England and Wales High Court (Administrative Court) Decisions

Neutral Citation Number: [2012] EWHC 3670 (Admin)
Case No: CO/5198/2011

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL
19/12/2012

B e f o r e :

THE HON. MRS JUSTICE NICOLA DAVIES DBE

Between:

The Queen on the application of David Tracey

Claimant

- and –

Cambridge University Hospital NHS Foundation Trust

First Defendant

Secretary of State for Health

Second Defendant

Equality and Human Rights Commission **Interested Party**

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Lord Faulks QC and Mr Simon Murray (instructed by Kennedys) for the First Defendant
Mr Vikram Sachdeva (instructed by DWP/DH Legal Services) for the Second Defendant
Mr David Wolfe QC (instructed by EHRC) for the Interested Party
Hearing dates: 5 to 9, 13 & 14 November 2012

HTML VERSION OF JUDGMENT

Mrs Justice Nicola Davies:

1. This is a claim for judicial review and a claim pursuant to section 7 Human Rights Act 1998 ("HRA 1998") in respect of:

   i) the failure by the first defendant to treat the claimant's late wife, Janet **Tracey** lawfully;

   ii) the failure by the first defendant to treat Janet **Tracey** in a manner that respected her rights under Articles 2, 3 and 8 ECHR, and in a manner that respected the claimant's rights under Article 8 ECHR; and

   iii) the failure by the first defendant to have in place and to operate lawfully an appropriate policy on the use of Do Not Attempt Cardio-Pulmonary Resuscitation orders ("a DNACPR");

   iv) the failure by the second defendant effectively to promulgate any clear policy or guidance on the use of DNACPRs, which is accessible to patients and their families, and which properly informs them of their rights and legitimate expectations in respect of the use of DNACPRs by hospitals such as that operated by the first defendant.

2. The first defendant is the Trust responsible at the relevant time for Addenbrooke's Hospital, Cambridge.

3. Mrs **Tracey** was admitted to Addenbrooke's Hospital on 19 February 2011 following a serious road traffic accident in which she sustained a cervical fracture. Approximately 1-2 weeks prior to this admission, Mrs **Tracey** had been diagnosed with terminal lung cancer. During the admission to Addenbrooke's hospital, Mrs **Tracey**'s clinical condition deteriorated. A DNACPR Notice was placed on Mrs **Tracey**'s medical records on 27 February 2011, it was cancelled on 2 March 2011. A second DNACPR Notice dated 5 March 2011 was placed on Mrs **Tracey**'s records. Mrs **Tracey** died on 7 March 2011.

4. Proceedings for judicial review were instituted by Mr David **Tracey**, permission to apply was

granted. On 9 March 2012, Ouseley J. ordered that the matter be listed for a hearing to determine the disputed issues of fact surrounding the circumstances in which the two DNACPR notices were placed in the medical records of Mrs **Tracey**. The second defendant was excused attendance for the hearing on the disputed issues of fact. 44 questions to be determined by the Court have been agreed between the claimant and the first defendant. Whether a substantive hearing upon the legal issues will follow is dependent upon the factual findings of the Court and further submissions from all parties.

Law and context to the factual dispute

Claimant's case

5. Imposition of a DNACPR order is "serious medical treatment" within the definition of section 37 of the Mental Capacity Act 2005 ("MCA 2005") and regulation 4 of the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 (SI 2006/1832) ("Regulation 4"). It is a serious interference with Article 2, 3 and 8 rights. Imposition of a DNACPR can only be "in accordance with law" if domestic legislation and/or the common law is sufficiently precise to avoid the arbitrary and confused exercise of the treating medical staff's discretion to impose a DNACPR.

6. The claimant contends that there is no adequate national guidance or standard protocol issued by the Department of Health or the Secretary of State in relation to DNACPR, nor is there a clear local policy operated by the first defendant and accessible to patients and relatives. As such, the interference with Mrs **Tracey** and the claimant's Convention rights is not "in accordance with law".

7. The imposition of a DNACPR notice engages the right to choose how one passes the closing moments of one's life, it will affect the treatment given to a patient who is undergoing cardiac arrest and requires cardiopulmonary resuscitation. It represents a serious medical treatment decision affecting personal autonomy, dignity and quality of life. "Serious medical treatment" is defined by s.37 MCA 2005 and Regulation 4 as:

> "treatment which involves providing, withdrawing or withholding treatment in circumstances where:
>
> (a) in a case where a single treatment is being proposed there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him,
>
> (b) in a case where there is a choice of treatments, a decision as to which one to use is finely balanced, or
>
> (c) what is proposed would be likely to involve serious consequences for the patient."

Mental Capacity

8. A person must be assumed to have capacity unless it is established that he or she lacks capacity (section 1(2) MCA 2005). A person is not to be treated as unable to make a decision unless all practicable steps to help that person to do so have been taken without success (section 1(3) MCA 2005). A person lacks capacity in relation to a matter if at the material time, he or she is unable to make a decision in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (section 2(1) MCA 2005). It does not matter whether the impairment or disturbance is permanent or temporary

(section 2(2) MCA 2005).

9. There is no issue as to the mental capacity of Mrs **Tracey**. The entries in the medical records are clear, it is accepted by the claimant and the first defendant that Mrs **Tracey** possessed mental capacity to make decisions at all material times prior to her death.

10. Sections 24-26 of the MCA 2005 provide statutory recognition to advance decisions to refuse specified treatments made by an adult when competent which are to have effect when the adult becomes incompetent. It is not suggested by any party that Mrs **Tracey** made an advance decision to refuse specified treatment, to refuse life-sustaining treatment or to request treatment within the meaning of the MCA 2005.

11. Essentially the claimant's case is that:

> i) Articles 2 and 8 ECHR require that in order for the imposition of a DNACPR in respect of a patient, to be lawful, the imposition of that order must be preceded by effective and informed involvement of the patient and, where appropriate, the patient's near relatives/next of kin;
>
> ii) Because of the significant consequences of the DNACPR order, Articles 2 and 8 require that the decision whether or not to impose a DNACPR order in respect of a patient require there to be 'clear and accessible' criteria which are communicated to those who are affected (patient and where appropriate relatives), and thus, 'known in advance' so that persons affected can, if so minded, challenge such opinion, or at least seek a second opinion.
>
> iii) The absence of effective and informed involvement with the patient and relatives, and the absence of 'clear and accessible' criteria 'known in advance' for the imposition of a DNACPR order, mean that the imposition of the two DNACPR's in the present case resulted in a violation of Articles 2 and/or 3 and/or 8 ECHR.

12. It is the case of the first and second defendants that there was no violation of the Convention in relation to the treatment of Mrs **Tracey** and, more specifically, as regards the DNACPR orders.

Trust Policy

13. The first defendant's policy at the relevant time was "*Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy*" published in December 2009.

14. Sections 6 and 7 of the Policy provide:

> "6 When to consider a DNACPR order
>
> A DNACPR decision should only be made after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interests of the patient, following assessment that should include likely clinical outcome and the patient's known or ascertainable wishes.
>
> 6.1 DNACPR decisions for adults

It is appropriate to consider implementing a DNACPR order where:

- the patient's condition indicates that effective CPR is unlikely to be successful
- CPR is not in accord with the recorded, sustained wishes of a patient who is mentally competent
- CPR is not in accordance with a valid applicable advance directive (anticipatory refusal or living will). For further information please refer to the Trust's advance statements, advance decisions and lasting powers of attorney in relation to future medical treatment policy
- successful CPR is likely to be followed by a length and quality of life which it would not be in the best interests of the patient to sustain.

7 Discussing DNACPR decisions with patients and relatives

7.1 Patient rights

The rights of the patient are absolute to any decision making regarding resuscitation. The patient's rights must be respected, and where clinically possible, patients should be consulted regarding DNACPR decisions. Ideally, patients should be consulted in advance as to who they want, or do not want, to be involved in decision making if they become incapacitated.

…

7.3 Discussion with relatives

Any discussion with relatives or close friends (if appropriate and with due regard to patient confidentiality) may be valuable in assisting with the decision. However, the final decision rests with the clinician – relatives cannot determine a patient's best interests, nor give consent to, nor refuse treatment on a patient's behalf unless acting under an LPA (see above). They should be assured however that their views will be taken into account.

…

8 Who can implement a DNACPR order

The overall decision for a patient's resuscitation status rests with the consultant in charge of the patient. When a consultant decision is likely to be delayed, a provisional decision can be made by an SpR (ST3 or above). The consultant **must** review this decision and countersign the proforma **within 72 hours**, otherwise the order is no longer valid and the patient will therefore be considered for full resuscitation.

…

9 Procedure for initiating a DNACPR order

Any decision regarding the implementation of a DNACPR order needs to be recorded in the patient's medical records **and** on the proforma by the most senior member of the medical team available (ST3 or above). This person now takes responsibility for ensuring that the decision is communicated to all relevant personnel.

When recording the decision the following **must** be noted:

- The reasons for initiation of the DNACPR order.
- The results of sensitive exploration of the patient's/relatives'/parents' wishes regarding resuscitation. If there has been no discussion with the patient because they have indicated a clear desire to avoid such discussion, this must also be documented.
- An indication of how often the decision will be reviewed or that review is not appropriate.
- The name and signature of the doctor responsible for the decision plus date and time of recording.
- The name and signature of the doctor responsible for the decision plus date and time of recording.
- The name and signature of the senior nurse in charge of the ward/patient as a record of communication plus date and time of recording.
- Within 72 hours of initiation of the DNACPR order, the name and signature of the consultant (if not initially completing the form) plus date and time of recording.

…"

15. The policy is not routinely provided to patients. The first defendant's Resuscitation Service Manager, Ms Lindsey Creek, states that "the policy is intended to provide guidance to clinicians on the issue of resuscitation and initiation of DNACPR notices". The policy is expressed to be "Trust-wide: for all staff employed by Cambridge University Hospitals NHS Foundation Trust with a responsibility for patient care". Mr Creek states that the Policy is "not commonly disseminated amongst members of the public or patients, unless a copy is specifically requested". A copy of the policy was not provided to Mrs **Tracey** or her family.

16. Having considered all of the evidence, I have concluded that simply answering the 44 questions would not begin to address the whole picture, still less would it place in context what happened and why. The questions are repetitious and sometimes less than helpful. In order to provide an understanding of what occurred during the last weeks of Mrs **Tracey**'s life, in particular the making of the DNACPR Notices, within this judgment I have set out the evidence of the family and the staff, medical and nursing, responsible for Mrs **Tracey**'s care during this period and made findings of fact.

Evidence

17. Janet and David **Tracey** had been married for 36 years. Mrs **Tracey** had two daughters from a previous relationship and two daughters with David **Tracey**, all four were brought up together. For the last twenty years of her life, Mrs **Tracey** had worked as a care home manager in a home for the elderly. On a date within the two weeks prior to 19 February 2011, Mrs **Tracey** and her husband had been told by an oncologist that she had developed lung cancer which was terminal, she had some 9 months to live. The oncologist told Mrs **Tracey** that chemotherapy was available, she could participate in a clinical trial relating to drugs aimed at preventing the reoccurrence of cancer. Mrs **Tracey** accepted this offer of treatment, she wanted to fight for her life and was not naïve as to what lay ahead by reason of her work.

18. On 19 February 2011, Mrs **Tracey** was involved in a serious road accident. Later that day, she was transferred to Addenbrooke's Hospital, admitted to Ward A4, the following day she was transferred to the Neuro Critical Care Unit (NCCU).

19. Mr Peter Kirkpatrick is a Consultant Neurosurgeon at Addenbrooke's Hospital. He was the consultant in overall charge of Mrs **Tracey**'s neurosurgical care. The neurosurgical unit at Addenbrooke's is a regional unit and a tertiary referral centre. It is one of the busiest in the country carrying out 3,000 operations per annum. The nature of the work, covering as it does a wide range of pathology, attracts a high rate of mortality and morbidity. Mr Kirkpatrick's own field is within the area of neurotrauma and neurovascular work, he sees some 400 patients a year with a mortality rate of between 10 to 20%. The reputation of the unit is for aggressive treatment. Clinicians working in it have published widely on the merits of the aggressive approach to patients which has led to an increase in the number of referral of clinically poor grade patients. Within the unit there has built up a culture of giving patients a chance they might not otherwise have, this encompasses a multi-disciplinary approach. Palliative care is provided to assist patients in their dying moments, in the majority of cases this relates to relatively acute injury.

20. During the period in hospital, Mrs **Tracey** was regularly visited by members of her family. As the claimant is self employed, he would generally visit his wife in the evening, arriving at about 5.00pm. Mrs **Tracey**'s daughters, Alison Noeland (Alison) and Kate Masters (Kate), spent lengthy periods at the hospital and were the family members who were primarily responsible for interaction with the medical and nursing staff. Claire **Tracey** (Claire), the youngest daughter, was a frequent visitor to her mother's bedside. Helen **Tracey** was unable to visit with the same frequency but was kept informed of events by her sisters.

21. It was the evidence of family members that Mrs **Tracey** was engaged with issues of care during her stay in hospital, she would ask what was going on, being quite medically minded from her work she wanted to know about the drugs, the equipment and what the nurses were doing. Claire told the nurses that they must tell her mother what they were doing as she wanted to be informed. During her hospital stay, Mrs **Tracey** communicated with the staff by writing on a pad of paper or by whispering. Some of her notebook entries were produced by Alison, the majority of those produced were written between 5 March 2011 and 7 March 2011.

20 February 2011 to 25 February 2011

22. Following admission, it was thought that Mrs **Tracey**'s presentation was clear cut in that she had sustained a high cervical neck fracture and required spinal/neurosurgical input, it soon became apparent that Mrs **Tracey**'s pathology was more complicated. She was suffering from severe chronic

respiratory problems which caused her to struggle with breathing, as a result Mrs **Tracey** was admitted to the NCCU and placed on a ventilator. Investigation revealed that effusions on her lungs were malignant and that she was in the advanced stages of terminal cancer. Damage caused to Mrs **Tracey** 's lungs by smoking and her advanced cancer appeared to be the predominant cause of her breathing difficulties but they were exacerbated by pneumonia which had developed consequential to the road traffic accident.

23. A multi-disciplinary approach was taken to Mrs **Tracey** 's treatment involving the intensivists/anaesthetists, neurosurgeons, oncologists, the respiratory team and latterly the palliative care team. Daily discussions took place between the radiologists, NCCU and neurosurgeons regarding her management. As Mrs **Tracey** 's respiratory problems were the aspect of her condition causing the greatest concern, the intensivists took the lead in Mrs **Tracey** 's treatment. Her respiratory problems, advanced cancer and the fact that she was not responding to treatment for her chest infection were having a significant impact upon her clinical condition. On 23 and 25 February 2011 attempts were made to wean Mrs **Tracey** from the ventilator. Both attempts at extubation were unsuccessful, reintubation was required as Mrs **Tracey** struggled to breathe unassisted.

26 February 2011

24. Mrs **Tracey** was reviewed by Dr Lavinio, Consultant Anaesthetist and Consultant in Intensive Care Medicine. He noted that she was short of breath, anxious with sub-optimal pain control. Dr Lavinio's concern was that by reason of the two failed attempts at extubation, successfully weaning Mrs **Tracey** from the ventilator might not be possible. Her condition was deteriorating despite maximal medical treatment. Dr Lavinio believed that Mrs **Tracey** would derive little benefit from continued ventilation. The reversible causes of her respiratory failure had been dealt with. The clinicians had limited therapeutic options available to treat the underlying advanced lung cancer (expected to cause recurrent chest infections) and the recent spinal injury (associated with limited mobility).

25. Dr Lavinio's plan was to keep Mrs **Tracey** intubated, order an ultrasound scan of her chest and possibly drain the effusion in order to assist extubation. Mrs **Tracey** 's poor prognosis meant that the clinicians would be required to consider and plan for the possibility of deterioration, respiratory or cardiac arrest. In his witness statement, Dr Lavinio put it thus:

> "Alongside considering initiating a DNACPR Notice I thought it would be appropriate to explore the option of setting a ceiling of treatment and to discuss the opportunity of issuing a "Do not re-intubate" Order in the event of a further failed extubation attempt. I requested further input from the oncology team to fully assess Mrs **Tracey** 's prognosis and to consider what further treatment would be in her best interests."

26. Dr Lavinio spoke to Alison Noeland to express his concern. He stated that Mrs **Tracey** 's daughter confirmed her understanding that it was her mother's wish to receive full active treatment, agreed that her mother's comfort was the main priority and that withdrawal of treatment ie withdrawal from the ventilator, might be in Mrs **Tracey** 's best interests if she failed to improve in the following days. Dr Lavinio raised these issues because he felt it would not have been in Mrs **Tracey** 's best interests to be reintubated in the event of a further unsuccessful extubation attempt. Dr Lavinio's note in the medical records includes the following:

"After discussion with daughter I understand Janet's wish would be to receive full active treatment. However she agreed that the main priority is comfort and ~~agg~~ agrees that withdrawal of treatment might be in the patient's best interests.

PLAN – Intubate and ventilate

- US chest +/- drain effusion

(this will not change prognosis but will make extubation easier)

- oncology input

- discussion with neurosurgical/NCCU/oncology team re one-way extubation."

27. When Alison saw her mother, she had been taken off the ventilator and was in a lot of pain. She recalls being called into a meeting room where there were a number of clinicians and being told that aggressive treatment was not working, her mother was going to be ventilated once more and a chest drain would be inserted. As to Dr Lavinio's note, Alison recalled the conversation but did not recall anything being said about "withdrawal of treatment", the doctors were talking about reintubation. She agreed that it was right to record her mother's expressed wish was "to receive full active treatment".

27 February 2011

28. Dr Hugo Ford, Consultant Oncologist and Divisional Director of the Cancer Division at Addenbrooke's Hospital, was asked by the clinicians in the NCCU to review Mrs **Tracey** and advise on the prognosis and outcome of her cancer. The review took place on this day, Mrs **Tracey** was immobile and being ventilated. It was the opinion of Dr Ford that Mrs **Tracey** would never be fit enough to receive chemotherapy, the best case scenario was a life expectancy of a few months but Mrs **Tracey** 's life expectancy was worse by reason of her chest infection/pneumonia, which was not responding to the treatment, and the fact that she was immobile by reason of her cervical fracture. Prior to and following the consultation, Dr Ford had discussions with Dr Lavinio. He recalled that Dr Lavinio being present for part of his discussion with Mrs **Tracey**.

29. Dr Ford stated that Mrs **Tracey** had difficulty communicating with himself and Dr Lavinio due to her severe respiratory problems. His impression was that she felt she would have a good prognosis with chemotherapy. Dr Ford advised Mrs **Tracey** that she would never be well enough to receive it. He also advised that if she was successfully weaned from the ventilator, reintubation would be inappropriate in the event of recurrence of her respiratory problems unless there was an acutely reversibly pathology. Dr Lavinio gave similar advice. Dr Ford recalled that when discussing the issue of reintubation with Mrs **Tracey**, she used a pen and paper to indicate that she wished to be kept involved in any such discussions. Dr Ford's entry in the medical records fully reflects his assessment, advice and Mrs **Tracey**'s "clear wish" to be involved in discussions.

30. Dr Ford could not recall whether he had discussed the issue of resuscitation with Mrs **Tracey** but he thought he did not have such a discussion. Although Dr Lavinio and he discussed the fact that resuscitation was not appropriate in Mrs **Tracey**'s case, the main focus of their discussions was her breathing difficulties and the appropriateness of reintubation. Both clinicians were of the view that it was

inappropriate for Mrs **Tracey** to remain on full time ventilation, at some stage it would be necessary to withdraw ventilatory support.

31. Dr Ford records the following in his witness statement:

> "Consideration of the issue of resuscitation often follows discussions regarding reintubation. This is because if a decision is made not to reintubate a patient, the next logical step is to plan for what will happen if the patient suffers a respiratory arrest after they have been weaned from the ventilator. It is therefore common to consider the appropriateness of putting in place a DNACPR Notice if there is a possibility that the attempt to extubate a patient will fail. On those occasions where a patient is successfully resuscitated following a cardiac arrest or respiratory arrest they are normally ventilated immediately afterwards. If a decision has been made not to reintubate a patient, then it is also sensible to consider the appropriateness of the DNACPR Notice given resuscitation often leads to ventilation."

32. When Dr Ford was subsequently informed that the DNACPR Notice dated 27 February 2011 had been cancelled, he was concerned as it was his view that Mrs **Tracey** had a very poor prognosis and any attempts at resuscitation would be of no clinical benefit to her.

33. Alison was present during Dr Ford's consultation. She recalls his advice was that chemotherapy "may not be an option". She did not remember her mother being told that reintubation following an unsuccessful weaning from the ventilator would be inappropriate. Her recollection is that the conversation focused on her mother's cancer prognosis and chemotherapy. Dr Ford told her mother that tough decisions would have to be made, in response Mrs **Tracey** wrote a note stating "please do not exclude me" and "i will do my damdest".

34. Shortly after Dr Ford left, Alison was called into a side room to speak with Dr Lavinio and Dr Goon, a Specialist Registrar in Anaesthesia. In her oral evidence Alison said that she was told by Dr Lavinio that "As we speak your mum is being taken off the ventilator, if she struggles again her sedation will be increased and we will let her slip away." Dr Lavinio said that it was "a medical decision", made in her mother's best interests and "you have no influence over the decision". Alison said "I was being told that it would happen, there was no room for me to question … I was told it in a way that did not invite comment." She said that she felt very afraid as she thought her mother would die that day, based on her experience of previous extubation. There was no conversation with anyone about CPR, had Alison been asked about CPR she would have said that her mother wished to live, it was not in her nature to overrule her mother's opinion. Alison understood and accepted that her mother would not be put back on the ventilator, as a result she hurried to ring the family in order for them to attend the hospital.

35. Kate joined Alison and Dr Goon. Dr Goon gave Kate information of a similar nature as had been given to Alison. Kate said that what she was told was distressing but simple enough to understand, so she asked no questions. There was no mention of a decision regarding resuscitation and the terms DNR or DNACPR were not used.

36. Kate recalled a nurse asking her if she had had the conversation with the doctor and the name of her sister, who had also been present. Kate gave her own and Alison's name which the nurse wrote down. Kate now understands that this discussion was followed by the instigation of a DNACPR form, at the time she was unaware of this and thought she was being asked for a routine entry in the medical notes.

37. The note made by Dr Lavinio is dated 27 February 2011 and reads:

> "Reversible causes of respiratory failure
>
> have been dealt with. I feel
>
> that no further "optimisation" is possible.
>
> PLAN: Extubate
>
> Analgesia
>
> Chest drain +/- pleurodesis and
>
> Continue antibiotics
>
> I believe that NIV could
>
> be appropriate with light sedation
>
> if Janet tolerates it.
>
> Do not re-intubate –
>
> DNR
>
> Daughter in picture."

Added to the note are the words:

> "Alison (Kate)"

38. The note is not timed but it follows the note made by Dr Ford of his consultation and precedes Dr Goon's note timed at 12:30 noting the discussion with Kate. The words "Alison (Kate)" would appear to have been written by the nurse.

39. Dr Lavinio's stated that he and Dr Ford agreed that it would be clinically inappropriate to reintubate Mrs **Tracey** if extubation was unsuccessful, they discussed the issue of resuscitation. Dr Lavinio was also of the view that it was in Mrs **Tracey**'s best interests not to be given CPR if she stopped breathing." Dr Lavinio described CPR thus:

> "CPR is an invasive procedure which involves significant force being applied to a patient's body when chest compressions are performed. This commonly results in rib fractures. In patients with unstable spinal fractures there is a risk that the force applied in such a life or death situation can result in neurological damage (paraplegia or tetraplegia) despite the best attempts of protecting the spine (in line stabilisation). A tube will be placed down the patient's throat to force breathing. If the decision is taken to try and resuscitate the patient with the use of a defibrillator electric shocks will be delivered to the chest region causing the skin to burn. Many patients who are successfully resuscitated suffer severe neurovascular

> defects, including brain damage. In patients that have a background of respiratory failure and have a poor oxygenation at base line such as in the case of Mrs **Tracey**, a cardiac arrest will result in further reduction of oxygen delivery to the brain, causing severe hypoxic-ischaemic encephalopathy. Even if the heart starts beating again and in the remote possibility of return of spontaneous circulation, the neurological outcome is likely to be extremely poor. In this case, CPR was futile and likely to result in persistent vegetative state or severe disability. I did not think there would be any benefit in putting Mrs **Tracey** through any of this."

40. Dr Lavinio's evidence was that he also broached the issue of DNACPR with Mrs **Tracey**. He explained to her that a DNACPR Notice meant that they would continue to provide her with full active treatment that was clinically appropriate and would be of benefit to her. At that time Mrs **Tracey** was able to communicate by nodding and shaking her head and by writing notes. Mrs **Tracey** understood what was being proposed and nodded to indicate agreement with it. Dr Lavinio made no entry in the medical records of any such conversation with Mrs **Tracey**.

41. Dr Lavinio said that there had been three attempts at mechanical ventilation, surgical chest drainage, chronic lung disease was present. Mrs **Tracey** had lost weight, she was frail, tired and was approaching the end of her life. Her oxygen level was deteriorating, the first organ to be affected would be the brain, followed by the heart. Dr Lavinio was attempting to protect Mrs **Tracey** from "an undignified act of violence". The clinicians had given her time to fight, he was impressed by how willing she had been to do so. The procedures had caused a lot of pain and shortness of breath. The clinicians wanted to reassure the family that they were not giving up on Mrs **Tracey** but they had limited scope in prolonging life. The burden of the decision was upon the doctors, not the family.

42. Dr Lavinio completed the first DNACPR Notice dated 27 February 2011. His evidence was that the reason for initiating the Notice was due to the futility of performing CPR in that it was unlikely to result in return of spontaneous circulation and extremely likely to result in persistent vegetative state or severe disability. In his witness statement, Dr Lavinio records:

> "As I have discussed the DNACPR with Mrs **Tracey**'s daughter and Dr Ford (in addition to Mrs **Tracey** herself) I recorded this on the form … At the time of completing the form the daughter accepted that CPR and re-intubation were unlikely to be successful and would only result in prolonged suffering. She made no objection to the DNACPR Order and never indicated to me that there were objections to the DNACPR Order being made by other members of the family."

The DNACPR Notice is reproduced at Appendix 1. The name and the signature of the nurse has been redacted from Appendices 1 and 2 as neither individual gave evidence nor played any part in these proceedings.

43. The Notice is signed by Dr Lavinio, dated but untimed. It records that the decision has been discussed with a "daughter" and Dr Ford. Dr Lavinio said that he was unable to give a satisfactory explanation as to why he did not record the fact of his conversation with Mrs **Tracey**. On the reverse of the form is a requirement to identify those with whom the decision has been discussed, Dr Lavinio accepted that it was poor record keeping on his part. Had such a discussion taken place, it would also have been important to record it in the notes. In his oral evidence, Dr Lavinio said that there were a number of conversations, Mrs

Tracey understood that she would not be reintubated or resuscitated. It is what the family referred to as letting Mrs **Tracey** "slip away". Dr Lavinio was challenged as to that, it being put to him that such would occur only in the event that Mrs **Tracey** was extubated. He said that if a clinician began to remove the tube and Mrs **Tracey** struggled, there would not be reintubation, she would be allowed to slip away. It would have been medically impossible to sustain life without mechanical re-entry. In allowing the patient to slip away, there would be no resuscitation, it would be protection of the patient from an undignified procedure.

44. Dr Lavinio did not accept that this represented a fundamental change on the part of Mrs **Tracey**, in respect of her stated wish for full active treatment as he said she received full active treatment to the end. He did accept that such a discussion and her agreement to DNACPR represented an important qualification of her earlier wish.

45. As to the words which he wrote on the form, namely "NOT FOR REVIEW", Dr Lavinio accepted that this represented a period which was not confined to the short period following extubation. Dr Lavinio was asked if he had explained to Alison that such a Notice applied to the period beyond extubation, he said that Alison must have understood this because what was being explained by "slip away" was that the clinicians were not going to resuscitate if the heart stopped. Dr Lavinio said he did remember discussing the form in detail, the discussion was about the level of care for Mrs **Tracey** and Alison understood that all were doing their best for her mother.

46. Mrs **Tracey** was successfully weaned from the ventilator. The family spent Sunday afternoon with her reading the newspapers and ensuring that she had as nice a time as she could. To her family, Mrs **Tracey** made no mention of any conversation with Dr Lavinio regarding resuscitation nor did she exhibit any knowledge of the DNACPR Notice.

47. That evening, following the departure of Mr **Tracey** and her sisters, Alison was chatting to a nurse about her mother. The nurse said something like "don't worry about the DNR it doesn't affect other treatment." Alison said it meant nothing to her, she was relieved her mother had made it through the day, she did not think much about it at the time.

28 February 2011

48. Mrs **Tracey** was able to sit up in bed, eat and drink. Alison felt sufficiently comfortable about her mother's condition to return to Norway. By Monday evening, Alison said that her mother was "doing really well", she was chatty, happy, she just "needed to get back on her feet" even though Alison knew she was poorly.

Cancellation of first DNACPR Notice

49. Following Alison's return to Norway she decided to do "some research on the internet about mum's condition. I recall the 'DNR' phase (sic) being used and so looked it up. I was horrified to discover what it meant as this was against mum's wishes and those of the family. I was worried how it would look on her file and whether she would get the proper treatment so called the hospital." As a result of her research, Alison telephoned the hospital. She was subsequently telephoned by a nurse, Michaela Asby, who told her that the form had been "pulled from the file". Asked why the form was there Alison was told that it had been as a result of a discussion with Mrs **Tracey**'s daughters. Alison said that was not true, she

would never have agreed to the form "It was not my place to agree, it was mum's decision and it was not mum's wishes to be DNR." Her mother could not have been aware of the Notice because she would not have been so happy or "perky", she would have asked the family to get rid of it.

50. Mr Kirkpatrick was contacted by his Specialist Registrar, Dr Alavi, on 2 March 2011 and informed that objections by Alison had been raised to the DNACPR Notice. By this time there had been a subtle improvement in Mrs **Tracey**'s clinical condition although her prognosis remained poor. She had a chest drain in situ, her breathing was easier and Mr Kirkpatrick's concern was that if she had improved and the family were uncomfortable with the Notice, then it should be removed. He authorised its removal pending discussions with the family. He felt strongly that a meeting should take place in which all the family were included, in particular, Mr **Tracey**. A note of a ward round by Mr Kirkpatrick on 4 March 2011 includes the entry: "PJK will meet the family c 16.00 today." Mr Kirkpatrick accepted that had the family not objected, the Notice would have remained in place.

51. Dr Ali Alavi made an entry in the medical records dated 2 March 2011 timed at 10:30am. It reads:

> "Her daughter Alison Noland (sic) has contacted Mikki, our CNP and expressed her objection against DNACPR.
>
> I D/W patient & she is also against DNACPR & wants to be resuscitated in case of cardio-respiratory arrest.
>
> I D/W P J K ? for resuscitation, DNACPR form to be removed."

52. Dr Alavi was responsible for cancelling the first DNACPR Notice, the copy of which (Appendix 1) demonstrates the two lines which he drew across it and the words which he wrote on it, namely:

> "Cancelled
>
> Ali Alavi
>
> because of patient wish and her daughter wish."

53. On the reverse of the form are instructions upon cancellation which include:

> "To Cancel a DNACPR
>
> SpR (ST3 or above) or consultant
>
> 1. Draw a diagonal line across the proforma and write 'Cancelled' along it. Print your name then sign, date and time the cancellation.
>
> 2. Ensure a corresponding entry is made in the notes informing of the cancellation and the rationale for this decision …"

Dr Alavi was of the required status, he did not date or time the cancellation.

2 March 2011

54. On 1 March 2011 Mrs **Tracey** was transferred to Ward A5, the Palliative Care Team became involved in her care. Dr Summers, a Specialist Registrar in Palliative Care, saw her and noted at about 11.45:

> "Mrs **Tracey** says that she was due to commence her chemo yesterday @ RMH and does not know what plan for this now is. Additionally she stated she is aware that her cancer is "terminal" – but has never discussed the prognosis. Mrs **Tracey** said she has never thought about or discussed resuscitation issues *with* her family or doctors and wishes to think about these issues *with* her family some more …
>
> Suggested Management
>
> 1) Palliative Care/Oncology/Primary team to explore issues around cancer care/chemo/resuscitation."

55. Sue Sharpe, Clinical Nurse Specialist, saw her at 12:45 on 2 March 2011 and made a note which records the following:

> "… I note Mrs **Tracey** Daughter against DNACPR at present
>
> I note Mrs **Tracey** had declined DNACPR but states she does not really understand this and needs further discussion …
>
> I have spoken to Dr Ali who is happy to attend with myself to discuss DNACPR with Mr **Tracey** present this P.M. …
>
> Ward to contact 4404 when Mrs **Tracey** present.
>
> I will attend and call Dr Ali. We can then discuss and give full information for Mr & Mrs **Tracey** to make an informed choice."

56. At 16:30 on the same day, Sue Sharpe made a note which includes the following:

> "We have asked her, her wishes and stated she may or may not survive CPR. Her lungs are weak. She feels adamant that this should be discussed with her husband –
>
> Until then she remains full resus.
>
> MRS **Tracey** does not wish to know her prognosis at present – Respiratory or oncology wise –
>
> She does understand that she is <u>not</u> fit for chemotherapy at present …
>
> Discuss all with Mr Kirkpatrick.
>
> We will continue to support."

57. On a day which he could not identify, Mr **Tracey** visited his wife. She was in tears and distressed and said that a doctor had told her about the DNR decision. Mr **Tracey** told his wife that neither he nor

the girls would do that to her. Mrs **Tracey** said she was being "badgered" about making a resuscitation decision by everybody and it was becoming a nuisance. Mr **Tracey** said that his wife did not want to have the conversations on her own and did not want to be repeatedly told she was going to die in hospital. She just wanted to get out of the hospital and that is what "we focused on." On 2 March, Kate Masters recalled her father telephoning her, he spoke of the conversation with her mother. Mrs **Tracey** said that she had said "No" to the clinicians, she told them that she just wanted to get better and out of hospital, she wanted someone to speak to herself and her husband together about the DNACPR form. Mrs **Tracey** had been told that the family had agreed to the previous form. The family were distressed at this as they thought their mother would have thought that they were agreeing to let her die.

3 March 2011

58. Kate Masters had a conversation with her mother, they discussed the DNACPR form. Mrs **Tracey** was upset as she thought the family had agreed to it. Kate asked her mother if she would consent to a complaint being made about she was being treated. As a result Kate raised their concerns with Patient Advice and Liaison Service, a meeting took place between Kate, Mr **Tracey** and Helen Reeve, a Senior Clinical Nurse to discuss the family's concerns. A note of the meeting includes the following:

> "… They have concerns regarding the DNACPR & the way a doctor spoke to her yesterday asking her how long she thought she had to live. They are also concerned that her chest drain was not inserted sooner.
>
> I have said that I will ask NCCU to speak to them regarding the issues in NCCU …"

59. The family raised concerns about other aspects of Mrs **Tracey**'s clinical care commencing with her admission to hospital. Kate told Helen Reeve that no one should speak to Mrs **Tracey** without one of the family being present.

4 March 2011

60. A clinician's note records that Mrs **Tracey** was having a "rough night", it details shortness of breath, anxiety, pain, her frail cachetic condition and continues:

> " … I THINK WE SHOULD RE-ADDRESS THE PLAN FOR MRS **TRACEY**. I BELIEVE SHE IS APPROACHING THE TERMINAL PHASE AND AN ACUTE NSURG WARD IS NOT AN APPROPRIATE PLACE FOR GOOD PALLIATIVE CARE.
>
> MAIN ISSUES:
>
> - PERSISTENT ANXIETY
> - SOB
> - UNREALISTIC FAMILY EXPECTATIONS …"

61. At 08:30 on 4 March 2011 Mrs **Tracey** was reviewed by Dr Simons, known to the family as Dr

Natasha, a Neurosurgical and Neuro Critical Care Senior House Officer. Dr Simons had been involved in the initial care of Mrs **Tracey** and appears to have been the doctor closest to the **Tracey** family.

62. Dr Simons had not seen Mrs **Tracey** for a number of days and was concerned at the deterioration. She made a note of a consultation with Mrs **Tracey** and her daughter which included the following:

> "Asked to see as daughter anxious
>
> Reports increased SOB …
>
> Imp very anxious patient and daughter? Bi basal effusions
>
> Unrealistic expectations from patient & daughter about prognosis
>
> Plan … (abg if deteriorating please as currently for all treatment? Is this appropriate.)"

The note reflected Dr Simons' concern as to the appropriateness of escalating Mrs **Tracey**'s care which would not alter her clinical outcome, she felt that Mrs **Tracey**'s comfort should be the priority.

63. Dr Simons described Mrs **Tracey** as "a very anxious patient", this made it difficult to engage with her in discussions relating to her care. Specifically, Dr Simons states:

> "Mrs **Tracey** did not wish to engage in discussions regarding issues relating to her care and her prognosis. On occasions when I attempted to initiate discussions with Mrs **Tracey** regarding her treatment and her future she did not want to discuss these issues with me. I'm unsure as to whether Mrs **Tracey**'s unwillingness to talk about the future was solely due to her anxiety or simply because she did not want to be made aware of her prognosis.
>
> 12. On the occasions when I did ask Mrs **Tracey** questions regarding the future in order to obtain her views on issues relating to her treatment, Mrs **Tracey** would either indicate that she did not wish to continue the discussion or would indicate that she would prefer to discuss when one of her daughters was present. Mrs **Tracey** would usually still not want to discuss issues relating to her treatment on prognosis when her daughters were present.
>
> 13. One of the aspects relating to Mrs **Tracey**'s care, which I attempted to discuss with her, was the issue of resuscitation. However, every time I initiated a discussion with Mrs **Tracey** on the issue she would either say that she did not wish to discuss the issue or she would say that she would speak to her family about it. The issue of resuscitation is a sensitive one and I did not want to distress Mrs **Tracey**. I therefore did not force the issue on the occasions that she indicated that she did not want to discuss it any further.
>
> 14. On the occasions when Mrs **Tracey** was willing to allow me to give her further information in relation to resuscitation, I spent some time with her explaining the process of resuscitation and what this involves also given Mrs **Tracey**'s clinical condition the information I gave was put forward in a gentle way to ensure she did not become distressed. One of Mrs **Tracey**'s daughters was present during this discussion. However, Mrs

Tracey remained of the view that she did not want to consider the issue any further. I cannot recall Mrs **Tracey** ever giving me a clear indication of what her views were on the issue of resuscitation."

Meeting, Mr Kirkpatrick and some family members

64. Mr Kirkpatrick had instructed his nurse practitioner to organise a meeting with the whole family. He said it was very difficult to communicate with them in order to have the important discussion to ensure that they understood the gravity of the situation, the prognosis and to help Mrs **Tracey** with end of life care. It was a difficult challenge for the staff, in 20 years Mr Kirkpatrick had never come across anything like the situation. He described the family as being "beyond denial". The difficulty was trying to get one member of the family to take charge. The staff felt that they were not getting very far in conversations with the daughters.

65. When Mr Kirkpatrick attended the meeting, he found that Kate and Claire were present but Mr **Tracey** was not. It was Mr Kirkpatrick's understanding that Mr **Tracey** was unable to attend because of his own ill health. Had Mr Kirkpatrick had known it was work which prevented Mr **Tracey** attending, he said he would have been more forceful in obtaining Mr **Tracey**'s attendance to the extent of picking up the phone and speaking to him.

66. The meeting was dominated by Kate, described by Mr Kirkpatrick as very intelligent, perceptive, sensible, calm and collected. In his oral evidence Mr Kirkpatrick said he was close to 100% certain that Kate fully understood the situation, namely that they were dealing with the terminal care of her mother. Mr Kirkpatrick told Kate and Claire that their mother was desperately ill from the outset. The first time he saw her he was not fully aware of her malignant disease but was taken aback by her appearance. She was cachectic, had lost a tremendous amount of weight and had a sallow appearance. It was obvious to him that Mrs **Tracey** had been very unwell for many months, he was surprised that it was only three weeks before that she had seen an oncologist.

67. Mr Kirkpatrick described the fact that Mrs **Tracey** was in the last phases of her life. The malignant disease was fast developing, her liver and bones were involved in the cancerous process, a CT of her chest had demonstrated a malignant collection of fluid. Mrs **Tracey** was distressed and in a lot of pain as a result of boney deposits. Ideally Mr Kirkpatrick would prefer Mrs **Tracey** to be at home in the final stage, Kate felt that this wasn't possible, the conversation moved towards a transfer to a hospice. In Mr Kirkpatrick's opinion there was no confusion as to what was being discussed, the information he was giving to Kate was well received, she asked pertinent questions.

68. The conversation then moved to the appropriate form of resuscitation. Mr Kirkpatrick said he would not use the letters DNACPR, he would have used as little "medical jargon" as possible. He would broach the subject in softer terms and say words to the effect: "your mother is extremely unwell, in the event that she stops breathing or her heart stops due to disease it would be wholly inappropriate to summon the cardiac team." Until this case, Mr Kirkpatrick said he had no reason to regret using such words. He had no doubt that Kate understood and fully accepted what he was saying. She told him that she would need to go and face the family, he gained the distinct impression that there was conflict within the family. It was agreed that until Kate had done this, the DNACPR Notice would remain cancelled. Mr Kirkpatrick expected Kate to return within 24 hours with the family view. He came away from the meeting satisfied that his advice would be interpreted in the spirit it was meant and that the family had a good account of that

advice. He believed that Kate was taking charge of the situation. Mr Kirkpatrick took issue with any suggestion that the meeting was not at his instigation or that there was a vagueness about it to the extent that Kate did not know who he was.

69. It was the evidence of Kate Masters that she had arranged the meeting with Mr Kirkpatrick. She wanted to know the plan for her mother's future treatment, Helen Reeves had told her that she should speak to the doctors about it. Kate's recollection was that they were told by Mr Kirkpatrick that their mother had days or weeks to live, he was clear that her mother was dying. Kate was not expecting the prognosis and told Mr Kirkpatrick that this was a different diagnosis to that previously given. Mr Kirkpatrick said he did not know why the family had been given the earlier prognosis. He told Kate that the time they had left would be very important to them and suggested they took time off to spend with their mother.

70. Kate described Mr Kirkpatrick as being very sincere, he said that the family should think carefully about where Mrs **Tracey** should spend her last days. Kate told Mr Kirkpatrick that it was not possible for her mother to go home, she would have to speak to the family or her mother could go to a hospice in the short term. Kate wanted to get her mother out of hospital. Mr Kirkpatrick gave no sense of urgency.

71. Mr Kirkpatrick did speak about resuscitation and gave an explanation as to what would occur in the event CPR was given. Kate Masters' witness statement records:

> "He asked Claire and I several times to agree to a DNACPR form and we said no. Mum had been asked about the DNACPR so I did not understand why he was asking us; she had already said no. It was not our decision to make, it was mum's and she had been clear. I would never have agreed to something she did not want and did not give this impression in the meeting … I may have agreed that the description being given did not sound nice for mum but I never agreed to a DNACPR being imposed without mum agreeing … I also certainly did not agree or suggest that I would discuss DNACPR with the rest of the family. There was nothing to discuss with them. Mum had said no."

72. Kate Masters' evidence was that Mr Kirkpatrick did not make it clear that it was in her mother's best interests to avoid this procedure although she said she did not think he was recommending CPR. She had no idea why Mr Kirkpatrick was discussing it as her mother was not going to have a heart attack so why was he "going on about it".

73. Aside from the meeting Kate Masters' evidence was that on a number of occasions, before and after the meeting, clinicians would raise the issue of DNACPR with her. She was given what she described as a graphic description of the procedure. Kate said it was clear that the doctors did not want her mother to have this but she felt that they were badgering her with these descriptions in order to put the Notice in place. She could not understand what the point of it was as her mother's heart was strong, she did not think her mother would have a heart attack. Had her mother stopped breathing, she would not have expected CPR, that would only have occurred in the event of a heart attack.

5 March 2011

Second DNACPR Notice

74. When Dr Simons began her shift, the night doctors indicated that they had received a lot of calls during the

night regarding Mrs **Tracey**. Dr Simons reviewed her and noted that she was continuing to deteriorate and had a very poor prognosis. She felt it was important to make Mrs **Tracey** as comfortable as possible and to consider how best to manage her symptoms. As part of the future management, it was necessary to consider the appropriateness of a DNACPR Notice given that Mrs **Tracey** did not have long to live. Dr Simons asked the family to attend the hospital that day as it was important to discuss with them Mrs **Tracey**'s prognosis and ensure that adequate plans were in place to manage her care.

75. Dr Simons spoke firstly to Kate on the telephone, she was unable to attend it being her daughter's birthday. Dr Simons recalls a detailed discussion as to her mother's prognosis, explained that Mrs **Tracey** was not responding to treatment for her chest infection and was continuing to deteriorate. Dr Simons advised Kate that she felt Mrs **Tracey** would benefit from prioritising comfort and withdrawing drugs which would not result in clinical improvement. She discussed placing a DNACPR in Mrs **Tracey**'s notes, stating that CPR would be futile and cause unnecessary suffering.

76. Dr Simons recalled apologising to Kate for the first DNACPR Notice. Her understanding of the family's complaint was that they had not been involved in the discussion which led to the Notice. Their specific complaint was that they were told it was a medical decision and therefore they did not have a part to play in the decision. Kate did not comment either way as to whether her mother wanted such a Notice.

77. By the end of her conversation with Kate, Dr Simons felt pleased because they had reached an understanding upon DNACPR. Kate had agreed it was not in her mother's best interests, she also agreed that her mother should be made comfortable. As Kate was upset about the first Notice, Dr Simons told her that she would be putting another one in place, Kate agreed to that course.

78. Kate Masters said that it was Dr Natasha who rang her. Kate had got to know and like Dr Natasha, she found her sympathetic and a good communicator. They had a chat but it was not very medical. Kate raised the matter of the previous form, asking Dr Natasha if she knew what had happened and Dr Natasha apologised. Dr Natasha did raise CPR and told Kate that it was not a very nice procedure, clinicians did not like doing it but her description of the procedure was nicer than that given by other doctors. Kate Masters did not accept that Dr Natasha had said that CPR would be futile nor did she accept that she had agreed to it, the doctor had completely misrepresented her.

79. The next conversation Dr Simons had was with Alison Noeland who arrived at the hospital at about 10:15, Claire was the next to arrive and Mr **Tracey** arrived around midday. Dr Simons' evidence was that she had similar conversations with each of the family members. During the discussions she confirmed that Mrs **Tracey**'s prognosis was days to short weeks and spent a considerable amount of time discussing the proposed DNACPR Notice. It is undisputed that Dr Simons provided family members with an explanation as to what CPR would entail. Dr Simons stated that she explained the DNACPR Notice to the family, she was confident that the family were aware of what the Notice was as they asked a lot of questions about it and indicated that they felt it would be cruel to put Mrs **Tracey** through something so undignified. She believed that she had provided the family with a careful explanation because she was conscious that they had raised concerns regarding the first Notice and wanted to make it clear to them exactly what the Notice was and the consequence of it being placed in Mrs **Tracey**'s notes. All of the family members to whom Dr Simons spoke in relation to the Notice were in agreement with it being completed and being placed in Mrs **Tracey**'s notes. Had Mrs **Tracey** or her family objected to

the DNACPR, Dr Simons would have sought advice from senior colleagues and left it to them to make the decision regarding DNACPR and to fill in the Notice.

80. In view of the fact that Mrs **Tracey** had a very limited life expectancy. Dr Simons explained that she felt it was in Mrs **Tracey**'s best interests to discontinue treatment and begin palliative care. There was discussion as to a suitable venue, Mrs **Tracey** had indicated she would like to go home but Mr **Tracey** and Alison felt this would not be possible as the bungalow was too small and Mr **Tracey** would not be able to cope.

81. Dr Simons also discussed with the family whether Mrs **Tracey** was suitable for the Integrated Care Pathway for the dying patient, "ICP". Dr Simons said that she was aware from previous discussions with the family that their expectations were that Mrs **Tracey** would survive considerably longer than the prognosis given by clinicians and therefore she approached the issue of the ICP tactfully. She explained that it was about making Mrs **Tracey** comfortable in the final days of her life and gave an explanation of the drugs that would be given. Dr Simons says that she was certain that Mrs **Tracey**'s family were aware that she was on the ICP as she recalled discussing the title of the document with the family. As the document has the words "dying" in it, the family wanted to ensure that Mrs **Tracey** would not see it. Dr Simons checked with the nursing staff as to whether Mrs **Tracey** looked at the notes at the foot of her bed and was advised that she did not. Dr Simons arranged for the ICP notes to be kept at the end of the bed. The family were initially reluctant for Mrs **Tracey** to be put on the ICP as they felt she had a much better prognosis than in fact she had, as a result, Dr Simons spent a considerable amount of time discussing the issue. Eventually they agreed on the basis that the purpose of the ICP was to ease Mrs **Tracey**'s pain and distress.

82. Alison Noeland's evidence was that she arrived at the hospital at about 10.00am and met with Dr Natasha with whom she got on well. Dr Natasha said that tests showed that the tumour in her mother's lungs was making it difficult for her to breathe and her mother had days to short weeks to live. Alison told Dr Natasha that the family were very upset about the previous DNR Notice. When Claire arrived, the conversation continued between the three of them and Claire raised the issue of feeding, Dr Natasha said her mother could go for weeks without food. Dr Natasha said she needed to speak about the DNR form and suggested that the family speak to their mother. Alison said she could not do that as she knew it would upset her mother. Alison understood what Dr Natasha was saying about DNR but as she knew her mother did not want the form, she could not agree to it nor did she ask about the form itself. When Dr Natasha described DNR, she said it only affected heart failure, it would not affect the other treatment. In the event that the family did not agree with such a form, Dr Natasha said she would go back to the medical team. As to Mrs **Tracey** going home, Alison thought there was too much equipment for the home. If her mother went to a hospice, Alison believed she could "get back on her feet" and live out her days.

83. Claire **Tracey** remembered "bits and pieces" of the conversation with Dr Natasha, it was quite long. Claire found Dr Natasha to be very sympathetic, she had been there all the way through and knew the family's background. She remembered Dr Natasha raising resuscitation and asking if they needed to speak to their mother about DNACPR, Claire said she could not go to her mother, it would be too emotional. Alison said that CPR was not something they could agree to. Alison and Claire recalled Dr Natasha telling them that in the event that the family did not agree with such a form, she would go back to the medical team. Alison's last words to Dr Natasha were "if that's what you have to do, tell them you've discussed it

with us and we cannot agree."

84. Alison believed that Dr Natasha had an understanding of her mother's wishes. The doctor was trusted by Alison, she had done all she could for her mother. Following this discussion Alison thought there could be no DNR Notice, no medical team was working that weekend, there was no opportunity for discussion with such a team, therefore no Notice could be put in place. The note made by Dr Natasha misrepresents the views of the family.

85. Alison and Claire accepted that Dr Natasha did raise the ICP, she told them that a document for the care of the dying patient would be in her mother's file. It was not for the family but for the medical or nursing staff. It was upon that basis that she told them not to worry. No information sheet was received relating to the ICP. Dr Simons said that the family did not want the information sheet.

86. Mr **Tracey** recalled arriving at the hospital between 12:00 and 12:30pm and speaking to Dr Natasha who said that they needed to make a resuscitation decision. She said that Janet's ribs could break and that she would be electrocuted and asked Mr **Tracey** if that is what he wanted to happen to his wife. He said "of course not" but "the decision was Janet's and Janet's alone." Mr **Tracey** said he did not agree to a DNACPR nor did Dr Natasha discuss ICP with him.

87. Dr Simons said that no one was able to say what they thought Mrs **Tracey** wanted. In speaking to the family, she emphasised that the doctors had to make a decision, she was involving them in it. Underlying Dr Simons' position was her knowledge that if Mrs **Tracey** were to be resuscitated, she would have to go to NCCU for reintubation, NCCU were unwilling to reintubate. She had no memory of telling the family that if they did not agree to the policy, it would have to go back to the medical team.

88. Dr Simons' evidence was that once the family of Mrs **Tracey** had agreed to a DNACPR Notice and to the ICP, she consulted a number of colleagues to confirm whether they were in agreement with her proposed plan for Mrs **Tracey**'s management. The decision as to DNACPR was not one she could make herself. In NCCU she spoke with Dr Guptha, a Consultant Anaesthetist, who was in agreement with the plan for palliative care and the DNACPR Notice. Dr Simons also spoke to the Palliative Care Team and the Neurosurgeons, all of whom were in agreement. Dr Simons filled in the first three boxes on the Notice, namely "Reasons for initiation of DNACPR Order", discussion of the decision "Plan for Review." The Notice is reproduced at Appendix 2.

89. Dr Simons was cross-examined by Mr Havers QC as to why, as an SHO, she was raising these matters with the family when at a meeting the previous afternoon, it was noted that the patient was for resuscitation. She said that when she saw Mrs **Tracey** on 5 March, her condition had significantly deteriorated. It was not as it had been on 4 March, she was certain that Mrs **Tracey** was coming towards the end of her life. Dr Simons took it upon herself to raise the issue of resuscitation with the family as she felt it was very important. It was her impression as a result of speaking with Mrs **Tracey**, the family and the nursing staff that there was still a sense of denial regarding Mrs **Tracey**'s prognosis and she thought it unfair for the family to be unaware of how long Mrs **Tracey** had left and what was in her best interests for this time.

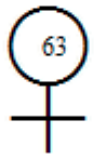
90. Dr Simons began her entry in the medical notes at 9.10am. She did not leave the hospital until 2.30 to 3.00pm, past her shift time. The discussions with the family ended between 1.00pm to 2.00pm. Dr Simons filled in the various parts of the DNACPR Notice and the ICP Notice before she left the hospital.

The nursing staff were concerned that there was no finalised care plan for Mrs **Tracey** and one was required. When speaking to the family she had the ICP in her hands, she ticked the relevant boxes when they were speaking and following her conversations with the family went back and filled in other parts of the form signing different pages. When she left the hospital Dr Simons believed that she had done her best for a patient she cared for and her family although it had been difficult.

91. The medical notes made by Dr Natasha on 5 March 2011 comprise two pages in Mrs **Tracey**'s medical records. The note is wrongly dated 05/04/2011. Dr Simons said that 09.10 represented the start of the note which would have been completed over a period of time. I have reproduced the entirety of the note:

"05/04/2011 G.NATASHA (SHO Neurosurgery)

09.10



1) Diagnosed with Metastatic Lung Ca 10/02

- sqaumous cell
- T4 NO3 MIB
- supraclavicular, mediastinal, hilar & coeliac lymphadenopathy.
- performance status 4, not appropriate for chemotherapy

2) RTA causing C2# 19/02 – caused by 3rd party

- family would like the coroner to be notified of this when the time comes.

3) Pnuemonia – chest drained 03/03

Fluid drained was parapnuemonic

- CXR & USS today confirms there is now

NO effusion

- Received 5/7 antibiotics on NCCU for pneumonia.

Then 9/7 antibiotics on the ward with NO clinical improvement.

IMP

1) Symptoms currently not being optimally treated and we should stop treatment of the pneumonia and begin palliative care.

2) Prognosis days to short weeks – discussed this with Mrs **Tracey**, Daughter Kate on phone, Daughters Alison and Clare in person. Mr **Tracey** in person.

3) Mrs **Tracey** says she would like to die at home. Mr **Tracey** & daughter Alison feel this would not be possible as the bungalow is too small for a hospital bed & Mr **Tracey** could not cope even with Macmillan input. Current agreed venue of care is Hospice near Ware.

4) I feel as does Mr **Tracey** & daughters Kate, Clare and Alison that resuscitation would not be in Mrs **Tracey**'s best interests & therefore a DNAR form needs to be completed – Registrar bleeped no reply, consultant called – Mr Kirkpatrick – message left.

Plan

1) Discussed case with Prof Gupta NCCU consultant who agrees with plan for palliative care.

2) Syringe driver started with advice from Palliative care consultant Dr Lorraine Peterson. Mrs & Mr **Tracey**, Daughters Kate, Alison and Clare are happy with this.

3) PRNs SC prescribed.

4) Unnecessary medications stopped.

5) ICP paperwork – doctors bits completed

- discussed with Mr **Tracey**, daughters Clare & Alison

- not for observations

- not for blood tests

- can eat & drink what she likes even if she aspirates

- Not for NG/TPN feedings

- Not for IV/SC fluids

6) Side room offered to Mrs **Tracey** – she declined.

7) Mr **Tracey** or one of their daughters may stay overnight. No visiting restrictions please in view of prognosis.

8) Asked nurses to initiate syringe driver, chase up Registrar signature of DNAR, complete

nursing part of ICP & immediate provision of continuing care form.

9) Have completed Doctors part of Immediate Provision of Continuing care form.

10) Have left message on Mr Kirkpatrick's phone about all of the above.

11) Katrina F2 on long day aware of all the above & will handover to night doctors.

12) If Mrs **Tracey** wants to remove her collar, she can

G. NATASHA

SHO

15 4654"

92. On the reverse of the DNACPR Notice are the instructions that the form is to be completed by a Specialist Registrar (ST3 or above, or a Consultant), Dr Simons interpreted that as referring to the signing of the form. She filled in the initial boxes, having done so, Dr Simons knew that a senior doctor would complete it, she hoped that Mr Kirkpatrick would be involved. Dr Simons omitted to include the fact that she had discussed the matter with Mr **Tracey**. As to her entry on the Notice "Patient does not want to discuss resuscitation" Dr Simons said that she had told Mrs **Tracey** she was concerned about her and it was important that she understood but Mrs **Tracey** declined to know more of the details. She was anxious, in a lot of pain and did not want to discuss these matters. Dr Simons asked Mrs **Tracey** if she would like to talk about her current condition and what Dr Simons felt should be done and Mrs **Tracey** said "No". Dr Simons did not pursue the matter with Mrs **Tracey** as it was causing her distress and was overly burdensome to talk to her about it.

93. Dr Koh, a Specialist Registrar in Neurosurgery at Addensbrooke's Hospital, was on duty on this evening. He was contacted by a member of staff as attempts to reach Mr Kirkpatrick had been unsuccessful and was informed that a DNACPR Notice was to be placed in Mrs **Tracey**'s notes following discussion with the family. The member of staff wanted Mr Koh to complete the form. As Mr Koh had not been involved in Mrs **Tracey**'s care, he said that before any form could be signed, he had to go through Mrs **Tracey**'s medical records. He did not speak to her but saw her from outside the cubicle. In reading the notes Mr Koh appreciated that three days earlier Mrs **Tracey** had expressed a wish to be resuscitated. Having noted that entry, he read subsequent entries and observed that Mrs **Tracey**'s condition was worsening, her oxygen saturation was low. Mr Koh noted that Mrs **Tracey** was unsuitable for chemotherapy and had a poor prognosis in view of her terminal lung cancer, serious unresolving infection and cervical fracture. By reason of the deterioration Mr Koh believed that he had to discuss Mrs **Tracey** with Mr Kirkpatrick before making a decision.

94. Mr Koh reviewed the detailed note of the discussion between Dr Simons and members of the family. He had no concerns as to the placing of a DNACPR Notice in Mrs **Tracey**'s notes given her very poor prognosis and the extremely low chance of CPR being successful. When he discussed the matter with Mr Kirkpatrick, he made reference to the details of the case and the note made by Dr Simons. Mr Kirkpatrick felt that the Notice was appropriate and approved it. Mr Kirkpatrick remembered the conversation with Dr Koh, he was expecting it as a result of his conversation with Kate Masters. It was

Mr Kirkpatrick's understanding that the family now agreed to the DNR Notice being reactivated, the decision was appropriate.

95. As to the requirements on the reverse of the Notice, Mr Koh was of the requisite status, namely ST3 or above, to complete the Notice. As to the contents of the Notice, he read through the entries and confirmed that what was on the Notice corresponded with the case notes. There was no reason to repeat the entries on a second Notice in his own writing. Mr Kirkpatrick was due to sign the Notice within 72 hours but Mrs **Tracey** died before this could take place.

6 March 2011

96. Luke Williams, a staff nurse at Addenbrooke's Hospital, was closely involved in the nursing care of Mrs **Tracey** following her transfer to Ward A5. Nursing staff had attempted to speak with Mrs **Tracey** about her prognosis on a number of occasions but she was adamant that she did not want to discuss it. Mr Williams' thought that Mrs **Tracey** was not coming to terms with the fact that she had a very short time left to live nor did she want to think about it. Her expectation of the treatment which she was receiving was that it should resolve her symptoms which he thought was partly due to the fact that nursing staff could not explain to Mrs **Tracey** that her symptoms were not resolving because of her underlying medical problems which were worsening. It was difficult to have meaningful discussions with Mrs **Tracey**, her family were reluctant for any staff to speak to her about her prognosis as they felt she would not be able to cope with the information.

97. Mr Williams had got to know Mrs **Tracey** and members of her family fairly well but had not met or communicated with Alison Noeland prior to 6 March 2011. In the early hours of that day, Mr Williams was the Acting Nurse in Charge, Alison was staying with her mother. Mr Williams said that Alison was awake and alert but distressed, he suggested to one of his colleagues that he should speak to her. Alison was in the day room, he went in and asked her how she was. Mr Williams initiated a discussion by asking Alison what she knew about her mother's condition, she was aware that her mother did not have long to live. Alison confirmed that Mrs **Tracey** was not aware of how advanced her condition was and was not aware of the DNACPR Notice which had been put in place on 5 March 2011. Mr Williams explained to Alison that whilst the staff were content not to force the issue of Mrs **Tracey**'s prognosis with her or the issue of the DNACPR Notice, they would be unable to withhold this information from her in the event that she changed her mind about wanting to know her prognosis and ask direct questions about it. Alison indicated Mrs **Tracey** would not be able to cope with hearing about her prognosis or the DNACPR Notice and that the family wanted to protect her from this information due to concerns about her fragile and anxious state. Mr Williams had not been involved in putting the Notice in place, however, when he spoke to Alison several hours after it had been done, she was aware of it and it was a part of their discussion. There was further conversation between them as to the family's presence on the ward and whether that was benefitting Mrs **Tracey** and the family.

98. The conversation lasted at least 20 minutes. Mr Williams said that Alison was not unhappy to engage with him. He raised the matter of the DNACPR Notice because Alison had been away and he wanted to know "where she was at in terms of care and the CPR order in order to establish what she thought and felt" in what he described as a context of uncertainty. The uncertainty related to the family and "who knew what at any given moment". Mr Williams was aware that there had been a first Notice which had been stopped, there was now another and he wanted to know what Alison felt about the Notice. Given the

number of family members who visited at differing times, some of Mr Williams' nursing colleagues were less than certain in knowing where each stood and what each knew.

99. Mr Williams believed he would have told Alison he had a duty of care to her as well as her mother, however, the wishes of the patient were paramount and came before those of the family. As Mrs **Tracey** was not willing to speak about such matters, that created difficulties. In cross-examination, Mr Havers QC criticised Mr Williams for having such a conversation in the early hours of the morning, Mr Williams did not accept the criticism and said that at no time was Alison reluctant to have the conversation with him. It was suggested to him that she was in a "frantic state" but he denied that.

100. Following his discussion with Alison Noeland, Mr Williams made an entry in the nursing record, timed at 02:00 hrs. The note includes the following:

> "Had an extensive conversation with Janet's daughter Alison who is in attendance to clarify what the family's views/wishes & experience were so far and what their hopes/expectations are, as well as offer support & recommendations about Janet's care – especially overnight. Alison confirmed that Janet is unaware of how advanced her condition is and of the DNACPR mandate, as ?? in denial & as a measure of protection by the family for her "fatigue/anxious state". I explained that this is acceptable at present, but that if Janet ask direct questions, we would be unable to withhold information or be dishonest (Alison understood) …"

7 March 2011

101. Mrs **Tracey**'s condition continued to deteriorate, she died at 10.38 on 7 March 2011. Alison and Claire were with their mother at this time. No CPR was given, none was sought.

The DNACPR Notice – the evidence of Mr Peter Kirkpatrick

102. 15 to 20 years ago such a Notice did not exist, the same team would care for one patient. As the health service expanded, a patient would be treated by different teams. This could lead to exposure, particularly at night, of undignified events following crash calls, namely a patient being resuscitated by a crash team who did not know the patient. The form was introduced to protect the patients and prevent the staff from embarking on inappropriate procedures.

103. Mr Kirkpatrick was clear: the imposition of a DNACPR Notice is ultimately a clinical decision. This point was not challenged by the claimant. It should be made following appropriate consultation and consideration of all aspects of the patient's condition. In making such a decision, Mr Kirkpatrick always takes into account the wishes of the patient and/or their family. He would debate with them the likely outcome following a resuscitation attempt but would not authorise resuscitation when a chance of a meaningful outcome was negligible. He regards the issue of resuscitation and DNACPR Notices as a sensitive one for patients and families and prefers to work with them in discussions to help them accept the futility of CPR and to better understand why a Notice is being advised.

104. The discussion with the relatives would generally be a "common sense discussion" leading to a sensible agreement about the DNR Order. The discussion would be clinician-led as the clinician would be the servant of the patient. It would the responsibility of the clinician to inform the relatives of the pathology and

of a final pathway. The primary consideration would be the best interests of the patient, secondary to that are the relatives. In the event of what Mr Kirkpatrick described as a "massive conflict" the clinician would act purely upon clinical sense even if that antagonised the relatives.

105. In the case of Mrs **Tracey** the clinicians were grappling with a clear cut conflict: the patient was in a miserable situation; she was in distress by reason of her breathing; dying from a terminal disease. The family could not understand the prognosis and wanted to protect Mrs **Tracey**. The difficulty for the clinicians was that the family were not allowing them to have a relevant discussion with Mrs **Tracey** but as between themselves, they would not make a decision. Mr Kirkpatrick said that normally a member of the family, it could be the son or daughter, would put his or her head above the parapet but within this family, no one was prepared to do that nor did they allow access to Mrs **Tracey** for such a discussion.

106. The medical team was unanimous in its prognostication: Mrs **Tracey** was dying; at some point there would be cessation of breathing; her heart would stop. What was contemplated was resuscitating a wife and mother who was in fact dying. As a clinician, Mr Kirkpatrick said that he found that unthinkable. He was content with the process of Mrs **Tracey**'s death as it allowed her dignity. Had Mrs **Tracey** arrested in front of him, Mr Kirkpatrick would not have called an arrest team.

Conclusion

107. Mrs **Tracey** was from her earliest days in Addenbrooke's Hospital, the subject of multi-disciplinary assessment and treatment. A full assessment of her condition included the intervention of the oncologists. Her initial treatment was aggressive, in keeping with the culture of the NCCU. It was only when such an approach failed to achieve any significant improvement that the clinicians observing and assessing her deterioration moved finally to consider the issue of resuscitation and the appropriateness of a DNACPR. Amongst the clinicians responsible for the care of Mrs **Tracey** during the last period of her life, there was unanimity: a DNACPR Order was appropriate in order to protect her from an undignified and cruel procedure which was of no clinical benefit.

108. The evidence of medical and nursing staff was that Mrs **Tracey** and her family were in denial as to her prognosis. The fact is clearly documented in the medical records. I find it is also reflected in the evidence of the family, in particular their stated belief that having been discharged from hospital, Mrs **Tracey** could "get back on her feet".

First DNACPR Notice

109. Dr Lavinio's evidence was clear: by 27 February 2011 Mrs **Tracey** was not for reintubation, a view shared by Dr Ford. As a matter of clinical fact, if such a patient suffers an arrest having been weaned from the ventilator, the issue of resuscitation would arise. Thus, the need to consider the appropriateness of a DNACPR Notice represents a logical, clinical step following a decision not to reintubate (Dr Ford paragraph 31 above).

110. I accept that this was the thinking of Dr Lavinio. He communicated his view on reintubation to Alison who felt she had to accept the position. Whether Dr Lavinio clearly communicated to Alison that resuscitation was not appropriate is less than clear. I accept it was the intention of Dr Lavinio to inform Alison of this next possible and logical step in the clinical process but whether in a wish to spare her the harshness of a

graphic explanation of CPR or a belief that in using words such as "slip away" he was conveying the entirety of such a scenario, I believe it likely that the entirety of the position was not fully understood by Alison.

111. The circumstances in which this conversation took place were less than ideal. Alison was confronted with a situation which could have led to the death of her mother within a relatively short time. She accepted that following extubation there would be no further reintubation and that her mother would be allowed to "slip away", implicit in that is that there would be no attempt to resuscitate Mrs **Tracey**. I do not believe that at the time of this conversation Alison fully appreciated the clinical implication of allowing her mother to "slip away". Given the circumstances in which she was given this information, her position can be understood.

112. As to Dr Lavinio I find:

i) The decision not to reintubate and thereafter not to resuscitate was a medical decision;

ii) He viewed the resuscitation decision, and with it the imposition of a DNACPR Notice, as a logical clinical step to be considered and resolved following a decision not to reintubate Mrs **Tracey**;

iii) Dr Lavinio believed that he had conveyed the resuscitation issue including the use of the DNACPR Notice to Alison who understood and agreed with it.

113. Alison's less than complete understanding of the resuscitation issue would be consistent with the research which she carried out upon her return to Norway. It was only then that she fully understood the meaning of a DNR Notice and its implications for her mother's future treatment. Of note is the fact that she carried out this research at a time when, on her account, there was an improvement in her mother's condition. As to her phone call to the hospital, I find that it was prompted by:

i) The knowledge she had obtained from her research of the full nature and effect of a DNACPR Notice; and

ii) The improvement in her mother's condition.

114. As to the conversation or conversations which Dr Lavinio said he had with Mrs **Tracey**, it is of note that:

i) Mrs **Tracey** is not named on the box on the DNACPR Notice, specifically directing the consultant completing the Notice to identify with whom the decision has been discussed;

ii) Dr Lavinio's note in the medical records includes no reference to conversation with Mrs **Tracey**;

iii) The NCCU care plan for 27/28 February 2011 reads "DNACPR patient not aware";

iv) Dr Alavi's note at 10:30 on 2 March 2011 records a discussion with the patient and that she "is against DNACPR and wants to be resuscitated."

v) Dr Summers' note at 11:45 on 2 March 2011 records "Mrs **Tracey** said she has never thought about or discussed resuscitation issues with the family or doctors and wishes to think about these issues with the family some more."

115. There is nothing in the medical/nursing records which suggests any agreement to DNACPR by Mrs **Tracey**. The tenor of entries prior to 4 March 2011 indicate that Mrs **Tracey** either did not agree or requested that any such discussion take place in the presence of her husband or daughters. If Dr Lavinio had such a conversation, it would have been of importance to note the same both on the DNACPR Notice and in the medical records. I am unable to accept that the absence of such a note is a result of no more than poor record keeping.

116. I do not doubt Dr Lavinio's real concern for his patient, nor his wish to spare her an undignified procedure which he, and other clinicians, believed to be of no clinical benefit. It may well be that such a concern also caused him to spare her a conversation which he knew was likely to cause distress to a suffering patient. In the absence of any documentation and in the light of what is known about Mrs **Tracey**'s view on the issue of resuscitation around the time of the first Notice, I am unable to accept Dr Lavinio's evidence that he spoke to Mrs **Tracey** about resuscitation prior to the implementation of the first DNACPR Notice.

117. Dr Lavinio was the Lead Consultant responsible for Mrs **Tracey**'s care on 27 February 2011. The Notice correctly records his (and Dr Ford's) view that "futility" was the reason for the initiation of the DNACPR Order. He correctly identifies two discussions: with a "daughter" (Alison) and Dr Ford. There was no requirement for a second clinician's signature on this Notice given that Dr Lavinio is a Consultant. Dr Lavinio dated but did not time the Notice.

Second DNACPR Notice

118. By 4 March 2011 the clinical condition of Mrs **Tracey** was one of unrelenting deterioration. The medical record at paragraph 60 above indicates that Mrs **Tracey** was approaching the terminal phase of her life. By this time the clinical deterioration of Mrs **Tracey** was such that treating clinicians had moved to consider how best to provide care for her in the terminal phase of her illness. Given the evidence, in particular of Dr Simons, I accept that her prognosis was not a matter which Mrs **Tracey** wished to discuss. Clinicians and nurses were concerned to discuss her care with Mrs **Tracey** and/or her family. The family were understandably protective of Mrs **Tracey** but that protectiveness, however well intentioned, created real difficulties for those responsible for her care in that it prevented discussion and had the potential to delay decision making which was becoming critical. Even on their own evidence, Alison and Claire were unwilling to discuss resuscitation with their mother on 5 March 2011.

119. The evidence of Mr Kirkpatrick as to the condition of Mrs **Tracey**, the response of her family and the difficulties which the same created for the treating clinicians was insightful, considered and compelling. Against such a background, his account of the meeting on 4 March 2011 rings true. The clinical account and advice which Mr Kirkpatrick gave to the Kate and Claire is at one with the clinical picture of Mrs **Tracey** as documented in the medical records and consistent with the belief of treating clinicians that DNACPR was not in the best interests of Mrs **Tracey**. Kate Masters spoke of his sincerity and his concern that the family should spend as much time as possible with Mrs **Tracey** who did not have long to live. As to Mr Kirkpatrick's evidence of the telephone conversation with Mr Koh the next day, I accept that Mr Kirkpatrick believed that, finally and as a result of the meeting, someone in the family had

taken charge. It was a belief that had about it a reasonableness which underscores my assessment of the credibility of his evidence as to the meeting with Kate and Claire.

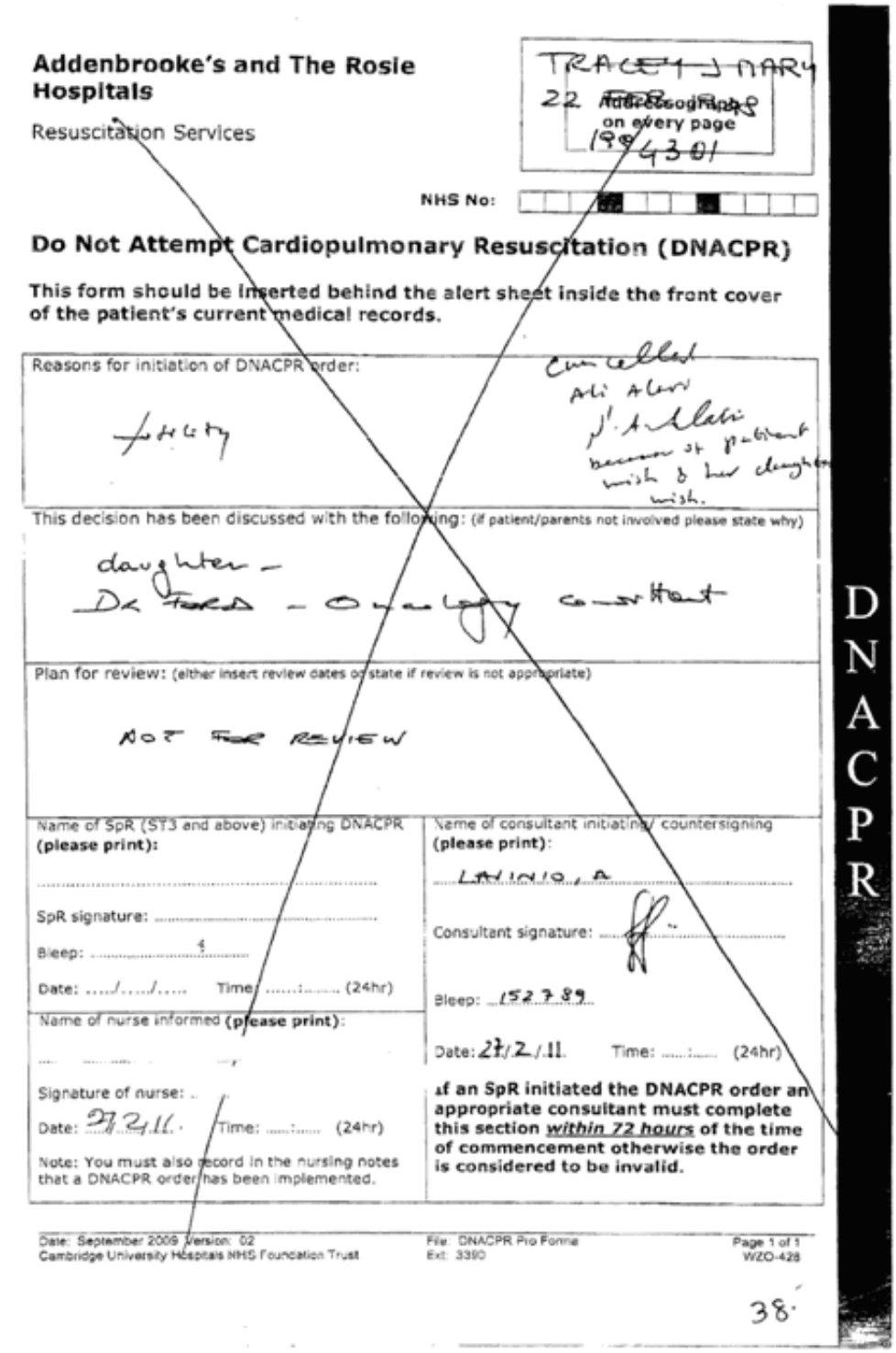
120. Dr Natasha Simons was a calm, thoughtful and dignified witness. It was at the end of her evidence that a hint of emotion broke through when she spoke of Mrs **Tracey**, a patient she "cared for". I have no difficulty understanding why this doctor was liked and trusted by the family. A reflection of the care which she brought to her work is demonstrated by the time which she spent with individual members of the **Tracey** family on 5 March 2011. She ensured that she spoke to all of them, she worked beyond her shift and completed detailed paperwork. Her concern was not only for Mrs **Tracey**, it was for the family who loved her. Dr Simons was aware that the family were in denial as to the true clinical picture, these were her efforts to put in place appropriate care for Mrs **Tracey**'s final days. I regard the claimant's criticism that it was inappropriate for a junior doctor to embark upon such a course as misplaced. Dr Simons knew the clinical picture, her patient, she knew the family. She was well placed to offer informed advice and she did. The information and advice given by Dr Simons was at one with the view of more senior clinicians within the multi-disciplinary team. Her knowledge, advice and actions were set out in her entry in the medical records. The detail of this two page note is reflective of the care which she brought to this matter. It is of note that having obtained the agreement of the family, Dr Simons further discussed the matter with senior clinicians, paragraph 88 above.

121. I have no hesitation in accepting Dr Simons' account of what took place on Saturday 5 March 2011. It makes clinical sense, it is consistent with the view I formed of Dr Simons, namely an informed and caring clinician. It is consistent with Mr Kirkpatrick's account of his meeting with Kate Masters on the previous day. If I were in any doubt as to the veracity of Dr Simons' account, I note the evidence relating to and the note made by Staff Nurse Williams on 6 March 2011 of his meeting with Alison Noeland. What this demonstrates is that a matter of hours later, Alison Noeland was aware that a DNACPR Notice had been placed in her mother's records albeit Mrs **Tracey** was unaware of that fact. Alison Noeland knew because that had been the advice given by Dr Simons and accepted by the family on 5 March. It was also the advice given by Mr Kirkpatrick and accepted by Kate Masters the previous day. I am satisfied that in so advising the family members, Mr Kirkpatrick and Dr Simons did so in terms that were or should have been capable of being understood. I am unable to accept the claimant's contention that what occurred on 5 March 2011 as between Dr Simons and the family was acceptance by the family that this was a purely medical decision and it was not for them to "agree" to the DNACPR. Such a submission does not begin to address the detail of Dr Simons' written record or the reality of the evidence.

122. When Dr Simons made her entries on the second DNACPR Notice, she was not the most senior member of the medical team or an ST3 or above. She omitted to include her discussions with Mr **Tracey** on the Notice. Dr Simons correctly recorded the clinical reasons for the Notice and the position of Mrs **Tracey** and her daughters. Mr Koh signed the Notice having discussed it with Mr Kirkpatrick. Mr Kirkpatrick had discussed the relevant issues with the family on the previous day. The decision was ultimately that of Mr Kirkpatrick, he approved the making of the DNACPR Order. Mr Kirkpatrick was unable to sign the Notice before the death of Mrs **Tracey**.

123. The answers to the 44 questions are to be found at Appendix 3. They cannot and should not be read in isolation.

Appendix 1



Addenbrooke's and The Rosie Hospitals

Resuscitation Services

TRACEY J MARY
22 DOB
Addressograph on every page
1994301

NHS No:

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

This form should be inserted behind the alert sheet inside the front cover of the patient's current medical records.

Reasons for initiation of DNACPR order:

futility

Cancelled
Ali Alavi
[illegible]
because of patient
wish & her daughter
wish.

This decision has been discussed with the following: (if patient/parents not involved please state why)

daughter –
Dr Ford – Oncology consultant

Plan for review: (either insert review dates or state if review is not appropriate)

NOT FOR REVIEW

Name of SpR (ST3 and above) initiating DNACPR **(please print):**

SpR signature:

Bleep: 4

Date: ..../...../..... Time: ..... (24hr)

Name of consultant initiating/ countersigning **(please print):**

LAVINIA

Consultant signature:

Bleep: 152789

Date: 27/2/11 Time: ..... (24hr)

Name of nurse informed **(please print):**

Signature of nurse:

Date: 27/2/11 Time: ..... (24hr)

Note: You must also record in the nursing notes that a DNACPR order has been implemented.

If an SpR initiated the DNACPR order an appropriate consultant must complete this section *within 72 hours* of the time of commencement otherwise the order is considered to be invalid.

Date: September 2009 Version: 02
Cambridge University Hospitals NHS Foundation Trust

File: DNACPR Pro Forma
Ext. 3390

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WZO-428

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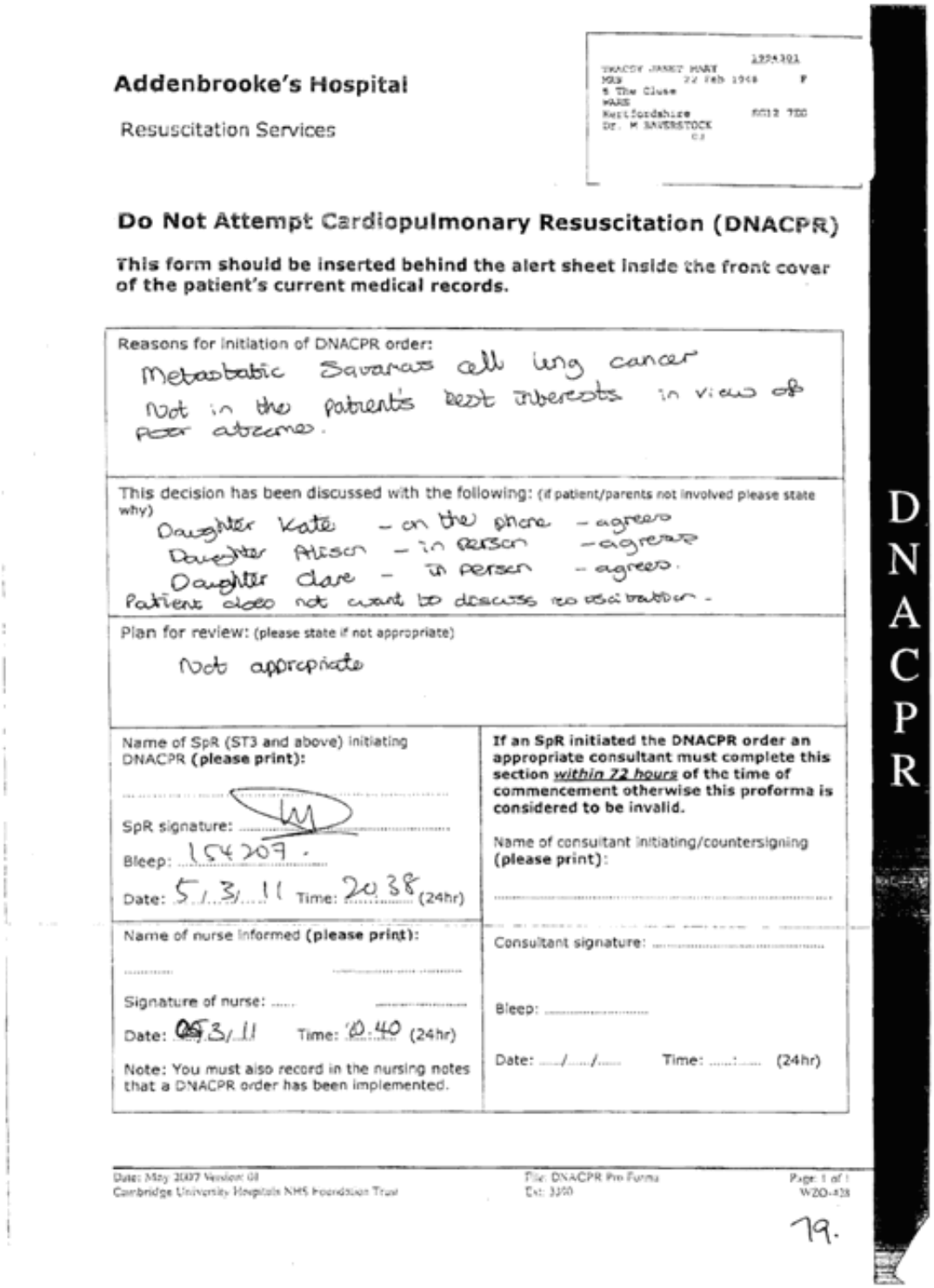
DNACPR

Appendix 2



Addenbrooke's Hospital

Resuscitation Services

1994301
TRACEY JANET HART
NHS 22 Feb 1968 F
9 The Close
WARE
Hertfordshire SG12 7EG
Dr. M SAVERSTOCK
GP

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

This form should be inserted behind the alert sheet inside the front cover of the patient's current medical records.

Reasons for initiation of DNACPR order:
Metastatic Squamous cell lung cancer
Not in the patients best interests in view of poor outcomes.

This decision has been discussed with the following: (if patient/parents not involved please state why)
Daughter Kate - on the phone - agrees
Daughter Alison - in person - agrees
Daughter Clare - in person - agrees.
Patient does not want to discuss resuscitation -

Plan for review: (please state if not appropriate)
Not appropriate

Name of SpR (ST3 and above) initiating DNACPR **(please print):**
.....
SpR signature: .....
Bleep: 15207.
Date: 5/3/11 Time: 2038 (24hr)

If an SpR initiated the DNACPR order an appropriate consultant must complete this section *within 72 hours* of the time of commencement otherwise this proforma is considered to be invalid.

Name of consultant initiating/countersigning **(please print):**
.....

Name of nurse informed **(please print):**
.....
Signature of nurse: .....
Date: 05/3/11 Time: 10.40 (24hr)

Note: You must also record in the nursing notes that a DNACPR order has been implemented.

Consultant signature: .....
Bleep: .....
Date: ...../...../..... Time: ...:... (24hr)

Date: May 2007 Version: 08
Cambridge University Hospitals NHS Foundation Trust
Title: DNACPR Pro Forma
Ext: 3350
Page: 1 of 1
W2O-438

79.

DNACPR

Appendix 3
Agreed List of Questions

References are to paragraph numbers in the judgment.

1. Did the Deceased have at the material times the capacity (within the meaning of the Mental Capacity Act 2005) to decide:

a. to engage in discussion with her treating clinicians regarding DNACPR;

b. whether to agree or object to a DNACPR notice being placed in her records;

c. whether to give directions as to consultation with family members regarding the placing of a DNACPR notice in her records?

Yes to a, b and c.

2. What written information regarding DNACPR notices and resuscitation decisions was provided to (a) the Deceased; and (b) her family members during the Deceased's admission to Addenbrookes in February/March 2011?

None to (a) and (b)

(paragraphs 13-15)

3. What information was available to (as distinct from necessarily provided to) the claimant and her family in February/March 2011 concerning DNACPR?

This issue is addressed in subsequent questions.

THE FIRST DNACPR NOTICE

4. What, if any, discussions did the Deceased's treating clinicians have with (a) the Deceased; and (b) with members of the Deceased's family regarding DNACPR generally prior to the point at which consideration was given to the placing of the first DNACPR notice in her medical records?

(a) Deceased – none (paragraphs 40, 43, 114-116).

(b) Dr Lavinio and Alison Noeland (paragraphs 34, 37, 42, 43, 45, 109-113)

5. What, if any, views did the Deceased give to the healthcare team as to her wishes regarding (1) the DNACPR; and (2) consultation with her family prior to the point at which consideration was given to the placing of the first DNACPR notice in her medical records?

None to (1) and (2).

6. What factors were taken into account when arriving at the decision to place the first DNACPR notice in the Deceased's medical records?

The futility of the procedure: Dr Ford (paragraphs 28-31), Dr Lavinio (paragraphs 37-39,

41-42).

7. Was the Deceased consulted prior to the placing of the first DNACPR notice in her records?

No.

8. If so, what was the nature and extent of that consultation?

N/A

9. If not, why not?

N/A paragraphs 114-116

10. Was the Deceased made aware that the first DNACPR notice had been placed in her records (1) at the time; (2) subsequently?

(1) No

(2) The Deceased became aware on or around 2 March 2011.

11. If not, why was the Deceased not made aware?

N/A

12. If so, how was the Deceased made aware of the first DNACPR notice, by whom and when?

Clinicians told the Deceased, paragraph 56.

13. Were any members of the Deceased's family consulted prior to the placing of the first DNACPR notice in records?

Yes – Q4

14. If so, by whom? And what form did the consultation take with the relevant family member(s)?

See Q4

15. If not, why was the Deceased's family not so consulted?

N/A

16. If the Deceased had the relevant mental capacity (see above), why were such family members consulted?

See Q4

17. If consultation did take place with a family member of members did that family member agree or disagree with the decision to place the first DNACPR notice in the Deceased's medical records?

See Q4

18. Was the Deceased's family made aware that the first DNACPR notice had been placed in the Deceased's records (1) at the time; (2) subsequently?

See Q4

19. If not, why not?

N/A

20. If so, by whom and when?

N/A

21. What, if any, steps were taken to record the placing of the first DNACPR notice in the Deceased's medical records, including the patient's wishes and the factors which were taken into account?

See Q4

22. Did such steps comply with the requirements of the first defendant's policy?

The Notice made no reference to the Deceased's wishes. The Notice was not timed.

23. Was a second opinion offered to the Deceased or her family as regards the placing of the first DNACPR notice upon her medical records? If not, why not?

No, it was not required.

24. What was the basis upon which the first DNACPR notice was cancelled?

Paragraphs 49-53

25. What, if any, discussions did the Deceased's treating clinicians have with (a) the Deceased; and (b) members of the Deceased's family regarding DNACPR generally prior to the point at which consideration was given to the placing of the second DNACPR notice in her medical records?

(a) The Deceased: paragraphs 56, 62

(b) Family: paragraph 58

26. What, if any, views did the Deceased give to the healthcare team as to her wishes regarding (1) DNACPR; and (2) consultation with her family prior to the point at

which consideration was given to the placing of the second DNACPR notice in her medical records?

(1) See Q25

(2) See Q25

27. What factors were taken into account when arriving at the decision to place the second DNACPR notice in the Deceased's medical records?

The factors were identified on the Second DNACPR notice. Evidence of Mr Kirkpatrick (paragraphs 63-67, 103-106, 119) and Dr Simons (paragraphs 74-80, 86, 87, 89, 90, 91, 120).

28. Was the Deceased consulted prior to the placing of the second DNACPR notice in her records?

No. By 5 March 2011 the Deceased did not wish to engage in such discussion, her family did not wish to involve her in such discussions, paragraphs 63, 82, 83, 96.

29. If so, what was the nature and extent of that consultation?

N/A

30. If not, why not?

See Q28

31. Was the Deceased made aware that the second DNACPR notice had been placed in her records (1) at the time; (2) subsequently?

No

32. If not, why was the Deceased not made aware?

See Q28

33. If so, how was the Deceased made aware of the second DNACPR notice, by whom and when?

N/A

34. Were any members of the Deceased's family consulted prior to the placing of the second DNACPR notice in her medical records?

Yes

35. If so, whom? And what form did the consultation take with the relevant family member(s)?

Dr Kirkpatrick (paragraphs 63-67, 118)

Dr Simons (paragraphs 74-80, 86, 87, 90, 119, 120)

36. If not, why was the Deceased's family not so consulted?

N/A

37. If the Deceased had the relevant mental capacity (see above), why were such family members consulted?

See Q28

38. If consultation did take place with a family member or members did that family member agree or disagree with the decision to place the second DNACPR notice in the Deceased's medical records?

The family agreed, see Q35

39. Was the Deceased's family made aware that the second DNACPR notice had been placed in the Deceased's records (1) at the time; (2) subsequently>

Yes, see Q35

40. If not, why not?

N/A

41. If so, by whom and when?

See Q35

42. What, if any, steps were taken to record the placing of the second DNACPR notice in the Deceased's medical records, including the patient's wishes and the factors having been taken into account?

See Q35

43. Did such steps comply with the requirements of the first defendant's policy?

Paragraphs 92-95. Legal argument will be required at the second stage of this matter as to whether the form was "completed" by the appropriate clinician.

44. Was a second opinion offered to the Deceased or her family as regards the placing of the second DNACPR notice upon her medical records? If not, why not?

No, it was not required.

URL: *http://www.bailii.org/ew/cases/EWHC/Admin/2012/3670.html*