial just to make such a finding against a claimant. The main reasons for the finding were that amending the defence at this stage served no purpose. A defendant can make a s.57 application without foreshadowing it in a pleading. Secondly, a pleading at this stage of the litigation had no real prospect of success and therefore did not satisfy the test for granting permission to amend. Lastly, the proposed amendment would cause prejudice to the Claimant as a plea of this nature would have to be reported to her legal expenses insurers which in turn would open up the possibility of them avoiding the policy ab initio.
Legal updates / Coroner Service	**House of Commons Justice Committee – The Coroner Service, First Report of Session 2021-22**	The publication highlights improvements, as the Committee sees it, in the Coronial system over recent years. Improvements since the Coroners and Justice Act 2009 have focussed upon the mandatory training and guidance for junior coroners that in itself establishes a uniformity of approach to the inquest process. In addition, it sees the reduction of the coronial areas as going some way to encourage yet further uniformity. A major theme of the report is to put "bereaved people at the heart of the Coroner Service" and this is reflected in the recommendation for non-means tested funding for families. The argument is that as the majority of Interested Persons in inquests are government bodies (NHS trusts, prisons etc) their legal counsel is already publicly funded so there is no reason why families should not also have state-funded legal representation. Currently, the fact there is no non-means tested funding creates an inequality of arms that leaves families bewildered and disengaged with the process. This issue is made particularly in respect to "public disaster" cases that are naturally more complex than other cases.

		Interestingly, the report points out that the shortage of pathology services in the country are a major contributor to the delay between index event and inquest, with pathology services being pivotal to the evidential base on which an inquest can proceed. The report suggests that the Ministry of Justice and the Department of Health and Social Care working closer together to bridge the demand with the shortfall of pathologists.
Inpatient care – CQC survey	**Care Quality Commission: 2019 Adult Inpatient Survey**	Whilst the industry waits the findings of the 2020 survey which will undoubtedly mention the impact the COVID-19 pandemic has had on people's experiences as an inpatient, the 2019 results are available to review. The findings are that there is a general increasing trend of people being admitted to hospital year-on-year which is putting a strain on an already financially stressed inpatient system. The report shows that, in general, people's experiences of inpatient care are good. The report does highlight that the frail and elderly have a negative experience, on the whole, of the system when they are discharged from hospital. This is due to the lack of information being provided to them at this stage and a general lack of communication from the hospital to the patient. It reports that 40% of people in hospital reported not being able to get help "within a reasonable amount of time". What is reasonable will vary from patient to patient, but the fact a large proportion feel that there is a delay between needing assistance and obtaining it is something the NHS will be asked to focus on going forward. It may be no surprise that people who had an emergency admission reported a worse experience whilst those who were engaging with hospitals on an elective basis reported more positive experiences. Presumably, this is coupled with the relative traumatic experience sustaining an emergency-requiring injury as well as the fact that Emergency Rooms are stressful areas for clinicians and patients alike. The 2020 survey will provide interesting reading as COVID has certainly put these aspects of hospital care under even more extraordinary pressure.

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