SUPREME COURT OF QUEENSLAND

CITATION:	*Cairns and Hinterland Hospital and Health Service v JT by JT's Guardian* [2014] QSC 251
PARTIES:	**CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE** (applicant) **v** **JT BY JT'S GUARDIAN** (respondent)
FILE NO/S:	280 of 2014
DIVISION:	Trial
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Cairns
DELIVERED EX-TEMPORE ON:	1 September 2014
DELIVERED AT:	Cairns
HEARING DATE:	1 September 2014
JUDGE:	Henry J
ORDERS:	1. **The time for service of the application be abridged.** 2. **It is in the best interests of JT that:** **(a) the prescription and or administration of antibiotics, insulin, artificial hydration and nutrition currently being provided to JT by way of percutaneous endoscopic gastronomy or by naso-gastric administration or by any other means be ceased;** **(b) cardiopulmonary resuscitation not be provided to JT.** 3. **The continuation or commencement of the measures described in Order 2 would not be inconsistent with good medical practice.** 4. **The cessation of the measures described in Order 2 is lawful.** 5. **There be no order as to costs.**
CATCHWORDS:	HEALTH LAW – PATIENT TREATMENT – WITHDRAWAL OF TREATMENT – PARENS PATRIAE JURISDICTION – where JT suffered an hypoxic injury secondary to diabetic ketoacidosis and cardiac arrest – where he remains in an unconscious state in hospital – where his life is perpetuated by feeding through percutaneous gastronomy tube – where JT previously expressed a wish to his wife and

family he would not want to remain in such a state – where JT's wife is his guardian for health matters – where the applicant seeks orders declaring it is in the best interest of JT that prescription and/or administration of treatment and nutrition provided to JT be discontinued and cardiopulmonary resuscitation not be administered – whether court should invoke *parens patriae* jurisdiction – whether JT is in a vegetative state or minimally responsive state – whether it is in JT's best interests to withhold or withdraw life-sustaining measures and cardiopulmonary resuscitation not be administered

Criminal Code 1899 (Qld) s 285, s 296
Guardianship and Administration Act 2000 (Qld) sch 2, s 5(2)

Aintree University Hospitals NHS Foundation Trust v James and Ors (2014) AC 591, applied
Northridge v Central Sydney Area Health Service (2000) 50 NSWLR 549, applied
Secretary, Department of Health and Community Services v BB (Marion's Case) (1992) 175 CLR 218, applied

COUNSEL: S Gallagher for the applicant
J Frizzo for the respondent

SOLICITORS: Corrs Chambers Westgarth for the applicant
O'Connor Law for the respondent

HIS HONOUR**:** This application, in its initial form, sought orders including an order that the applicant, which controls the hospital in which JT is housed and treated, cease the prescription and/or administration of insulin, artificial hydration and nutrition currently being provided to JT by way of percutaneous endoscopic gastronomy or by nasogastric administration, or by any other means, and not provide cardiopulmonary resuscitation to JT. The practical effect of those orders involved a request for this court to tell those managing the medical care of JT what to do.

The applicant's position has since modified so that the orders now sought are not that the applicant cease or abstain from doing those things, but that it will be declared to be in the best interests of JT that those actions ought not occur, that they would be inconsistent with good medical practice, and that their cessation would be lawful.

JT's wife became his guardian for decisions about personal matters, including health care, by an order of QCAT on 13 February 2013. She supports this application, but of course is the respondent. While a participant in the proceedings, she is not a driver of it. She might, herself, have taken a more determinative approach, given that her role as guardian of JT in respect of health care includes by operation of schedule 2 section 5(2) of the Guardianship and Administration Act 2000, the withholding or withdrawal of a life-sustaining measure for the adult if the commencement or continuation of the measure for the adult would be inconsistent with good medical practice.

Her cautious approach in not being a driver of the present proceeding, notwithstanding her role as JT's guardian and potential power to act in her dealings with the applicant without an application of this kind occurring, is understandable.

The question of whether the withholding or withdrawal of life-sustaining measures in respect of JT would or would not be inconsistent with good medical practice is not itself the determinative question in this proceeding, although to the extent that the applicant may, after my orders, seek to consult the respondent, both parties will be able to do so with the benefit of information as to my view about one of the orders sought, namely that the continuation or commencement of the measures would be inconsistent with good medical practice.

The jurisdiction of the court which the application seeks to invoke is the parens patriae jurisdiction. That long established protective jurisdiction of the Court empowers the Court to protect those who cannot help themselves; to protect the human dignity and rights of individuals who are disabled in such a way that they cannot protect such dignity and rights for themselves. It extends to the protection of the life and bodily integrity of persons who are unable to protect themselves by reason of unconsciousness, see, for example, *Northridge v Central Sydney Area Health Service* [2000] 50 NSWLR 549. In *Secretary, Department of Health and Community Services v BB (Marion's Case)* (1992) 175 CLR 218, the High Court recognised the overriding criterion for the exercise of the parens patriae jurisdiction is the protection of the best interest of the health and welfare of the person the subject to it. It is a criterion virtually indistinguishable from the test referred to in light of English decisions, admittedly a test with a statutory derivation, of the best interests of the person sought to be protected where that person is a patient and is the subject of life-sustaining care without which the patient will die.

The assessment of what is in the best interest of the health and welfare of JT falls to be determined subjectively, that is, it is not exercised by reference to perceived objective acceptable standards of existence in the minds of healthy and undisabled persons. Rather it has regard to the actual state of the person to be protected regardless of how extraordinary that person's circumstances might be thought to be by reference to objectively healthy people. Thus, the best interests of the person to be protected is assessed by reference, in effect, to what that person would, if able to express an informed view on it, regard as being in his or her best interest.

I turn then to JT's circumstances. JT, a 37 year old married father of two, suffered a severe hypoxic injury secondary to diabetic ketoacidosis and cardiac arrest on the 16th of November 2012. He was away in another city at the time for a work seminar and reported to his wife in the evening that he was feeling unwell. In the morning, not having heard from him, his wife raised the alarm by telephone and staff at the hotel where he was staying discovered him unconscious. He had cardiopulmonary arrest en route to hospital. He was in a diabetic ketoacidosis coma with hyperkalaemia. The hospital engaged in urgent life-preserving intervention. He would clearly have died but for that intervention. It may readily be inferred that at that time were he able, he would have consented to intervention for it was not yet known how extensive the damage he had suffered was. His loved ones would have been of a similar mind. The health authorities, therefore, are not to be criticised for having attempted to preserve his life in this emergency.

The upshot, though, is that after all that modern medical science can do for him has been done, he lies in a hospital bed in an apparently unconscious state, his life being perpetuated by feeding through a percutaneous gastronomy tube inserted in his abdomen,

a catheter inserted in him to cope with body waste, and insulin being regularly injected into him to deal with his body's diabetic state.

Prior to this catastrophe, save for his diabetes, JT enjoyed a normal life with a normal family and expressed normal comments about what he would want to occur were he to ever, as he put it, "end up as a vegetable" or "couldn't wipe my own arse". He made it plain in such a situation he would not want to be left like that and would want his loved ones, as he put it, to, "turn the bloody machine off". He had a longstanding dislike of hospitals. He made it plain through comments to his wife that were he to end up in an induced state unable to care for himself and unable to properly function, permanently hospitalised, that he would not want her to, "ever let me be like that".

Since his hospitalisation his loved ones have, of course, visited him. It has been extremely difficult for them as time has gone on as it became increasingly obvious there was going to be no improvement and that they would not have their husband, father, son or sibling back. The difficulty in a psychological sense for his children has been particularly profound, unsurprisingly. Doubtless that adverse impact is the very kind of thing JT used to have in mind when he made plain he did not want to be lying like a vegetable in hospital, inferentially because of the distress in an ongoing way that would occasion his loved ones and its pointlessness to his existence.

His loved ones who visit from time to time have not detected meaningful improvement. His wife has been a particularly regular visitor. She perceives his condition has gravely deteriorated.

She noticed that he has experienced at times muscle contractions where everything appears to be stiff. As she puts it:

> *To start with you could touch him without him looking like he's crunching up, but everything is now frozen up. If you touch him he recalls from the touch as if it hurts…*
>
> *In the time that [JT] has been in the hospital I've never seen anything from him that indicates any awareness of anyone. I think he can be aware if there's a noise of something around him, but it doesn't compute. There is no sign of recognition of me or the kids or any other visitor that I'm aware of. Initially, you could think he was looking at you, but it was really like he was looking through you not at you. Sometimes you would move and it would seem like he might follow you with his eyes, but I don't know whether he did. Now, he lies there staring or with his eyes closed. When he stares he does not alter where he's looking. I think he can hear but don't think he can compute what the sound is. I remember once a door banging like it had been slammed. His whole body flinched but it didn't blink…*
>
> *I have never seen him respond to any deliberate stimuli and any apparent reaction. I've never been able to get him to reproduce anything that might have been a response to stimuli…for a long time I thought there was no change in [JT's] condition but I recall visiting him on 6 February 2014 and when I felt that there was a definite change for the worse which has continued. I felt that he was completely unresponsive to anything whatsoever. Maybe I've truly realised or possibly he may have*

> *deteriorated a little. I really don't know but there was something very different.*

A variety of medical evidence is before the Court. HE, senior medical officer at the hospital with primary care of JT, opines JT is unaware of his surroundings, has shown no sign of improvement in his condition in the last 12 months, appears to be in a persistent vegetative state from which there is no prospect of recovery and that it would be in keeping with good medical practice to withdraw life-sustaining measures. If those measures are withdrawn he would develop diabetic ketoacidosis and die within two to five days, in her opinion.

DM, a physician and director of rehabilitation medicine for the applicant, assessed JT on 14 August 2014, an assessment that included reference to his clinical history. He detected that there was tracking to visual stimuli with JT's eyes following moving visual stimulus in a visual field but reported no other response to stimuli. Because the trajectory of recovery from anoxic brain injury tends to result in an early plateau within six to 12 weeks he opined there was little optimism that there would be any further neurological recovery. He agreed with an assessment of MA, to which I will shortly come, that JT is in a minimally responsive state.

HD, rehabilitationist and rheumatologist, examined JT on the 22nd of February 2014 in addition to examining and assessing his records. In doing so, he was aware of MA having in the past noted some tracking by JT in respect of visual stimuli. HD detected no such tracking, noting inter alia:

> *His eyes showed no sign of fixation or following when a familiar object was moved within view or with voice…there is no extra ocular movement of the eyes with testing the vestibular reflex…at no time did [JT] say any words or show signs of interacting with the environment or persons in it.*

The doctor's report goes on to explain that JT was physically re-examined on a number of occasions during his consultation and the responsiveness, including the absence of eye following, was consistent. He opined that JT is in a permanent vegetative state.

The term "permanent vegetative state" is usually applicable in cases of traumatic brain injury after the lapse of 12 months and in the case of anoxic ischaemic encephalopathy after a period of more than three months has elapsed. It appears the term "permanent vegetative state" is used interchangeably with the term "persistent vegetative state".

HD reported some patients with severe alteration in consciousness have clinical findings that do not meet the criteria for vegetative state, explaining:

> *These cases have behavioural evidence of consciousness, but the patients remain unable to reproduce the behaviour consistently. Such a condition is referred to as a minimally conscious state.*

He explains:

> *The vegetative state is diagnosed on clinical examination after coma in which eye opening and development of a sleep/wake cycle are present, however no evidence of conscious awareness, discernible by evidence of*

> *self or environmental awareness, is demonstrated on a reproducible or sustained basis by one or more of the following behaviours:*
>
> - *following simple commands;*
> - *gestural or verbal yes/no responses (regardless of accuracy);*
> - *intelligible verbalisation;*
> - *purposeful behaviour, including movement or affected behaviours which occur in contingent relation to relevant environment stimuli and are not due to reflexive activity.*

He opines that persons with a minimally responsive state (minimal conscious state) will exhibit one of those purposeful behaviours. His report provides some examples of qualifying purposeful behaviour, which includes:

> *Pursuit eye movement of sustained fixation that occurs in direct response to moving or salient stimuli.*

I cite the behaviour associated with eye movement in response to stimuli, for an issue has arisen in this case in relation to that reaction.

HD identifies eight criteria for diagnosis of a permanent post-coma unresponsive permanent vegetative state. By reference to all eight of those criteria, he opines JT is in a vegetative state or permanent post-coma unresponsiveness. He opines JT has no prospect of recovery and that because of his extensive cortical brain damage JT would have no awareness of his state. If his treatment were to continue, the doctor explains that he would continue to remain in a non-sensate permanent vegetative state unless his cardiorespiratory functions fail, probably within the next three to five years, though possibly longer.

He opines that in the absence of insulin treatment he would, within 48 hours, go into diabetic ketoacidosis and, ultimately, his heart would stop within a matter of four to five days. HD opines continuing medical treatment, including tube feeding and insulin, is futile as it is only enabling the hopeless situation, that is, one in which JT has, by all measures, no quality of life, to persist. It is difficult to rationally consider the concept of quality of life, in my view, as a measure in reference to JT, in that his state of brain damage is such that his mind simply has no awareness of anything at all.

RA, consultant neurologist, examined JT, and his associated records, on 22 February 2014. Her conclusions opine that he has no ability to follow simple verbal commands, give yes or no answers verbally or with gestures, no ability to follow objects or move with his eyes in a voluntary and meaningful fashion, and no ability to respond to unpleasant stimuli with voluntary movements or meaningful emotion.

As she observes, whilst confronting to the examining physician (in that his eyes are open and he is breathing spontaneously), he exhibits absolutely no evidence of awareness of self or surroundings. She considers sufficient time has elapsed to have been able to make a diagnosis as to vegetative state and opines that JT is in a permanent vegetative state with no prospect of recovery. Continuing treatment, in her opinion, offers JT no benefits in that he has no awareness of self or environment. As with HD, she considers it would be consistent with good medical practice to withdraw life-sustaining treatment. In expressing that opinion, both she and HD have regard not merely to the clinical state of JT but also the impact of his state upon his loved ones as well as his own reported wishes in the past

were he to end up in the state he is now in. In that sense, good medical practice is not limited to the clinical state of the patient but also the patient's wishes.

MA, consultant neurologist at a local hospital, examined and assessed JT from 31 July 2013 to 15 August 2013. He initially considered JT was in a vegetative state but altered his opinion because he considered JT no longer fulfilled criteria for a persistent vegetative state as he was able to repeatedly track to a large, visual stimulus which was said to be a colourful picture on an iPad. He explains it occurred on a number of attempts on two of the days during his involvement in 2013 with JT. He considered that repeated observation precluded a diagnosis of a persistent vegetative state, and he preferred a diagnosis of a minimally conscious state or minimally responsive state as it is also known.

In an affidavit on 14 July 2014, albeit one based on information he had obtained back in July and August of 2013, he opined:

> *[JT] has shown slight improvement neurologically from a persistent vegetative state to a minimally conscious state. It is possible (but as yet undetermined) that there may be further slight improvement although there can be no reasonable expectation that he would improve beyond a state of severe disability. As I do not believe that he remains in a persistent vegetative state and that it is not yet clear whether he has yet reached his best level of neurological function, then I believe a decision on withdrawal of care would be better based on [JT's] previously expressed wishes.*

This matter came before me on the 15th of July 2014. When I apprehended the digression in opinion as between particularly MA and Doctors HD and RA I expressed a desire to hear evidence from MA. I have heard evidence from him today.

In the interim, arrangements were made for JT to be transferred and admitted to the hospital where MA practices. JT remained there from the 13th of August to the 21st of August during which time MA reviewed him on multiple occasions. He reports that during that time JT showed evidence of visual tracking on repeated examinations. However, JT remained unable to follow simple commands, indicate yes/no by voice or gesture, verbalise, show emotional response to various stimuli or reach for proffered objects.

At first blush concerning digression between MA's observations of tracking and the observations of other experts that there was no visual tracking is likely explained by a variance in method. As he explained in evidence today, tracking by the eyes is commonly tested by use of a small object such as a pin being moved whereas contrary to that practice MA used a much more sizeable object. The process he explained involved the use in a later session of an iPad Mini showing on it a particularly colourful photograph incorporating children playing. It would be appreciated that such a device has its own light generation and has more obvious visibility than, for example, a dull object of the same dimensions. Further, MA explained that the iPad Mini would be held only two feet from JT's eyes during the movements to ascertain whether tracking occurred.

There is no reason to doubt the reliability of MA's account in respect to tracking. The rational conclusion to reach is that tracking has not been detected by a number of the other medical professionals I have mentioned because they have not used such an obvious means of attracting the attention of the eye.

What is of significance with this tracking as MA explains, is that it is not an instinctive reaction of the body as, for example, may occur if JT were pricked with a pin and flinched. Such a reaction would be purely driven by the brain stem and no broader functioning. It would thus be consistent, with a vegetative state. The eye tracking detected by MA must involve, albeit to a minuscule degree, some degree of functioning beyond the brain stem in the cerebral hemisphere; the thinking or awareness part of the brain.

When queried as to the significance of this phenomenon as indicative of what, if anything, might still be going on inside JT's mind, MA pointed to the absence of other indicia to explain its significance. As he put it, the complete absence of any other reproducible reactions beyond those which might automatically be carried out through brain stem functioning, meant that the eye tracking detected by him must involve such absolutely minimal functioning beyond the brain stem within the cerebral hemisphere as to involve no comprehension or understanding. Put another way, whilst the signal provided by the moving mini iPad may apparently be noticed, there is no evidence that the signal it provides is being interpreted in any sense.

In light of MA's evidence, I am hesitant to conclude definitively that the persistent vegetative state opined by other medical practitioners is present. However, given MA's evidence about the absolutely minimal significance of what he has detected with eye tracking and having regard to the absence of any other reactive behaviours, the practical reality from the perspective of a lay person that JT's state is really no different whether he is diagnosed as being in a persistent vegetative or a minimally conscious state. The best that might be said in a clinical sense is that MA's diagnosis of a minimally conscious state is the more conservative diagnosis. The reality for JT is there is no difference.

The other important feature of MA's evidence today is to qualify his earlier expressed opinion that JT may have improved from a vegetative state to a minimally responsive or conscious state by the time he detected eye tracking in 2013. On the whole of the evidence and now that I am better informed about the method of tracking used by him compared to that likely used by others, the probability is that there was no improvement at all. The more likely position is that had other practitioners used the same apparently less conventional means of testing for visual tracking as that used by MA they would have achieved the same result. In other words, the probability is that there has been no material change for the better in JT's state at any stage since the catastrophe which befell him at the outset.

Given the length of time that has gone by, all medical practitioners are of the universal opinion that there is simply no prospect of improvement. Notwithstanding the progression in MA's opinion as discussed earlier, he, too, considers, given JT's hopeless state and inability to ever regain the ability to understand, interact or communicate, it is consistent with good medical practice to withdraw his life-sustaining supportive treatments.

Against that background I turn then to whether I ought conclude it is in the best interests of JT that the life-sustaining care he is currently receiving not continue and, for that matter, that cardiopulmonary resuscitation not be administered. I consider that question by reference at the outset to the legal position of those who are charged with JT's care. Because the chain of events described earlier has the consequence that JT is in the constant care of the applicant and without the ongoing provision of that care he inevitably will die, the applicant and its employees would invariably be concerned by the prospect that the withdrawal of life-sustaining measures might give rise to criminal responsibility pursuant to section 285 and perhaps the operation of 296 of the Criminal Code.

In the ordinary course, a person in JT's position, if conscious and sane, cannot be the subject of physical medical treatment of the body without consent. That merely reflects the law of assault. Ordinarily, patients who may be unconscious but whose state calls for urgent medical attention are taken to impliedly consent to the interference with their body which such attention requires and which absent that consent would otherwise amount to an assault. However, here the circumstances are such that JT's condition tends to preclude an implication of consent. If it be concluded that the invasive care presently being administered is no longer in his best interests, then it would logically follow that the Court acting in the parens patriae jurisdiction in his best interests would not be able to consent on his behalf to the continuation of such care.

It is important to approach a legal problem of this kind by reference to the simple legal framework I have just mentioned. That approach was usefully summarised by the United Kingdom Supreme Court in *Aintree University Hospitals NHS Foundation Trust v James and Ors* (2014) AC 591:

> *[T]he fundamental question in such cases was whether it would be in the patient's best interests, and therefore lawful, to have the treatment, rather than whether it would be in his best interests to withhold or withdraw it; that if the treatment were not in his best interests the court would not be able to give its consent on his behalf and it would follow that, since it would then be unlawful to give such treatment, its withholding or withdrawal would be lawful and not in breach of any duty towards the patient; that in considering the best interests of a particular patient at a particular time, decision makers had to consider the patient's welfare in the widest sense, not just medical but social and psychological; that the test to be applied was subjective, not objective, and decision makers had to try to put themselves in the place of the individual patient and to ask what his attitude to the treatment would be, and to that end should consult those who are looking after him or interested in his welfare to ascertain his wishes, feelings, beliefs and values and the things which were important to him; that a treatment should be regarded as futile and so not in the patient's best interests only if it was ineffective and of no benefit at all to him and was not to be so regarded merely because it had no real prospect of curing or palliating the life-threatening condition from which the patient was suffering.* (per headnote)

Consideration of the broader circumstances makes it proper for me to take into account the uncontested evidence of JT's commonly-expressed attitude were he to suffer the diabolical fate of effectively lying unconscious, unaware and without hope of recovery in a hospital bed, that medical professionals not be permitted to maintain his life further. Moreover, taking the subjective approach, I readily infer in the circumstances of this case that were JT able to comprehend the devastating impact that his living death is having upon his loved ones, he plainly would not want the situation to continue.

Finally, returning the focus to his medical state, the practical reality is that his body is being the subject of invasive care without hope of him ever regaining even an elementary state of awareness or understanding of his existence. In all of the circumstances I infer that on any view he could no longer be taken to be consenting to the invasive care being imposed upon his body. In my view it is no longer in his best interests for that care to continue and the court does not consent on his behalf to the continuation of such care. It

follows that the withdrawal of that care would be lawful; indeed, that its continuation would be unlawful.

The orders I am asked to make go specifically to particular forms of care currently being administered. They do not include, for example, care of a kind calculated at preserving his dignity following the withdrawal of the care mentioned in the orders. It may be inferred readily that it is in his best interests that care involving simple preservation of dignity ought be maintained whilst those charged with his care deal with the consequence of the withdrawal of the life-sustaining care mentioned in the order.

The effect of my orders will be that it is in the best interests of JT that those critical means of care be ceased and that cardiopulmonary resuscitation not be provided. The order will make provision for the cessation of the presently life-preserving measures to be lawful. To assist the applicant's position with its dealings vis-à-vis the respondent, JT's guardian, the order will also declare that the continuation of the measures I have mentioned would be inconsistent with good medical practice.

My orders are:

1. The time for service of the application be abridged.
2. It is in the best interests of JT that:
   (a) the prescription and or administration of antibiotics, insulin, artificial hydration and nutrition currently being provided to JT by way of percutaneous endoscopic gastronomy or by naso-gastric administration or by any other means be ceased;
   (b) cardiopulmonary resuscitation not be provided to JT.
3. The continuation or commencement of the measures described in Order 2 would not be inconsistent with good medical practice.
4. The cessation of the measures described in Order 2 is lawful.
5. There be no order as to costs.