APPROVED

THE HIGH COURT

WARDS OF COURT

[2023] IEHC 321
[WOC 11755]

IN THE MATTER OF C.F.

RESPONDENT

JUDGMENT of Mr. Justice David Barniville, President of the High Court, delivered on 13 June 2023

INDEX

NO REDACTION NEEDED

1. Introduction

1. This is my judgment on an application by the Health Services Executive (the "HSE") for various orders providing for the proper care and treatment of the respondent, C.F. ("Mr F."). Mr. F. is a 75-year-old man who is very ill and, at the time of the application, was a patient in a HSE hospital outside Dublin. He has dementia and lacks capacity. He has a number of very serious underlying medical issues, including severe peripheral vascular disease. The essential issue to be addressed in this case is whether Mr. F. should have his right leg amputated above the knee in order to try to prevent an imminent life-threatening haemorrhage and other very serious complications. There is a significant difference of opinion between the clinicians in the hospital as to whether the amputation should go ahead. Since Mr. F. lacks capacity, the decision as to whether to consent or not to the amputation falls to me. My decision must be based on what is in Mr. F.'s overall best interests, having regard to all of the circumstances of the case.

2. Mr. F. is the subject of a pending wardship application, in respect of which I have received a report from one of the medical visitors on Mr. F's capacity, pursuant to s.11 of the Lunacy Regulation (Ireland) Act 1871. I received this report on foot of an order which I made on 3 April 2023. Arising from that report, I made an inquiry order in respect of Mr. F. on 19 April 2023, and directed that the medical visitor's report stand and be proceeded upon as a petition presented for an inquiry as to the soundness or unsoundness of mind of Mr. F. That inquiry order was very recently served on Mr. F. and the inquiry has not yet been held. The court's wardship jurisdiction was, therefore, invoked in respect of Mr. F. prior to the commencement of the Assisted Decision Making (Capacity) Act 2015 (as amended) ("the Act"). The application the subject of this judgment has been determined in accordance with the court's wardship jurisdiction, which continues to apply in the circumstances having regard to s. 56 of the Act.

3. As noted above, the HSE's application was made in circumstances where there were conflicting medical opinions as to whether Mr. F. should have his right leg amputated in order to address an imminent risk of a life- threatening haemorrhage. Following an initial hearing on 3 April 2023, I decided that it would be lawful for the treating team concerned to treat and care for Mr. F. but with a ceiling of care short of amputating his right leg. At that point, there was agreement between the doctors. However, medical opinion subsequently diverged, with Mr. F.'s treating consultant vascular surgeon advocating for amputation and others arguing strongly against amputation in the overall best interests of Mr. F.

4. The HSE then issued a motion seeking the court's directions for the proper care and treatment of Mr. F. The HSE was not in a position at that stage to seek the court's consent or otherwise to an amputation, or to treatment and care with a ceiling of care

short of amputation, because of the difference in medical opinion. The hearing of that application took place over two days on 9 and 11 May 2023. As the hearing progressed and the evidence was teased out, the position of the HSE evolved so that, ultimately, its position was that the preponderance of the evidence was that the court should refuse to consent to an amputation and should instead consent to the alternative treatment proposed, which would be to allow Mr. F. to be discharged from hospital and to return to the care of his family with appropriate palliative and other care. That was also the position adopted by James Bardon, the guardian *ad litem* appointed by the court on 3 April 2023.

5. Immediately following the hearing on 11 May 2023, I gave my decision with some brief reasons. I indicated that I would give more detailed reasons in the form of a written judgment. I decided that it would not be in Mr. F's overall best interests to have his leg amputated and that, instead, it was in his best interests that he be discharged home from the hospital when clinically appropriate with the care arrangements outlined in evidence in place. In those circumstances, I declined to give my consent to the amputation and instead consented to the alternative treatment proposed. I attach as an appendix to this judgment a transcript of the decision I gave on 11 May 2023. I made an order giving effect to that decision on 12 May 2023. This judgment sets out the full details of the case and my reasons for the decision.

6. At the outset of the initial hearing of the application on 3 April 2023, I made certain orders pursuant to s. 27 of the Civil Law (Miscellaneous Provisions) Act 2008 and pursuant to the inherent jurisdiction of the court as outlined by the Supreme Court in *Gilchrist v Sunday Newspapers Ltd* [2017] IESC 18. I ordered that Mr. F.'s identity should not be published. I also directed that the name of the hospital and the location of Mr. F.'s residence would not be identified, save that it could be published that he

comes from a place in a remote part of the West of Ireland. In order to maintain the integrity of those orders, I also ordered that the doctors who gave evidence be identified by reference to their professional titles rather than their names. That was to avoid potentially identifying Mr. F. himself and the hospital.

Part A: Factual Background and Evidence

2. Factual Background

7. On 3 April 2023, the HSE made an *ex parte* application to the court for various orders in relation to Mr. F. Mr. F. is a man of almost 75 years of age (at the time of the application) who has been an inpatient in the hospital since 14 June 2022. Mr. F. presented to the Accident and Emergency Department of the hospital with right lower Limb-threatening Ischaemia. This is a limb and life-threatening condition. The consensus of all the doctors in this case was that Mr. F. also has dementia and significant cognitive impairment. Following some initial difficulties and complications after his admission to hospital, Mr. F. was diagnosed with severe peripheral vascular disease in his right leg at above knee level. A CT scan of his brain was carried out, which ruled out Acute Brain Pathology as a cause of his presenting confusion. Mr. F. was profoundly ischaemic and was constantly at imminent risk of limb loss. Urgent surgery was required in order to bypass the damaged area of his right leg and to seek to deliver perfusion to his entire leg in an attempt to salvage his right lower limb.

8. With the consent of his family, on 15 June 2022, urgent lower limb bypass surgery and fasciotomy for limb salvage were performed on the basis of necessity. The initial surgery went well, and the lower limb bypass graft was successful. The lower limb

was, following surgery, well perfused. However, Mr. F. had a protracted post-operative course due to his failure to accept medical advice post-surgery. He has remained confused and non-compliant with treatment. He refused to engage in physiotherapy and, as a result, has a fixed flexion of his knee joint on the right limb.

9. Mr. F. required VAC (Vacuum Assisted Closure) therapy for his fasciotomy wounds. However, against medical advice and instruction, he repeatedly removed the wound dressing and interfered with his wounds in various ways, including by putting butter, jam, marmalade, and hot drinks such as tea and coffee on top of his wound and in the vicinity of the bypass area. That resulted in a breakdown of the wound, recurrent infections, a failure to heal and a persistently exposed femoral-pop graft. This has, in turn, resulted in tissue breakdown and graft infection.

10. The infected graft is synthetic and made from PTFE (Polytetrafluoroethylene). The graft which provides the bypass is now exposed. Mr. F's tibioperoneal arterial trunk is at immediate risk of rupture, which would lead to life-ending haemorrhage. Synthetic PTFE grafts typically have a higher risk of rupture and haemorrhage (with a monthly incidence of graft rupture of around 0.3% and a monthly incidence of bleeding at around 1.2%). However, in Mr. F's case, the risks are much higher because of his interference with the graft, the consequent exposure of the graft and the onset of enduring infection. The exposed graft not only leaves Mr. F. at an immediate high risk of life-threatening haemorrhage, but also of impending sepsis. The treatment of vascular graft infections is very problematic in Mr. F's case.

11. Normally, what is recommended is extra-anatomic revascularisation followed by graft excision (which carries an operative mortality rate of up to 18%, an amputation rate of up to 16% and an infection recurrence rate of up to 18%). However, extra-anatomic bypass surgery is not an option for Mr. F. This is because there is no viable option for

the creation of an anastomosis in the leg which, the evidence establishes, is now beyond salvage because of the continuing infection.

12. Consideration was also given by a plastic surgery specialist to the feasibility of the creation of a myocutaneous flap as an alternative to amputation. However, the plastic surgery team advised that there is no surgical or other option to protect his exposed graft and that the only appropriate course of treatment is to carry out an above-knee amputation.

13. The medical/surgical pathway of treatment advised for Mr. F. is an above-knee amputation. The evidence indicates that leaving the exposed and compromised damaged graft is a continuing and ongoing threat to Mr. F's life. Further, a haemorrhage that will lead to him "*bleeding out*" is inevitable if he is left in his present condition and that could happen at any time. A further reason why, from a medical/surgical perspective, amputation is indicated is Mr. F's fixed flexion deformity on the limb, which means at this point he has little functionality of his right lower leg. In addition, the evidence demonstrates that the continued failure to heal because of infection is likely to soon lead to a systemic sepsis. On that basis, the opinion of Mr. F's treating consultant vascular surgeon is that the only medical option for Mr. F. is to have an above knee amputation as an immediate life-saving measure. In his view, the risk of sepsis and infection recurrence is exceptionally high because the graft is infected with pseudomonas and coliform bacteria, which are particularly virulent and challenging to treat. It is the consultant vascular surgeon's opinion that Mr. F. will die from sepsis or haemorrhage if his leg is not amputated, and that time is of the essence as a sepsis is possible at any time, as is a life-ending haemorrhage.

14. Mr. F. has been, and remains, adamant that he does not wish to have his right leg amputated, despite advice from his surgical/medial treating team that that is his only

option at this time. Mr. F's consistent position is that he is prepared to die rather to have his leg amputated. While that in itself creates a dilemma for his treating team, it is particularly so in circumstances where all of the doctors who have examined Mr. F. have expressed the view that he lacks capacity to give or to refuse consent to medical treatment, including an amputation.

15. The view of all doctors who have expressed an opinion on the issue of capacity is that Mr. F. lacks capacity to consent to surgical treatment, including amputation. I will refer later to the evidence of the consultant geriatrician and the consultant psychiatrist for later life, who have provided their opinion on Mr. F's lack of capacity, as has the medical visitor, Dr. F., who is another consultant psychiatrist.

16. Mr. F's treating team were faced with a dreadful dilemma in late March/early April, and that dilemma continues to this day. The dilemma is that, while the medical/surgical view is that Mr. F. needs to have his right leg amputated, there is strong evidence that if this is done against Mr. F's wishes, it is likely to cause him *"considerable psychological distress"* (according to his consultant geriatrician) or *"catastrophic mental distress"* (in the view of the hospital consultant psychiatrist).

17. Mr. F's repeated statements that he would rather die than be without his leg are an indication that he would react very poorly to discover that his leg had been amputated against his wishes. The consultant geriatrician is of the view that the effect on Mr. F's wellbeing of his leg being amputated, on foot of a court order and against his wishes, is likely to be dramatic. There were, and are, clear doubts about Mr. F's ability to adjust to living without his leg having regard to his various conditions, including his dementia and cognitive impairment.

18. At the time of the *ex parte* application before me on 3 April 2023, the combined reports before me from the consultant vascular surgeon, the consultant geriatrician,

and the consultant psychiatrist, indicated that a strict medical approach to Mr. F's treatment and care would require amputation of his right leg. While the amputation of the leg would solve the medical crisis, this would likely lead to a significant disturbance to his mental wellbeing, which would amount to a further crisis that would impact on him for the rest of his life. On that basis, the consultant vascular surgeon was prepared at that time to defer to the views of the consultant geriatrician in particular, and to accept his opinion that an amputation would not overall be in the best welfare interests of Mr. F.

19. The position presented to me at the time of the application on 3 April 2023, was that the combined view of the various medical disciplines involved, namely surgery, geriatrics and psychiatry, was that the medical pathway (*i.e.* amputation) should not be followed, and that a plan should be devised to discharge Mr. F. to a place where he could be cared for in a way which gave him as much pleasure in life as possible.

20. Possible placements for Mr. F. post-discharge included either a return to his home in a remote location in the West of Ireland to live with his wife and son, or admission to a nursing home. A return to home was felt not to be ideal due to its remote location and the likely need to access medical treatment. At the time of that application, the consultant vascular surgeon was recommending discharge to a facility where Mr. F. could get immediate care when the inevitable further breakdown of his graft occurred.

21. While Mr. F. wished to go home, his family was of the view that he could not be cared for at home in the absence of an amputation, having regard to the serious risks involved. Mr. F's family was also opposed to Mr. F. being placed in a nursing home. Their preference was for Mr. F's leg to be amputated, and for him to then return home. The consultant geriatrician was of the view that a discharge to a nursing home relatively close to his home should be considered, where he could be supervised and

made comfortable when complications arise and where his care could be managed appropriately in the meantime. All of this evidence was provided in the form of an affidavit of the consultant vascular surgeon, which was originally provided to me in unsworn form for the purposes of the hearing on 3 April 2023, and which was subsequently sworn on 14 April 2023. The surgeon gave oral evidence before me at the hearing on 3 April 2023, as did the consultant geriatrician.

3. Reports Available to the Court on 3 April 2023

22. The consultant surgeon exhibited to his affidavit various reports, including a report of his own (undated), a report of the consultant geriatrician (dated 30 March 2023), a report of the consultant psychiatrist (dated 31 March 2023) and a report of a consultant plastic surgeon (dated 31 March 2023). It is necessary that I set out here some of the detail contained in those reports as they are relevant to the subsequent divergence in the views of the doctors involved as to the appropriate treatment and care which should be provided to Mr. F.

a. Initial Report of the Consultant Vascular Surgeon

23. In his first report, the consultant vascular surgeon made many of the points set out in his affidavit, which I have just summarised. He noted that Mr. F's confusion has been an ongoing issue throughout his stay in hospital. After the surgery in June 2022, Mr. F. kept wandering between wards and he sustained multiple falls, none of which were significant. He required continuous monitoring by healthcare assistants. The geriatric team assessed him on numerous occasions regarding his ongoing confusion. Their impression was that his confusion was due to multifactorial delirium. The delirium failed to settle, despite interventions suggested by the geriatric team.

24. Consideration was given to discharging Mr. F. from hospital in July 2022, on the basis that, although his wound had not healed completely, it was suitable for outpatient management. It was initially agreed to discharge Mr. F. to a temporary nursing home while awaiting long-term care. A bed was allocated for Mr. F. in September 2022, in a particular nursing home, but, for various reasons, that move never took place, and further attempts to find alternative nursing homes proved difficult. Mr. F's family were reluctant to send him to certain nursing homes and, due to their opposition, they were not prepared to sign the relevant Nursing Home Support Scheme forms. Mr. F. expressed his wish to return home. Ten hours of home help were allocated to him; however, his family were of the view that Mr. F. could not return home having regard to the ongoing problem with his leg.

25. The consultant vascular surgeon referred to the risks involved in carrying out the above-knee amputation of Mr. F's right leg. The weighted average of mortality rates at 30-day, 90-day, one-year, and five-year periods after major lower limb amputation are 13%, 15.40%, 47.93% and 60.60%, respectively. The mortality risk associated with amputation due to any vascular pathology, which would apply to Mr. F., is eleven times greater than the risk associated with amputation-specific complications from impaired mobility. Post-operative mortality after emergency above-the-knee amputation ranges from 40% to 90%. In his evidence to the court on 9 May 2023, the consultant vascular surgeon estimated that Mr. F. had a 50% chance of mortality within 30 days of the proposed surgery to amputate his right leg.

26. The consultant vascular surgeon also considered the risks to Mr. F. in not having the amputation. Emergency management of necrotising fasciitis of the lower limb carries a mortality rate of between 23% and 76%, regardless of the treatment options.

27. The consultant vascular surgeon outlined the risks and impact on Mr. F. of proceeding with the amputation against his wishes. He noted that above-the-knee amputations can have a significant clinical impact on the lives of patients. Their mobility is significantly affected. There is a 49% increase in oxygen consumption during ambulation in patients with an above-the-knee amputation. Approximately 65% more energy expenditure is required to ambulate in above-the-knee amputees compared to patients without an amputation. That number can be increased to 100% when the amputation is performed due to vascular compromise, as in Mr. F.'s case, compared to trauma. In his evidence to the court on 9 May 2023, the consultant vascular surgeon described this as being like asking a patient with an amputated leg to run from the Four Courts to Dublin Port and back. The increased energy expenditure and decreased mobility could ultimately affect the patient's personal and professional lives.

28. The surgeon also indicated that he could not foresee that Mr. F. would gain a bipedal gait, as rehabilitation and prosthesis would be two significant challenges in light of his cognitive impairment. He also mentioned phantom limb pain as being another complication from the amputation and noted that this has been estimated to affect up to 80% of patients who undergo a limb amputation. These impacts will also be augmented by post-traumatic stress disorder and depression, which are well-known psychological complications of amputation. He further noted that approximately 40% of patients suffer from post-operative delirium and that, during the adaptation period, psychological problems such as depression, anxiety and post-traumatic stress disorder will occur. He said that psychological issues could also interfere with rehabilitation and cause additional psychosocial problems. He noted in his report before the court on 9 May, that, given the seriousness of these complications, appropriate measures

have to be taken to prevent them from occurring, however he did not specify in his report what those measures would be.

b. Initial Report of the Consultant Geriatrician

29. In his first report of 30 March 2023, the consultant geriatrician noted that he had assessed Mr. F. on four occasions for the purposes of his report and had discussed the case with the consultant vascular surgeon and with the consultant psychiatrist. His assessments were primarily with respect to Mr. F's capacity to decide to refuse the recommended above-knee amputation. He also considered the more general issue of Mr. F's capacity to manage his person and affairs, including his capacity to decide where he would live. Mr. F. was, at times, seeking to return to his own home rather than going to a nursing home where his needs might be more easily met.

30. In his report, the consultant geriatrician considered the risks to Mr. F. in not receiving the above-knee amputation. They are:

(a) haemorrhage, referring to the consultant vascular surgeon's view that a life-threatening haemorrhage is inevitable for Mr. F. without surgery and that no intervention will, in practice, save his life if such a haemorrhage occurs and it could occur at any time, and

(b) recurrent infection, noting that repeated infection of the graft is also inevitable and that the most severe infections carry a very high mortality rate, although infection to date has been controlled by intravenous antibiotics. Such antibiotic treatment would not be readily available if Mr. F. were living in the community.

31. He then considered the risks to Mr. F. in having the amputation. Those risks are:

(a) mortality, noting that about one in ten patients with severe vascular disease will die within 30 days after surgery because of their vascular disease, and about 50% of such patients will be dead within a year of surgery. I note that the consultant vascular surgeon put the risk at higher than that in his evidence on 9 May, where he said that Mr. F. had a 50% chance of dying within 30 days of an amputation,

(b) post-operative delirium, his view was that some period of delirium would be almost inevitable for Mr. F.,

(c) loss of mobility, he agreed with the consultant vascular surgeon that, due to cognitive problems and frailty, Mr. F. would not be a suitable candidate for a prosthetic limb,

(d) phantom limb pain, meaning ongoing painful sensations which seem to come from the part of the limb that us no longer there, which he noted affected up to 80% of patients with a limb amputation. He stated in his report that "*although a limb is gone, the pain is real*" and

(e) post-traumatic stress disorder and depression, which he said are well-known psychological complications of amputation which would be more likely if the patient had not agreed with and been reconciled to the surgery.

32. The consultant geriatrician noted that every time he saw Mr. F., he was alert, cheerful and happy to talk to him. Mr. F. was not acutely unwell or complaining of any symptoms at any time when the consultant geriatrician saw him. He noted that Mr. F. walks up and down the ward for much of the day but can fail to identify his own room. Mr. F. was not delirious when the consultant geriatrician saw him and was able to attend and concentrate during their conversations. The consultant geriatrician

expressed the view that he feels Mr. F. has dementia, which has been probably contributed to by his vascular disease. He was unable to give the month or year correctly, however, he was not willing to participate in formal cognitive testing. At times he knew that he was in hospital and that had been there for some months, but for much of the time he thought he was at home.

33. In assessing Mr. F's capacity to make a decision with respect to the amputation, the consultant geriatrician noted that, with respect to the communication of a decision, Mr. F. was clear and consistent every time he met him in expressing his absolute opposition to the amputation of his leg. He expressed the view that Mr. F. was also able to retain information long enough to reach decisions, despite having some short-term memory impairment.

34. With respect to with Mr. F's understanding as to the seriousness of the risk imposed by his leg, the consultant geriatrician noted that Mr. F's position ranged from accepting that his leg could continue to become infected and that it would *"never get better entirely*", although disagreeing that the infection could be life-threatening, to denying that there was any problem with his leg at all on another occasion. He would not accept that severe, life-threatening bleeding was at risk. When pressed as to whether he would want to keep his leg even if it could lead to his death, Mr. F. was clear, stating "*if I die, I die – that's all*".

35. Mr. F. was aware that he had experienced pain in his right leg before, but that the pain had improved (he is on modest doses of opioid painkillers). Mr. F. said that the pain which was left was small and tolerable but agreed that, if the leg pain became very bad and could only be relieved by amputation, then he would consider having an amputation. However, he was vehement on all occasions that amputation would be intolerable to him stating, on one occasion, *"you may as well just bury me in* [a beach

near his house], *just throw me in the sea over there"* and *"I need two legs to walk – that's a fucking crazy idea"*.

36. With respect to his ability to use and weigh up relevant information, Mr. F. could not accept that he was inevitably going to have a life-threatening haemorrhage or that recurrent severe infections were likely, and so could not use and weigh up that information in his decision making.

37. It was the consultant geriatrician's opinion that, *"on (a very finely judged) balance"*, Mr. F. lacked capacity to make a decision regarding his proposed surgery. In particular, he was unable to accept, or to use and weigh, important information about the main imminent threats to his life and health, namely, haemorrhage and infection of the leg. The consultant geriatrician did accept that there was a counterargument that retaining his leg and his ability to walk was such an important and dominant value from Mr. F's perspective that it swamped all other possible considerations, and further, that he was able to say that intolerable pain would be a matter he might be willing to take into consideration regarding the amputation of his limb.

38. The consultant geriatrician considered the likely impact on Mr. F. of an unwanted amputation. In his view, a number of factors had to be taken into account. First, the surgery is not risk-free and there is a risk of mortality and morbidity due to his vascular risk profile. Second, Mr. F. enjoys walking up and down and that is factor the consultant geriatrician considers to be important. Mr. F. will never walk again if his leg is amputated. However, he may well try to do so given his cognitive impairment and that will create a high risk of falls. Third, avoiding pain is very important to Mr. F and he is pain free at present. The consultant vascular surgeon identified a significant risk of phantom limb pain after amputation. Fourth, the psychological impact of an amputation would be significant, and the consultant

geriatrician's view is that this is likely to be greater where the patient has not agreed with and reconciled to the surgery. In addition to depression and post-traumatic stress disorder, it was his view that there is a very high likelihood of anger and upset if Mr. F. were to come to after surgery and find that his leg is gone.

39. The consultant geriatrician then considered alternatives to amputation. If a decision not to proceed with amputation is made, it was his view that it would not be appropriate that Mr. F. would remain in the unsuitable environment of an acute hospital. In his view, an approach focusing on symptom control (palliation) and maximising quality of life, including the involvement of the community palliative care team as needed, would be required. This would involve an acceptance that development of severe haemorrhage or sepsis, particularly outside an acute setting, would almost inevitably lead to Mr. F's death. However, in his opinion, that would, on balance, be the best and most appropriate option for Mr. F. He felt that two options should be explored.

40. The first option was returning to home, although the consultant geriatrician noted that Mr. F. would have significant care needs on discharge from hospital and that his family were opposed to a return to home in the event that the amputation did not take place. It would be necessary to put in place a significant care package in light of Mr. F.'s care needs.

41. The alternative was placement in a nursing home. Reference was made to a particular nursing home in the west of Ireland which had some advantages, in that it was primarily Irish-speaking, and it would be the most accessible nursing home for Mr. F's family and friends. It was the consultant geriatrician's view that the care, including palliative care, provided in that nursing home is excellent. There would,

however, have to be an application under the NHSS for funding, and the family was unwilling to assist with that application.

42. In conclusion, the consultant geriatrician expressed the view that Mr. F. did lack capacity to make a decision in relation to the proposed amputation. It was his view that performing an amputation contrary to Mr. F's strongly expressed views would not be in his best interests. In his opinion, a palliative-focused approach, whether in Mr. F's own home or more easily achieved in a nursing home close to his home would be the best option in Mr. F's case, acknowledging that not performing the amputation may hasten his death.

c. Initial Report of the Consultant Psychiatrist

43. In her first report of 31 March 2023, the consultant psychiatrist provided her opinion on Mr. F's capacity to consent to the amputation, as well as the likely effects on Mr. F. of an amputation being performed against his wishes. She noted that, when she met with Mr. F. on 16 March 2023, he was fully alert, made good eye contact, was fully engaged with the conversation and he was apparently delighted to have a visitor. He was walking slowly up and down the corridor of his ward using a Zimmer frame, engaging in banter with the nursing staff and greeting members of staff he saw at a distance both in both Irish and English.

44. The consultant psychiatrist was of the view that there is evidence of probable underlying cognitive impairment, noting that Mr. F. had no idea had how long he had been in hospital. He was also unable to tell her how many children he had, or their names, and he also made reference to his mother in the present tense, although she was long since dead. He was unable to tell her the day, date, or year and at times appeared to think he was at home; however, he was unwilling to engage in any formal

cognitive testing. He showed no signs of distress, and he was jovial, pleasant, and cooperative.

45. When asked about his leg he said *"sure there is no pain now"*, *"its grand",* and *"it's only a small thing"*. When told about the risks posed by the exposed graft in his leg, the dangers of infection, and of catastrophic bleeding, Mr. F. said *"is that right"* but appeared unconvinced. When she explained the proposed treatment in simple terms, he became stressed and stated clearly on several occasions *"you're not taking my fucking leg"*, *"I'd rather die in the morning than be without my leg"* and *"sure I've no pain"*. That conversation continued for about 30 minutes. Mr. F. was consistent and emphatic that he would rather be dead than have his leg removed. The consultant psychiatrist was of the view that Mr. F. clearly demonstrated an ability to communicate his decision and an ability to retain to the information he had been given long enough to express his firm view. He also demonstrated an ability to understand the information given, although he disagreed with the medical opinion he was given. He did not accept that there was a serious risk to his life caused by the current state of his leg.

46. The consultant psychiatrist was of the view that Mr. F. showed impairment in his ability to use and weigh relevant information regarding the risk of haemorrhage or of infection and did not seem to comprehend or accept the severity of the condition of his leg and the complexities of the nature and vulnerabilities of the graft. However, she noted that Mr. F. demonstrated a clear and consistent belief that his life would be meaningless to him without his leg. He repeated on several occasions *"you might as well kill me now"*, *"I'd rather be dead than lose my leg"* and *"I may as well be dead in the morning if you take my leg"*.

47. It was the consultant psychiatrist's opinion that Mr. F. did not pass all four components of the formal test for capacity. However, she saw a *"huge ethical dilemma"* in overriding his clearly, consistently expressed wishes to refuse an amputation.

48. She stated that there is a *"real risk of catastrophic mental distress, a belief he has been ignored and his wishes contravened, and a significant deterioration in the quality of life he currently enjoys if Mr. F. has this surgery against his will and preference"*. She also noted that, as the consultant vascular surgeon had outlined, there are also risks to the surgery and a chance that Mr. F. might experience phantom pain. She explained that he is not a good candidate for adaptation to prosthetic limb use and that his forgetfulness, due to likely underlying dementia, would make it very difficult for him to learn how to adapt to the use of a prosthetic limb. She noted that his whole day is spent pacing up and down the corridor and if he were confined to a bed or chair it is likely, in her view, that he would become agitated, distressed and that his quality of life would be *"substantially impaired"*.

49. In her view, therefore, while surgical intervention might significantly improve his chance of living longer, there is a concern that, if the amputation went ahead despite his vehement opposition to it, this would *"negatively impact the quality of what life he has left"*. The consultant psychiatrist fully supported a placement in the nursing home to which the consultant geriatrician referred.

d. Report of the Consultant Plastic Surgeon

50. In his report dated 31 March 2023, the consultant plastic surgeon confirmed the view of the consultant vascular surgeon that there are no reconstructive options suitable for Mr. F. to salvage his right leg. His recommendation was that the above-knee

amputation of his right leg be carried out. He agreed with the consultant vascular surgeon that continuing to manage the wound with dressings would likely result in further infection, potential graft rupture and life-threatening haemorrhage.

4. The HSE's First Application

51. The HSE's *ex parte* application was heard by me on 3 April 2023. The application was heard on an *ex parte* basis, although the HSE had wisely arranged for James Bardon, a solicitor, who was proposed as guardian *ad litem* for Mr. F., to visit Mr. F. at the hospital on 30 March 2023. Mr. Bardon prepared a report for the hearing on 3 April 2023. The reports before the court on 3 April were those referred to earlier in this judgment.

52. The HSE's application on that date was for various orders, including the appointment of Mr. Bardon as guardian *ad litem,* as well as an order sending out the medical visitor to examine and report to the court on Mr. F's capacity. It also sought an order that it would be lawful for the hospital to provide Mr. F. with such medical, psychiatric and nursing care and treatment in the hospital as may, in the opinion of his treating doctor or psychiatrist, be necessary in providing for Mr. F.'s best medical treatment and welfare interests, including but not limited to attending to his immediate medical needs *"but applying a ceiling of care in not amputating his right leg in accordance with his expressed wishes and despite medical advice.* The HSE was clear that what was being sought was an order that it be lawful for the hospital to act in that manner, and to apply a *"ceiling of care"* which would involve not amputating Mr. F's right leg, because of his clearly expressed wishes and notwithstanding the medical advice to the contrary.

53. The consultant vascular surgeon and the consultant geriatrician gave evidence remotely at that hearing in accordance with their reports. While accepting that the ordinary medical pathway would be to amputate Mr. F's right leg, the consultant geriatrician referred to a daunting list of risks involved in taking that course. He further stated that he would be horrified at the thought of dealing or treating with Mr. F. following an amputation in circumstances where he was so opposed to losing his limb.

54. I heard from Mr. Bardon, guardian *ad litem,* on 3 April 2022. In his report, Mr. Bardon noted that Mr. F. told him that his leg was fine. When Mr. F. was then told that he could die if the leg was not amputated, he replied *"if I die, I die"*. Mr. F. was dismissive of the concerns expressed by the treating clinicians, and he repeated the statement *"if I die, I die"*. He stated that there was nothing wrong with his leg and that he did not want it amputated. Mr. Bardon stated that it was clear that, while Mr. F. was adamant that he did not wish to have his right leg amputated, he was unwilling to accept that there was anything wrong with his leg and could not weigh the information relating to the imminent threat to his life from a haemorrhage or infection. Mr. Bardon agreed with the conclusions expressed on capacity by the other doctors.

55. Having considered all of the material available to him, and having reflected on his meeting with Mr. F., it was Mr. Bardon's view that Mr. F's family should be consulted immediately and that, subject to any concerns raised by them, he supported the treatment plan outlined by the consultant vascular surgeon, namely, not to proceed with the amputation, and instead to plan for Mr. F's discharge to a place where he could be cared for, giving him as much a pleasure in life as possible.

56. Having carefully considered all of this evidence and the legal submissions advanced by counsel for the HSE, I was satisfied that I should make the declaration sought, namely that it would be lawful for the hospital to proceed with the proposed treatment plan in Mr. F's best interests, including by attending to his immediate medical needs, but applying *"ceiling of care"* in not amputating his right leg. I was satisfied that the doctors had considered all relevant matters and had reached their conclusion that Mr. F's best overall interests were served, not by amputating his right leg, and instead by proceeding with the agreed treatment and care plan which had been outlined to the court. I was satisfied that, at that stage, it was appropriate, having regard to the submissions I had received, to declare that the proposed care and treatment plan was lawful. However, I directed that a notice of motion be issued so the matter could be considered at a further hearing, at which I anticipated that I might be asked to give or refuse my consent to whatever form of treatment and care was being proposed at that stage by the treating clinicians.

5. Medical Visitor's Report and Inquiry Order

57. The medical visitor, Dr. F., examined Mr. F. on 11 April 2023. He provided a report to the court dated 14 April 2023. In the course of his report, Dr. F. noted that Mr. F. was initially agreeable to all hypothetical treatment options put to him. However, when reference was made to amputation and the consequences of amputation, Mr. F. stated that he did not wish to be without his leg. He was also ambivalent about the need for, and the nature of, treatment for his limb pain, stating *"sure it's alright"* and *"I might need something alright"*. Initially, Mr. F. stated that removing part of the leg would be acceptable if the doctor says so, but then said *"I wouldn't want that* [amputation]*...you'd only have one f***ing leg!"*.

58. Dr. F. expressed the view that Mr. F's cognitive functioning was significantly impaired at the time of the assessment. Mr. F's understanding of the nature of his health status and treatment needs was significantly impaired. His presentation at the time of assessment was consistent with the diagnosis of *"acute confusional state with a background of organic mental disorder – dementia with behavioural disturbance"*.

59. Dr. F. expressed the opinion that Mr. F's understanding of his health conditions and his treatment needs are significantly influenced by his organic mental disorder associated with acute cognitive impairment. Mr. F's ability to retain information, to understand information, to use it and to weigh such information is impaired. Mr. F's capacity to communicate his wishes, albeit inconsistent, appeared to be unimpaired. His capacity to manage his healthcare needs is significantly impaired due to the cognitive deficiencies arising as a result of acute confusional state and pre-existing organic mental disorder – dementia. His ability to make decisions based on information provided to him, to consider alternative treatment and care options such as potential further surgical intervention and his ability to understand the consequences of those decisions, including the exacerbation of existing physical disability, are also significantly impaired.

60. It is Dr. F's opinion that Mr. F. is a person of unsound mind who is incapable at this time of managing his affairs. He felt that Mr. F's mental disabilities would benefit from ongoing supervised care and appropriate safeguarding measures. He expressed the view that Mr. F's hospital placement and current care arrangements in an acute hospital ward are inappropriate to his needs, and that he would benefit from ongoing supervised treatment and nursing support in a non-acute care environment. Dr. F. also expressed the view that Mr. F's capacity to manage his healthcare needs is impaired

as a result of an acute confusional state which is liable to fluctuate over time and organic mental disorder – dementia, which is likely to progress.

61. Having considered the medical visitor's report, I made an inquiry order on 19 April 2023 directing that the report stand and be proceeded upon as a petition presented for an inquiry as to the soundness or unsoundness of mind of Mr. F. The inquiry order was served on Mr. F. at the hospital by a solicitor for the HSE on 9 May 2023.

6. The HSE's Second Application

62. The amended notice of motion issued by the HSE on foot of the order of 3 April 2023, sought different orders to those sought on the *ex parte* application. Rather than seek an order providing for the lawfulness of the treatment plan outlined to the court on 3 April 2023, providing for the *"ceiling of care"*, which provided for the treatment and care of Mr. F. short of amputation of his right leg, in this motion the HSE sought an order for directions as to the proper care and treatment of Mr. F. and an order, pending Mr. F's discharge from hospital, permitting the hospital to provide Mr. F. with such surgical, medical, psychiatric, and nursing care and treatment in the hospital as may, in his treating doctor or psychiatrist's opinion, be necessary in providing for his best medical treatment and welfare interests, including, but not limited to *"such medical care and/or surgical care and treatment for the clinical management of the respondent's right leg in accordance with the respondent's best medical and welfare interests following the directions of this Court at No. 3 above 'the treatment plan'"*. Various other orders were sought.

63. Effectively, therefore, what I have been asked to do on foot of the HSE's application is to give direction for Mr. F's proper care and treatment and to determine whether I

should give my consent to the above-knee amputation of Mr. F's right knee or whether I should approve some other care and treatment plan on the basis of my decision as to what is in Mr. F's best interests. In light of the evidence and the divergence of views which developed between the doctors involved since the hearing of 3 April 2023, it was appropriate for the HSE to seek orders in these terms rather than a declaration of lawfulness with direct provision for a *"ceiling of care"* short of amputation. I will consider the applicable legal principles once I have outlined the up- to-date evidence which was heard by me on 9 May 2023, and on 11 May 2023.

64. All of the reports which were before me on 3 April 2023, were again before me for the purposes of the HSE's motion. The motion itself was grounded on an affidavit sworn by Zoe Hughes, a solicitor for the HSE. Ms. Hughes exhibited updated reports from the consultant geriatrician (dated 26 April 2023), the consultant vascular surgeon (undated, received on 1 May 2023), the consultant psychiatrist for later life (dated 2 May 2023) as well as an undated social work report, and a report of the multidisciplinary team received on 26 April 2023. There was a further affidavit sworn by Ms. Hughes on 8 May 2023, which exhibited an occupational therapy functional report dated 4 May 2023, and an undated report of another consultant vascular surgeon (received on 6 May 2023) who provided a second opinion to that provided by the main treating consultant vascular surgeon. I also received an affidavit from Mr. Bardon, together with his second report dated 8 May 2023.

65. I heard oral evidence from the consultant geriatrician, the consultant psychiatrist, and the main-treating consultant vascular surgeon. I will refer first to their updated reports and then to any additional evidence which emerged during their oral evidence.

a. Updated Report of the Consultant Geriatrician

66. In his updated report, the consultant geriatrician noted that he had seen Mr. F. on two occasions since his previous report. On both occasions, Mr. F. was in good form and happy to talk to him. On the first of those occasions, he chatted with Mr. F. as Mr. F. proceeded up and down the long corridor of the ward on his frame, greeting members of staff as he went along. He recognised individual staff members and was complementary of some and not so complementary of others. Nurses reported that Mr. F. has experienced more pain over the last month and his painkilling medication has been increased. Mr. F. told the consultant geriatrician that it (his leg) *"can be a bit sore"* and *"it's not too bad"*. Mr. F's mobility was not restricted by pain. The consultant geriatrician understood from the consultant vascular surgeon that Mr. F's overall leg condition had deteriorated in the period since the hearing on 3 April 2023.

67. Having carried out a further assessment, the consultant geriatrician confirmed his previous opinion that Mr. F. lacks capacity to make a decision regarding proposed surgery involving amputation of his right leg. He was unable to accept and understand important core information about the main imminent threats to his life and health, namely haemorrhage and infection. Mr. F's desire to retain his leg and his mobility was a strong as before. Mr. F. did not believe that severe life-threatening bleeding was a risk. He reiterated clearly that he would want to keep his leg even if that would lead to his death, although he did not accept that that could happen. With regard to infection, Mr. F. said *"if it's there, treat it"*. However, he would not agree that it might be so bad as to threaten his life and warrant amputation. Mr. F's vehemence about retaining his leg was as strong as it had always been. Mr. F. was not aware where he was at the time and when pressed, he thought he was at home. He expressed no wish to move anywhere, saying *"why would I want to leave, its grand*

here". Mr. F. repeated that the nursing home close to his home was a very good place and that he knows it.

68. Having confirmed his opinion that Mr. F. lacks capacity to make a decision regarding the proposed amputation, the consultant geriatrician expressed the view that a palliative focused approach in a nursing home close to his home remained the best option in Mr. F's case. He acknowledged that not performing the amputation may hasten his death and he noted the consultant vascular surgeon's opinion from their recent discussion that Mr. F's overall leg condition had deteriorated. The consultant geriatrician stated that he was increasingly doubtful that any adequate care package would suffice to keep Mr. F. comfortable and well for any reasonable period. He was of the view that the HSE nursing home referred to previously where care, including palliative care if required, could be provided would be the best alternative for Mr. F., and one that Mr. F. would find acceptable.

b. Updated Report of the Consultant Psychiatrist

69. In her updated report, the consultant psychiatrist noted that she reassessed Mr. F. on 27 April 2023. He was pleasant and cooperative throughout the assessment and was pleased to see her. He remembered seeing her before but confused her with another member of staff. Mr. F. was in good form, friendly and very happy to engage with the consultant psychiatrist. He was walking along the corridor on his Zimmer frame when she arrived but was very happy to return to his own room to complete the assessment. Mr. F. was fully alert, made good eye contact and was fully engaged with the conversation and was, again, delighted to have a visitor. On questioning, he told the consultant psychiatrist that his leg was now *"very sore"* but reiterated that he had no interest in surgery to remove his leg under any circumstances, even though his

leg is now painful. He said that he was happy to go to the particular nursing home referred to earlier when it was mentioned, stating *"that's a great place"* and *"I'm trying to get there"*. With prompting, he agreed that he was currently in the hospital but had initially been unsure of this.

70. The consultant psychiatrist again explained the risks posed by the exposed graft, the dangers of infection and catastrophic bleeding. However, Mr. F. did not appear able to absorb that information, looking doubtful and saying *"it's not too bad"* and *"just give me something for the pain in it"*. When she again explained the proposed treatment in basic terms and why it was recommended, Mr. F. became agitated, stating clearly and unequivocally on several occasions *"you're not taking my fucking leg"* and *"I'd rather go into the water than be without my leg"*. Mr. F. remained consistent and adamant that he would rather be dead than live without his leg.

71. The consultant psychiatrist carried out a repeat formal functional capacity assessment and reached the same conclusion as before, in that he again showed impairment in his ability to use and weigh relevant information regarding the risk of haemorrhage or infection. He was not willing to accept there was a serious risk posed to his life by the current state of his graft. He did not demonstrate that he understood the true risk to his life posed by potential catastrophic haemorrhage or infection as a consequence of avoiding amputation. Mr. F. continued to demonstrate the emphatic and consistent belief that he did not wish to live without his leg, repeating on several occasions *"I'd rather be dead than without the leg"*.

72. The consultant psychiatrist then conducted a benefit/burden analysis of amputation as against a palliative approach to Mr. F's care.

73. The benefits of amputation were clearly outlined in the reports of the main-treating consultant vascular surgeon and in the second opinion recently obtained. They are:

(a) Mr. F. would likely have a longer (at least short term) survival by elimination of the risk of haemorrhage and infection, and (b) he would be pain-free.

74. In the consultant psychiatrist's opinion, the burden imposed by amputation would be *"significant"*. She described the burdens involved as follows:

(a) Mr. F. would probably be rendered bed/chair-bound in circumstances where independent mobility is very important to Mr. F's sense of self and his enjoyment of life, in that it allows him to interact with others around him, be sociable and offset any agitation or restlessness, which is a common consequence of declining cognition.

(b) Mr. F. would be a poor candidate for managing a prothesis.

(c) Mr. F. would be a significant falls risk with the consequent negative consequences for his risk of further morbidity, fractures, and/or head injury.

(d) Mr. F. might experience phantom limb pain, as outlined by the main-treating consultant vascular surgeon.

(f) Most importantly, in the view of the consultant psychiatrist, Mr. F. is likely to feel ignored, overruled and *"quite possibly assaulted"* by the removal of his limb without his agreement and against his repeatedly expressed will and preference. This is likely, in her opinion, to be in keeping with a view he has always held and the same view he would have expressed if asked about this decision before he developed cognitive impairment.

75. The consultant psychiatrist stood over and repeated the conclusions she expressed in her previous report. First, Mr. F. lacks capacity. However, she continues to see a huge ethical dilemma in overriding Mr. F's clearly and consistently expressed wishes to refuse an amputation. Second, in her view, there is a *"very real risk of catastrophic mental distress*, *a belief that he has been overruled, and his wishes*

dismissed and a further significant deterioration in his quality of life" if Mr. F's leg is amputated despite his repeatedly expressed will and preference. The consultant psychiatrist recommends that the opinion of the palliative care team should be sought, particularly in relation to the feasibility of pain management, should a decision be taken to avoid amputation.

c. Updated Report of the Consultant Vascular Surgeon

76. The consultant vascular surgeon who has been treating Mr. F. and who provided the previous report to the court and gave evidence at the hearing on 3 April 2023, also provided an updated report. As I outline, he altered his position somewhat when compared to his previous affidavit and evidence to the court. He was much more forceful in his view that Mr. F. should have the amputation and was not prepared to yield to the views expressed by the consultant geriatrician and consultant psychiatrist in terms of Mr. F's overall best interests. Ultimately, the consultant vascular surgeon was prepared for me to take the decision based on all of the evidence.

77. In his updated report, the surgeon referred to Mr. F's history, noting that he has been confused since admission, with the lack of capacity and any insight about his condition and its consequences. He notes that Mr. F. becomes irritable more than usual due to his *"continuous right leg pain"* and that the pain scored 8/10 on a subjective scale most of the day, despite potent analgesia.

78. The surgeon explained that Mr. F's right leg still had three wounds, which were shown in photographs attached to his report. The primary wound is at the inner side of the right leg and is still discharging pus with little signs of inflammation around it. The graft is still exposed. The two other wounds consist of two smaller sinuses on the outside of the leg which show no improvement with interval pus discharge. However, Mr. F. does still manage to walk around the ward with his walking aid. He still

receives regular antibiotics and wound dressings to control his leg infection. Mr. F. regularly refuses various forms of treatment and tests. A CT scan carried out on 29 March 2023, revealed a suspicious mass in his stomach. While Mr. F. was advised of the urgent need for an endoscopy test to assess that issue further, and to confirm and to confirm or exclude malignant growth, he did not agree to proceed with that test. He also needed an MRI scan for a painful left shoulder but did not agree to that either. A scan carried out on his right leg on 13 April 2023, confirmed that the graft was still infected.

79. The consultant vascular surgeon explained that Mr. F. is at significant risk of sepsis and life-threatening bleeding and death. He stated that given the seriousness of those complications, *"appropriate measures"* had to be taken to prevent them from occurring. While not in express terms, the consultant vascular surgeon had come to the view that the so-called medical pathway referred to in his earlier affidavit should now be followed, and that the leg should be amputated rather than the alternative palliative care approach. I will come to the direct evidence of the consultant vascular surgeon shortly.

d. Report from Second Consultant Vascular Surgeon

80. As I mentioned, a number of other reports were provided to the court for the purpose of the HSE's application. There is a second opinion from another consultant vascular surgeon. In that report, the surgeon agrees with the treating surgeon that "*infected exposed synthetic grafts are at risk of bleeding (blow out at anastomotic sites)"* and spreading infection (Necrotising Fasciitis or Septicaemia), and that "*both of those conditions are associated with high morbidity and mortality*".

81. The surgeon is of the opinion that, from a *"surgical point of view"*, Mr. F. should have the above-knee amputation as he does not appear to have any further revascularisation options. However, he goes on to say in his report that respect for the patient's autonomy is *"central in making these decisions, commensurate with* [the] *patient's decision making capacity…"* as an above-knee amputation *"has serious impact on quality of life especially when one takes into account age, general condition and comorbidities of this group of patients and is associated with mortality in perioperative period (10 – 15%) and unfortunately mortality is up to 50% in three years"*. The first consultant vascular surgeon confirmed in evidence that, in his view, Mr. F. had a 50% chance of dying within 30 days of an amputation.

e. Occupational Therapy Functional Report

82. There is also an occupational therapy functional report. In that report, the occupational therapist considered Mr. F's current function and mobility, and how that might change if Mr. F. was to undergo the amputation. In her report, the therapist notes that Mr. F. was previously mobile both indoors and outdoors. He is currently mobile in hospital on the ward using a gutter frame. There is an established contracture at the right knee and ankle which causes difficulty in getting good foot contact on the floor as a result of which Mr. F. needs to use the gutter frame. He needs supervision with the use of the frame due to the risk of falls.

83. The occupational therapist outlines that, if Mr. F. were to undergo an amputation, given his current level of cognitive impairment and the experience with Mr. F. after his previous surgery, it would be difficult for him to learn and retain the steps involved in new and unfamiliar tasks such as using a self-propelling wheelchair, and that progressing to prosthetic use would be *"very unlikely"*. She explains that people

with amputations are at increased risk of falling. The risk will be compounded in Mr. F's case by reason of his diminished cognition and his already poor safety awareness. There is also a risk of further delirious episodes post-surgery which could cause further cognitive decline. While it would not be possible to predict any outcome with certainty, in the therapist's view, potentially the best outcome, if Mr. F. were able to engage safely with rehabilitation, would be obtaining assistance from one person for transfers and wheelchair use. There would also be the potential that he would not progress to this point and would need the assistance of two people and supportive equipment for all basic movements. In other words, the therapist does not envisage Mr. F. being independently mobile.

f. Social and Multidisciplinary Team Reports

84. There is also a detailed social report and a multidisciplinary team report. The social report suggests that the level of community care which Mr. F. has been allocated (10 hours per week) could prove to be insufficient in the event that Mr. F. is discharged home to his family. That, apparently, is the maximum amount of community care hours which can be allocated in the area in which Mr. F. lives due to carer shortages.

85. The report notes that, as of 26 April 2023, Mr. F's family remain of the view that they want Mr. F. to be discharged home having had his leg amputated. They are not agreeable to him moving into a nursing home and will not cooperate with the fair deal application form process. The report indicates that the community nursing home referred to earlier have advised that they can prioritise Mr. F. if that is the judgment of the court and if, following their assessment, he is deemed suitable for their service.

86. The multidisciplinary team report refers to the level of care needed by Mr. F. He needs more than hourly intervention throughout the day and requires continuous

supervision to maintain his welfare and wellbeing. He sleeps approximately three hours at night but is restless otherwise and needs frequent staff intervention to ensure that he is safe and well. Mr. F. can be disinhibited with other patients and that behaviour has to be managed through staff intervention. The conclusion of the MDT report is that:

> *"Due to the nature, extent, intensity, and frequency of his care needs…, staff recommend a nursing home environment with staff available at all times of the day and night or a comparable level of home help that would augment what his family can realistically* [provide]*, so that he continues to receive* [the] *care and support he requires. He has been allocated 10 hours per week home help, which staff consider to be very much short of what he will need."*

g. Updated Report of Mr. Bardon, guardian ad litem

87. I was also provided with an affidavit sworn by Mr. Bardon on 8 May 2023, which exhibited a detailed report prepared by Mr. Bardon that day. In his report, Mr. Bardon referred to the various meetings and conversations which he had with members of Mr. F's family and, in particular, his son, his wife and his wife's niece.

88. Mr. Bardon visited Mr. F. on 5 May 2023. In the course of his conversation with Mr. F., Mr. F. clearly told Mr. Bardon that he did not want to have his leg amputated and stated that he would get a gun and shoot any person who took his leg from him. He said that his leg was *"grand"* and that everything would be fine. Mr. Bardon explained to him that his doctors said he could die at any time if his leg was not amputated. However, it was clear that he did not take that on board. When Mr. Bardon asked Mr. F. if he was ready to die, Mr. F. told Mr. Bardon that he would be fine and stated *"if I die, I die"*. Mr. F. thought he was at home at the time.

89. Mr. Bardon outlined in his report the views which the family then held, which were that they would prefer if the proposed amputation went ahead so they could take him home. When asked how they thought Mr. F. would have responded if, at a time when he had full capacity, he had been asked whether he would agree to an amputation, the family stated that their belief was that his response would have been the same as it is now, namely, that he would not want to have his leg amputated and that he would accept the consequences that followed from that decision. Mr. Bardon reported that the relationship between Mr. F., his wife and his son is clearly a close, loving, and respectful one and their interactions were gentle and appropriate.

90. Mr. Bardon agreed with the views of the consultant geriatrician, the consultant psychiatrist, and the medical visitor that Mr. F. lacks capacity to consent or to refuse to consent to the proposed amputation. In considering what would be in Mr. F's best interests, Mr. Bardon expressed the view that the case was *"particularly difficult and complex",* and that the choice faced by the court was *"stark"*. He considered the evidence available in the reports prior to the hearing and the consistently expressed wish of Mr. F. that he would not have his leg amputated.

91. Mr. Bardon proceeded from the starting point that what is in Mr. F's best interests is that his life should be prolonged, and that the consultant vascular surgeon should carry out the amputation. However, having regard to the consistent and strenuous objections made by Mr. F. to the amputation, and having regard to the views of the consultant geriatrician and the consultant psychiatrist, Mr. Bardon concluded that he found the opinions of the consultant geriatrician and the consultant psychiatrist to be persuasive, particularly when combined with Mr. F's clearly expressed wishes. He agreed that, should Mr. F's leg be amputated against his wishes, the consequent loss of mobility would have a catastrophic effect on Mr. F's mental health and would be

likely to materially affect his future capacity to derive enjoyment and satisfaction from his life. On that basis, Mr. Bardon had *"very reluctantly concluded that it was in Mr. F's best interests that his wishes be respected and that the recommended amputation did not take place"*.

7. Hearing of 9 May 2023 and 11 May 2023

92. I heard evidence on 9 May 2023, from the consultant geriatrician, the consultant psychiatrist, and the main-treating consultant vascular surgeon. I also spoke with Mr. F. himself who appeared remotely from his hospital bed. On 11 May 2023, I heard evidence from a palliative care consultant and further evidence from the consultant geriatrician.

a. Evidence of the Consultant Geriatrician

93. In his evidence, the consultant geriatrician stood over the views he had expressed in his two reports. He saw Mr. F. most recently on 5 May and 8 May 2023. He confirmed that Mr. F. was very clear and consistent throughout that he is not willing to have his leg amputated and that he expresses that view with *"great vehemence"* on each occasion that the consultant geriatrician has met him. While Mr. F. has acknowledged a *"biteen of pain"* at times, he says that it is not too bad. However, on every occasion, Mr. F. was absolutely adamant in refusing to consider amputation as an acceptable option for him. He is still able to mobilise up and down the corridor using a gutter frame.

94. The consultant geriatrician outlined the impact of an amputation on Mr. F's mobility. He could not see any realistic way that Mr. F. would be able to use a prosthetic limb. He also felt that Mr. F. would find it very difficult to adapt to the use of a self-

propelled wheelchair as there was a great deal of learning involved in using that. He felt that Mr. F. would end up in bed and be chair bound in the event of an amputation. He also explained that Mr. F. has peripheral vascular disease and, while it is hard to predict the progression of that disease, Mr. F. remains very much at vascular risk into the future.

95. He confirmed his opinion that Mr. F. lacks capacity and he outlined the benefits of amputation and the risks. The benefits are that it would eliminate the risk of bleeding to death and severe infection. There is a risk of substantial psychological upset in Mr. F. coming around after an operation and finding that his leg has been amputated. He also referred to the potential complications after an amputation has been carried out, and felt that it would be very disturbing for Mr. F. He confirmed that there was no ethical problem with the amputation being performed but the issue for him is the burden that the amputation would impose on Mr. F. He felt that there was a risk for post-traumatic stress and depression after the operation and a very high risk of post operative delirium as well as phantom limb pain and loss of mobility.

96. Having considered all of the relevant benefits and burdens, it was his view that Mr. F's best welfare interests would be met by not having the amputation, but rather that a plan be devised for Mr. F's discharge to a place where he can be cared for. He also felt that a discharge to a nursing home, and in particular to the nursing home that Mr. F. had previously mentioned, would be the most appropriate plan. However, the consultant geriatrician noted that this would not exclude further discussions with Mr. F's family regarding a discharge back to the family home.

97. Ultimately, the consultant geriatrician was of the view that, taking everything into account, Mr. F. would be better off by not having the amputation. He confirmed what he said at the previous hearing on 3 April 2023, that he would be horrified at the

thought of trying to deal and treat with Mr. F. if his leg was amputated as Mr. F. would very likely be very upset, very angry and distressed after having consistently described his opposition to the amputation.

b. Evidence of the Consultant Psychiatrist

98. In her evidence, the consultant psychiatrist confirmed that, in her view, Mr. F. did not meet the functional test for capacity, particularly as he was unable to use and weigh relevant information concerning the risk of haemorrhage and infection with his leg and the seriousness of his condition. She confirmed that, in her opinion, Mr. F. lacked capacity to make a decision whether to consent or not to the amputation of his leg at this particular moment in time. She stressed that Mr. F. had been *"vehement, adamant, consistent at all times that* [she] *met with him, he made it absolutely explicit that he does not want to lose a leg, to a quite remarkable degree actually…"*. Despite being told about the great risk to his life with the risk of haemorrhage and infection in his leg, Mr. F. did not agree but was *"absolutely adamant"* and expressed the view that *"he'd rather be dead than live without the leg, that he would rather go into the water than have the leg taken from him, that life wasn't worth anything to him without his leg"*. She said that *"in no uncertain terms and very consistently he expressed that opinion"*.

99. In expressing her view that it was in Mr. F's overall best interests not to have the amputation, she confirmed that she had considered the position and the ethics of the issue from every perspective. The consultant psychiatrist went through the various risks and benefits of having and not having the amputation as outlined in her report and expanded on these in the course of her evidence.

100. With respect to the impact on Mr. F's mobility in the event that he were to have the amputation, the consultant psychiatrist outlined that Mr. F. *"loves to be on the move"* and that this may partly be due to his background and personality and his way of living (he is a farmer and a fisherman in a remote location). She explained that his need to move around may also be as a result of the dementia, which can cause a person to become more restless and to need to pace and move up and down. She explained that Mr. F. *"obviously gets great enjoyment from being on the move"* and that he is a *"very sociable gentleman"*. He gains *"huge enjoyment out of his interactions with the other staff and the patients up and down the corridor"*. A major burden for him, in the consultant psychiatrist's view, would be the likelihood that he would be rendered bed-ridden or chair-bound in the event of an amputation and that this could not be underestimated.

101. She confirmed the views of the consultant geriatrician as to the likelihood that Mr. F. would not be able to manage a prothesis and also would have difficulties in coping with a wheelchair and she agreed with the views expressed by the occupational therapist as to the risk that Mr. F. would need at least one person, and possibly two people, to assist him with mobility with the use of a wheelchair. This would have a major effect on his independence.

102. She described Mr. F. as being *"fiercely independent and very strong minded"*. She was *"very concerned"* about the fact that he would become significantly dependent on others in the event of the amputation taking place and she saw that as being *"a real risk to his mental wellbeing"*. She also referred to the fact that Mr. F. is currently able to use the gutter walker very successfully and is managing to mobilise up and down the corridor of the hospital with great enjoyment. While she accepted that there is a falls risk currently, she felt that the falls risk after an amputation would be a much

bigger issue, as it was quite likely that, because of Mr. F's dementia, he might well at times forget that his leg is gone. He would also have to be told again and again that his leg had been amputated, in much the same way as it is necessary to tell a person with dementia that they have lost a loved one due to a bereavement. Mr. F. would go through the distress again and again. Her concern is that Mr. F. would attempt to move in spite of the fact that he does not have his right leg, and that this would make him even more of a falls risk.

103. The consultant psychiatrist was particularly concerned to stress the need to give respect to Mr. F's autonomy, and for respect to be given to his wishes. She felt that a very convincing factor to be taken into account in deciding whether or not to require an amputation was the vehemence with which Mr. F. was consistently expressing his desire not to lose his leg. She felt that, while it was not possible to be certain, and she would defer to Mr. F's family on this, her impression was that the vehemence and consistency with which Mr. F. expressed his views was probably consistent with the view he would always have held. She reiterated her view that there would be a very real risk of *"catastrophic mental distress"* if the amputation went ahead. She agreed with the consultant geriatrician in that respect. She added that, because of Mr. F's advancing cognitive impairment, the distress he would be likely to suffer on discovering that his leg was gone was something that he would have to go through not just once but potentially many times, as every time he goes to sleep, he might wake up having forgotten that the leg had been amputated. She completely agreed that conserving and preserving life is the first and most important duty of a physician, but it was also necessary to consider the quality of life at issue. Her view was that Mr. F. should not have his leg amputated in accordance with his consistently expressed views.

104. She felt that Mr. F's family, who know him best, may be of the view that he would be resilient and would be able quickly to adapt, however she felt that Mr. F's memory issues would be a complication and the impact that any fluctuating delirium, as well as the underlying cognitive impairment, might have which might make the adjustment more difficult than the family might initially believe. She also felt that there was a significant risk of delirium which could be caused by the surgery itself, but potentially also by repeated bouts of severe infection. This likelihood of delirium is, in the consultant psychiatrist's view, likely to impact on his baseline level of cognition, and that one of the reasons for this impact would be surgery.

c. Evidence of the Consultant Vascular Surgeon

105. The main-treating consultant vascular surgeon then gave evidence. He confirmed his two reports and provided further detail in relation to Mr. F's extensive peripheral vascular disease, which he noted affected every part of his body, including his heart and his brain and not just his leg. Mr. F. has ischaemic heart disease and also diabetes. All of these could induce serious problems for Mr. F., including his ability to mobilise, and could lead to him suffering a heart attack or a stroke irrespective of the particular issues caused by his leg. The consultant vascular surgeon explained that, on some occasions, Mr. F. would say that if he got to the point where he was in severe pain that then he would be prepared to let them amputate the leg. However, he had never got to that point. There would be no problem if Mr. F. had capacity, and the consultant vascular surgeon regularly encounters patients with capacity who do not wish to undergo an amputation, even though they may die without it.

106. The surgeon explained that he had changed his position from that adopted at the 3 April 2023 hearing in light of the deterioration in the condition of Mr. F's leg and, in

particular, the development of the two sinuses on his leg connected to the infected graft below the knee, which is where much of the pain is coming from. Mr. F's mental condition was being influenced, not only by his dementia and constant lack of capacity, but also by delirium, acute confusion, and hospital psychosis as well as various other factors. The change in the consultant vascular surgeon's position was also influenced by his belief that a nursing home would not accept Mr. F. in his current condition due to the extreme risk of haemorrhage and infection. Those are the reasons why the consultant vascular surgeon was not prepared at this point to yield to the views expressed by the consultant geriatrician and the consultant psychiatrist and instead was advocating for an amputation, although he fully accepted what those other consultants were saying. He also accepted that there was no ethical problem with proceeding or not proceeding with the amputation. Either approach would be ethically acceptable. However, as a surgeon he was advocating for the amputation and was concerned with what would happen if the amputation was not performed.

107. He felt that Mr. F's cognitive function would improve between 50% to 70% after the amputation. That is not a view supported by the consultant psychiatrist or the consultant geriatrician, and I am inclined to prefer their evidence in that respect. He acknowledged that Mr. F. would develop some form of depression after an amputation, as that is normal for about 80% of people who have such surgery, as is phantom pain. He said the appropriate medications can deal with those issues.

108. Fundamentally, the consultant vascular surgeon was advocating for surgery to save Mr. F's life and wanted clarity from the court on that issue. Equally, he said that if the court concluded that the amputation should not be performed, he wanted to see a comprehensive palliative plan. He and his team were concerned at the idea of letting a patient bleed to death, as against the likely post-operative depression with which

Mr. F. would likely suffer. Although ultimately, he repeated on many occasions that he respected the views of his psychiatric and geriatric colleagues and would accept the decision of the court.

109. He also referred to the need for protection from the court in terms of the *"very high medical legal environment"* faced by those working in the hospital. In the circumstances where he and his team were differing from the psychiatric and geriatric teams as to the plan to be adopted, it was necessary for the court to make the decision. He felt that there was *"medical inertia"* at present and that he was unable to tell Mr. F. what the plan was, in circumstances where Mr. F. has been in hospital for almost a year. He said that he *"looking for guidance, that's all"*.

110. At one point, the consultant vascular surgeon expressed the view that, if Mr. F. had an amputation, he would live *"another two years maybe, three years maximum"*. However, later, when he was brought through the weighted mortality rates post-amputation, which were set out in his first report, the consultant vascular surgeon confirmed that Mr. F., having regard to his age, state of health and underlying vascular problems, would have a 50% mortality rate within 30 days of an amputation. He described the effect of amputating the leg in terms of the stress of the surgery as being similar to asking Mr. F. to jump from the Four Courts to Dublin Bay and back again. He acknowledged that, if the amputation was performed, Mr. F. would have problems, and if the amputation was not performed, Mr. F. would have similar problems. He acknowledged that in his report he stated that the mortality risk associated with an amputation in the case of those with vascular disease would be eleven times greater than those suffering from complications from impaired mobility without the vascular pathology. He referred to possible complications after surgery as including the risk of developing a massive heart attack, developing a stroke, and

developing renal failure. In fairness to the consultant vascular surgeon, his primary concern was to try to save Mr. F's life which, although the proposed amputation had the morality risk which he mentioned, he felt was better than doing nothing.

d. Further Evidence of the Consultant Geriatrician

111. The consultant geriatrician was then recalled to give evidence following the main-treating vascular surgeon's evidence, primarily to deal with the options for Mr. F's care in the event that he were discharged from hospital. He remained open to Mr. F. being discharged home with detailed consultation with members of Mr. F's family. He explained that he was very familiar with the nursing home situation and, in particular, the nursing home close to Mr. F's home, and felt that this nursing home would be capable of addressing Mr. F's needs. In order for the nursing home to be considered, there would have to be an application made on behalf of Mr. F., where he would have to be clinically assessed and an NHSS application would have to be completed. He disagreed with the consultant vascular surgeon that no nursing home would accept Mr. F., although he acknowledged it was very difficult to identify a particular place and a particular plan without an application being made. He described the care in the particular nursing home mentioned as being excellent, although other nursing homes would also be suitable, including other HSE community nursing homes and those in the private sector. He disagreed with the consultant vascular surgeon on whether a nursing home would accept Mr. F. based on his experience.

112. He agreed with the consultant vascular surgeon that the main risk at present is the risk of a catastrophic bleed, which would be life-ending within a very short period of time, even if Mr. F. were in an acute hospital at the time of the bleed. That was not a

palliative issue, and, at present, Mr. F's pain was not uncontrollable or close to being uncontrollable. He explained that palliation might arise for any symptom that might develop, and that palliation could address all of the risks identified by the consultant vascular surgeon arising from Mr. F.'s underlying vascular disease. He agreed with the surgeon that, if Mr. F. suffered a rupture of his graft and a major haemorrhage, he would bleed to death *"fairly quickly"*. It would not be a painful event and he would *"simply drift into unconsciousness and die peacefully"*. That would not be a matter of palliative care being required.

e. Evidence of Mr. F.

113. I had the benefit of hearing from Mr. F. himself during the course of the hearing. Mr. F. appeared remotely from his hospital bed, where he was accompanied by a solicitor from the HSE. While understandably a little confused at what was going on, Mr. F. was a charming, engaging, and pleasant man and was exactly as he had been described by the consultant geriatrician and consultant psychiatrist. It was a pleasure to speak with him.

114. Mr. F. indicated that his leg was *"a bit sore"*. When asked what he thought about the doctor saying that he would like to amputate the leg, Mr. F. replied *"oh no – he's not going to take my leg off. Or any other doctor I'm telling you, boy, because I have a big gun here and I will shoot you"*. He then said he was *"only joking"*. When asked why he would not let the doctor amputate his leg, he said *"oh Jesus there is no point going around with one leg"*. He said that he wanted to have *"the two legs on"*. He said that without that he *"wouldn't be able to go everywhere"*. When asked whether he would reconsider it on the basis that he might live longer if he had an amputation he said *"if I had to think about it for another while…I'll think about it alright"*. And

he said *"I'll ring you"* and *"I'll be in touch with you"*. He then said *"I'm afraid myself to go cutting it off"*. He said *"I'd be afraid"* and that *"he'd have to throw me somewhere"*. He then said *"maybe now if I get more pain in my leg, I'll ring you"*. In answer to a question from me, he said *"there's no pain now"* (in his leg). He then said *"I'm afraid I'd be afraid to take it off"* and *"I'd have to get a new leg"*.

115. The consultant geriatrician was of the view that when Mr. F. said he would get back to people and would think about an amputation, he did not really mean it and he was just fobbing them off. He agreed that Mr. F. had said that if the pain got too bad that he would consider the amputation.

116. Further evidence was required, and the hearing was adjourned to the afternoon of 11 May 2023.

f. Evidence of Consultant in Palliative Medicine

117. The court heard evidence on 11 May 2023 from a leading consultant in palliative medicine. With exceptional speed and efficiency, she provided a detailed report as well as an addendum report following a meeting with Mr. F's family. The family were extremely cooperative and supportive of palliative care involvement with a discharge home into their care, with input from the palliative care Team (the "PCT") and his GP, when required.

118. The palliative care consultant first met Mr. F. within an hour of his referral to the Hospital Specialist palliative care Service (the "PCS"). The palliative care consultant reported that, during her interaction with Mr. F, he stated that he would not be happy with an amputation and that he "*wouldn't let them take my leg.*" When told of the risk of life-threatening bleed, he replied "*I do not want to be in hospital."* Mr. F. further told the palliative care consultant that "*[t]he only bed I want to be in is my own."*

119. In her report, the palliative care consultant assured the court that even though Mr. F. lives in a remote area in the West of Ireland, "*this has not been a barrier to implementing our patients' wishes in the past".* The PCS have gone as far as to enlist the Army and Coastal Services to airlift patients home in the past. However, should Mr. F. be treated in a hospital setting, he would receive the same level of palliative care, that being *"akin to a specialist hospice*."

120. The palliative care consultant explained that role of the PCT is to create and implement a palliative care plan that accounts for all potential eventualities arising from a patient's particular medical condition. This plan is then discussed with the patient, his or her family and the patient's GP. The palliative care consultant said that it was her understanding that Mr. F.'s GP is situated near his family home, commenting that, in Mr. F.'s community, *"it is likely the old style of general practice where they know their community and they are very available."* However, should a "*very rare and difficult symptom"* arise*,* the palliative consultant advice service is available 24 hours a day, seven days a week in the West of Ireland (Saolta Region), where Mr. F. resides. The majority of out-of-hours advice is given over the telephone.

121. The focus of palliative care is to improve quality of life. The palliative care consultant considers that Mr. F. is appropriate for early palliative care involvement, given his quality of life wishes and the potential complications of further pain and life-threatening bleed. Both potential complications are addressed separately in her report.

122. As regards pain management, the palliative care consultant reported that the PCT has good experience of managing non-cancer pain, with approx. 40% of referrals to the PCT being non-cancer patients. During the consultation, Mr. F. denied having much pain and the palliative care consultant noted that he was, at that time, on the opioid OxyContin. The report provides that non-cancer pain, and, in particular, vascular/

gangrene pain, responds better to other types of painkillers, such as tapentadol. The palliative care consultant discussed the introduction of that drug with Mr. F. In her evidence, in response to questions from counsel for the HSE regarding phantom pain, the palliative care consultant stated that the PCT have quite a lot of experience with phantom limb pain, noting that tapentadol, ketamine, and methadone are effective at treating this symptom.

123. As regards the management of a life-threatening bleed, the palliative care consultant reported that the PCT is accustomed to planning for this eventuality. In her oral testimony, the palliative care consultant commented that, if Mr. F. suffers a major bleed, it will not be possible to resuscitate him to any sustainable quality of life, so they would *"allow natural passing."* She noted that inappropriate resuscitation can be "*very distressing"* where a decision to not resuscitate is not made. She explained that a decision to not resuscitate is "*imperative*" to achieving the best quality of dying. She reported, that, in her experience with intensive education of families and carers, the planning and management plan helped to facilitate "*the most comfortable dying possible*".

124. In her oral testimony, the palliative care consultant commented that "*if* [Mr. F.] *is not having an amputation and he is at home where he wants to be and he has a bleed, we empower natural passing as comfortable as possible."* In response to questioning from counsel for the HSE regarding the willingness of nursing homes to admit a patient who posed a risk of suffering a life-threatening bleed, the palliative care consultant stated that, "*once palliative care is involved, the nursing homes in our catchment area, are very comfortable to look after a patient because they know they get our support all the time"* and she has not known a nursing home to refuse a patient where the PCT was involved.

125. The palliative consultant, in her report, set out the palliative care plan for Mr. F. in bullet-point format. The "*immediate care plan"* for the family includes the provision of dark blankets, which reduce the visibility of blood, and "*easy to administer drugs*" in wafer or tablet form that allow the family to essentially anaesthetise Mr. F. to reduce confusion and distress. The family are advised to stay with the patient during this time as an acute bleed can make the patient very anxious and fearful. The GP and/or Public Health Nurse and/or Community Palliative Care Team are informed in advance of what drugs to administer and how, in order to manage the patient's symptoms of ongoing distress. As regards the day-to-day care, the palliative care consultant stated that the family would be supported by the PCT in familiarising themselves with Mr. F.'s medication, but that dressing his wounds would be tended to by a trained professional such as a Public Health Nurse, given the higher risk of infection. The Clinical Nurse Specialists on the PCT liaise with their colleagues in local home care and the public health nurse in the community.

126. As regards the steps involved in Mr. F.'s discharge from the hospital, the palliative care consultant commented that it would be a "*multi-complex discharge"* requiring the involvement of a multidisciplinary team, likely overseen by the geriatric services. The PCS, the physiotherapist, the occupational therapist, and social worker would each be involved to ensure that the house is ready for his return home. She noted that there is a *"big focus on getting equipment into houses"* and that the Health Board provides a rapid response if a patient needs a bed or other equipment at home. She said that she hoped things would be ready within a week or two, but that cannot be guaranteed.

127. It had been suggested by the consultant surgeon that Mr. F. could return home for one day, on a trial basis, to ensure that the family felt confident they could care for him.

When asked by the court as to the practicability or wisdom of this suggestion, the palliative care consultant commented that they often suggest this option to families on the basis that discharging patients home can be *"very frightening"* for the patient's family, because, once discharged, their hospital bed is gone, and the only opportunity for readmission is through Accident & Emergency which is very stressful. She considered that there would be "*pros and cons"* to Mr. F. being discharged for a day, given his very poor recall. When asked about this subsequently, the consultant geriatrician, who was recalled to give evidence, explained that every discharge home is, in effect, a trial. He felt that the discharge home could take place in about a week on the basis of a multi-disciplinary approach, involving a range of different consultants and other professionals, including occupational therapists, the public health nurse, and a social work team.

128. The palliative care consultant helpfully added an addendum to her report following her meeting with Mr. F.'s family in the afternoon of 10 May 2023. The meeting focused on symptom control at home and the support the PCT can offer, which is an *"extra layer of support"* available on a "*priority of need"* rather than routine basis.

129. The family, who appeared "*calm and reassured",* were very supportive of palliative care involvement and Mr. F's potential discharge home, saying that "*once there is a clear plan and we understand what to do and who to contact we are very happy to give care at home. The plan is clear and makes sense".* The family understood that, if the amputation is not to proceed, a life-threatening event would be irreversible. The addendum to the report concluded by stating that *"Mr. [F.'s] family were very cooperative to address all appropriate action following the Court's decision."*

130. Mr. Bardon, the guardian *ad litem* provided a supplemental report in advance of the hearing of 11 May 2023. He explained that following the hearing on 9 May,

arrangements were made for Mr. F's family to meet with the palliative care team led by the palliative consultant on 10 May 2023.

131. Mr. Bardon spoke with members of Mr. F's family on 10 May 2023. They informed him that the family had carefully considered and reflected on the evidence given to the court by the consultant vascular surgeon to the effect that, if Mr. F's leg was amputated, there would be a 50% chance of him being alive one month later. As a result, the family was now of the view that Mr. F. should not undergo the amputation. They will be happy to take Mr. F. home so that he can enjoy as best he can the remainder of his life in the familiar environment of his home.

132. The family had a very constructive meeting with the palliative consultant and agreed to work on a plan that would allow Mr. F. to return home, and to be cared for by his family within from the palliative care team when required. That team had already contacted Mr. F's GP, who confirmed that he would be happy to support a plan that allowed Mr. F. to return home. The family also met with the consultant vascular surgeon, who indicated that it might be possible to allow Mr. F. home for a day this week on a trial basis to make sure that the family was satisfied that they could support and care for Mr. F.

133. Mr. Bardon was very complementary of the palliative consultant and the speed with which she was in a position to provide a detailed and considered plan at very short notice. He was also very complementary of the excellent care which Mr. F. has received from all of the staff at the hospital and complemented the staff, management and consultants involved in Mr. F's care for the efficient and effective manner in which the provisional plan had been put in place. Having considered this updated evidence, Mr. Bardon was of the view that Mr. F's wishes should be respected and

that it is in his best interests not to undergo the amputation. That view is now shared by Mr. F's family.

134. A provisional plan is now in place, following discussions between the palliative consultant and Mr. F's family that would allow Mr. F. to return home where he would be cared for by his family and supported by the palliative care team and Mr. F's GP as necessary. That development was welcomed by Mr. Bardon as it gave effect to Mr. F's wishes. Mr. Bardon believes that it is in Mr. F's interests that that plan be implemented. So do I.

8. Summary of Relevant Facts

135. That is the extent of the evidence which evolved during the course of the hearing. Arising from all of this, it seems to me that the critical facts for the purpose of my decision in this case are as follows.

136. Mr. F., who is almost 75 years of age, is a very ill man. He suffers from severe peripheral vascular disease. He was admitted to the hospital in June 2022 on an emergency basis with right lower limb-threatening ischaemia and required urgent lower right leg bypass surgery and fasciotomy in order to save his leg. While the initial surgery went well, there have been many serious complications post-surgery.

137. Mr. F. has dementia and significant cognitive impairment. He lacks capacity based on the functional test of capacity (as described by Laffoy J. in the High Court in *Fitzpatrick v. F.K.* [2009] 2 I.R. 7 ("*Fitzpatrick"*) and now in s. 3 of the 2015 Act.

138. Mr. F. repeatedly interfered with his wounds post-surgery. The graft has become infected, and he is at imminent risk of fatal haemorrhage as well as sepsis. The surgical team have argued for an above-knee amputation of his right leg in order to save his life. However, the consultant vascular surgeon acknowledged the risks

involved in performing such an operation on Mr. F. in light of his underlying complex medical condition. While estimating that Mr. F. could potentially survive for two, and at most three years, after the amputation, he confirmed in evidence that Mr. F. had a 50% chance of mortality within 30 days of surgery. The other doctors involved in Mr. F's care, including the consultant geriatrician and the consultant psychiatrist, felt that the risks to and the downsides for Mr. F. in performing the amputation outweighed the benefits.

139. Despite his lack of capacity, Mr. F. has repeatedly, consistently, and with great vehemence expressed the view that he does not want to have his leg amputated. He told me that himself from his hospital bed during the course of the hearing. While I accept that he did leave open the door to possibly reconsidering amputation in the event that the pain in his leg was to become too much to bear, his pain is being managed well with medication. At the present time, he is most adamant that he does not want an amputation.

140. The consultant geriatrician and the consultant psychiatrist are of the view that an amputation would cause enormous psychological distress to Mr. F: *"severe psychological distress"* (according to the consultant geriatrician) and *"catastrophic mental distress"* (according to the consultant psychiatrist). They also point to other significant adverse consequences of an amputation in the case of Mr. F., including loss of independence (as he is not a candidate for a prosthesis and would likely be unable to manage a wheelchair due to his combined conditions and his dementia) the effect of which would mean that Mr. F. would likely to be chair or bed bound post-surgery. He would be a significant falls risk with a consequent risk of further morbidity, fractures, and head injury. He is also likely to experience phantom limb pain and, significantly, he is likely to feel ignored, overruled and *"quite possibly*

assaulted" (in the words of the consultant psychiatrist) by the removal of his right leg without his agreement despite his repeatedly express wish not to have his leg removed. I accept all of this.

141. I also accept the evidence of the palliative care consultant as to how the palliative care team could manage Mr. F. were he to be discharged to his home without an amputation.

142. Mr. F's family's position has evolved during the course of the proceedings, as has the position of the HSE itself. While initially being of the view that in order to be able to care for Mr. F. at home he would need to have the amputation in light of the very severe complications arising from his earlier surgery, having carefully considered all of the evidence during the course of the proceedings, the family's position has evolved. They are now supportive of Mr. F's discharge home without an amputation and under the care of the palliative care team. Mr. Bardon, the guardian *ad litem* is also of the view that this would be in Mr. F's best interests, as is the HSE, having had the opportunity of considering all of the evidence given in the course of the proceedings.

143. I accept that, from an ethical perspective, each of the doctors involved in Mr. F's care is acting entirely appropriately, ethically, in good faith, and in the *bona fide* view of what is in Mr. F's best interests.

144. Ultimately, because of Mr. F's lack of capacity, it falls to me to make the decision in this case on the basis of these facts. I am conscious of the significance of the decision I am required to make for Mr. F., for members of his family and for all those involved in his treatment and care.

145. Having considered all of the evidence and the relevant legal principles which I will detail in the next section, I am satisfied that the correct decision is that Mr. F. should

not have the amputation but should be discharged home to the care of his family, with the assistance of the palliative care team and other support professionals. Together, they will provide the best and most appropriate care for Mr. F. This is the decision which I believe properly respects Mr. F's rights to bodily integrity, autonomy, dignity in life and death, and privacy.

146. It is, on the basis of all of the evidence and on the basis of the legal principles touched on below, my view that this decision is very much in Mr. F's best interests. By applying these principles, I conclude, therefore, that it is in Mr. F's best interests not to have the amputation and to be discharged home to the loving care of his family and the assistance of the palliative care team and other supporting professionals.

Part B: Legal Principles and Application

9. Agreed Legal Principles

147. There was no dispute between the HSE and Mr. Bardon, the guardian *ad litem*, as to the applicable legal principles. Nor, indeed, was there any dispute as to how those principles should be applied to the facts of the case as they emerged during the course of the hearing. These principles are now, in fact, well-established.

148. As noted earlier, there is no dispute between the parties that Mr. F. lacks capacity based on the functional test at common law outlined by Laffoy J. in the High Court in *Fitzpatrick,* which is very similar to the functional capacity test now set out in s. 3 of the 2015 Act. As can be seen from the authorities, however, the fact that Mr. F. lacks capacity does not mean that considerable weight should not be given to his repeatedly and consistently expressed wishes not to have his leg amputated. On the contrary, significant weight should, in my view, be given to those wishes as part of the court's

consideration of the overall circumstances of the case in reaching a decision as to what is in the best interests of Mr. F.

149. Although my decision in this case was given on 11 May 2023, after the 2015 Act came into operation, the jurisdiction which I am exercising is the wardship jurisdiction formerly exercised by the Lord Chancellor of Ireland and which is now vested, by s. 9 of the Courts (Supplemental Provisions) Act 1961, in the President of the High Court, by virtue of s. 56 of the 2015 Act. The wardship jurisdiction of the court continues to apply in respect of proceedings in being on the coming into operation of the 2015 Act (as amended). The court's wardship jurisdiction was invoked on 3 April 2023, prior to the coming into operation of the 2015 Act on 26 April 2023, when I made the various orders referred to earlier, including an order pursuant to s. 11 of the Lunacy Regulation (Ireland) Act 1871 directing that the medical visitor visit Mr. F. to carry out an assessment of his capacity, and an order appointing Mr. Bardon as guardian *ad litem*. Those orders were sufficient to invoke the court's wardship jurisdiction which, by virtue of s. 56 of the 2015 Act, continues to apply to these proceedings. I am exercising my wardship jurisdiction, therefore, and not the inherent jurisdiction of the court.

150. Where a patient lacks capacity to accept or refuse medical treatment, as in this case, the court may intervene, on foot of its wardship jurisdiction, to make such order as it considers to be in the patient's best interests in deciding whether to give its consent to a particular form of treatment, having regard to all the circumstances of the case.

151. In the leading case in this area, *In Re A Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79 ("*In Re A Ward"*) Hamilton C.J. described the test as follows:

> *"In the exercise of this jurisdiction the court's prime and paramount consideration must be the best interests of the ward. The views of the committee and family of the ward, although they should be heeded and careful consideration given thereto, cannot and should not prevail over the court's view of the ward's best interest."* (At p. 106)

152. In describing the test in the context of potentially life-saving treatment for a minor ward, Kearns P. stated in *Re S.R. (A Ward of Court)* [2012] 1 I.R. 305:

> *"In determining whether life-saving treatment should be withheld, the paramount and principal consideration must be the best interests of the child…."* (para. 55, p. 323)

153. In a similar fashion, in *In Re C. (A Ward of Court)* [2021] IEHC 318 ("*In Re C"*), Irvine P. described the test as follows:

> *"When exercising its wardship jurisdiction or its inherent jurisdiction in relation to a minor, the court acts in loco parentis to the ward/intended ward. However, Katie is an adult who has been brought into wardship by reason of her lack of capacity. Accordingly, and in principle, it falls to the court to make the decision for Katie as to whether her life-sustaining treatment should be withdrawn and to make that decision consistent with her best interests."* (para. 55)

154. Mr. F. is a person in respect of whom the court's wardship jurisdiction has been invoked and, although he has not been declared a ward of court, the court must nonetheless decide whether it is in Mr. F's best interests for the court to provide its consent to the amputation, or to refuse that consent and instead consent to the alternative treatment and care outlined in the evidence.

155. This is not the type of case in which the court can dispense with the requirement for consent as was the case in *In Re J.J.* [2021] IESC 1. In that case, the clinicians involved gave evidence that the further provision of treatment would be unethical. However, in the present case, all of the clinicians who gave evidence confirmed that it would not be unethical to proceed with the amputation or to pursue an alternative treatment route. This is not a case, therefore, where the clinicians seek to rely on their right not to carry out treatment which they consider to be unethical. In those circumstances, the approach taken in *In Re J.J.,* where the court made a declaration of lawfulness rather than providing consent or otherwise to a particular form of treatment, cannot apply in this case. I agree with the reasoning set out by Irvine P. in *In Re C.* at para. 72. I must, therefore, decide whether to grant my consent or otherwise to the amputation.

156. In her judgment, in *In Re A Ward*, Denham J. identified several factors to be taken into account in determining the best interests of a patient who lacks capacity when deciding whether substituted consent should be given for a particular course of treatment. She noted that the *"totality"* of the patient's situation had to be considered. The (non-exhaustive) list of factors identified by Denham J. to be considered by the court were as follows:

> *"(1) The ward's current condition.*
>
> *(2) The current medical treatment and care of the ward.*
>
> *(3) The degree of bodily invasion of the ward the medical treatment requires.*
>
> *(4) The legal and constitutional process to be carried through in order that medical treatment be given and received.*

(5) The ward's life history, including whether there has been adequate time to achieve an accurate diagnosis.

(6) The prognosis on medical treatment.

(7) Any previous views that were expressed by the ward that are relevant, and proved as a matter of fact on the balance of probabilities.

(8) The family's view.

(9) The medical opinions.

(10) The view of any relevant carer.

(11) The ward's constitutional right to:—

(a) Life.

(b) Privacy.

(c) Bodily integrity.

(d) Autonomy.

(e) Dignity in life.

(f) Dignity in death.

(13) The constitutional requirement that the ward's life be (a) respected, (b) vindicated, and (c) protected.

(14) The constitutional requirement that life be protected for the common good. The case commences with a constitutional presumption that the ward's life be protected.

(15) The burden of proof is on the applicants to establish their application on the balance of probabilities, taking into consideration that this Court will not draw its conclusions lightly or without due regard to all the relevant circumstances."

157. As was observed in the course of submissions by counsel and Mr. Bardon, while Denham J. noted that any *"previous views"* expressed by the ward may be relevant, currently expressed views are also highly relevant, as is clear from the judgment of MacMenamin J. in the Supreme Court in *M.X. v. Health Service Executive* [2012] 3 I.R. 254 ("*M.X.")* and the judgment of O'Malley J. in *A.C. v. Cork University Hospital* [2019] IESC 73 (see in particular, para. 245).

158. I also have a slight reservation about the expression of the burden of proof and the standard of proof in the list of factors identified by Denham J (no. 15). I tend to agree with the view expressed by Kelly P. in *In Re J.M.* [2018] 1 I.R. 688 ("*In Re J.M.")*, that, since these proceedings did not involve a *lis inter partes*, it is probably unnecessary to speak of the burden of proof or the standard of proof, but nothing at all turns on that in these proceedings. I have taken my decision on the basis of clear and convincing evidence.

159. Before considering each of the factors identified by Denham J. in the context of the facts of this case, some further fundamental principles need to be mentioned.

160. First, an adult person with full capacity must provide consent if medical treatment is to be provided, subject to some very rare exceptions: *In Re A Ward,* per Denham J. at p. 156. As noted by Kelly P. in *In Re J.M.*, *"every competent adult has the right to withhold consent to medical treatment"* (at p. 712). Hamilton C.J. in *In Re A Ward* stated:

> *"…I am satisfied that if she were mentally competent that she would have, in the circumstances of her condition, the right to forego the treatment or to have the treatment discontinued and that the exercise of that right would be lawful and in pursuance of her constitutional rights"* (at p. 126).

161. As further noted by Kelly P. in *In Re J.M. "the right to refuse medical treatment extends to treatment which is necessary in order to protect or sustain that person's life"* (at p. 712). Kelly P. quoted from a number of the judgments in *In Re A Ward* supporting this fundamental principle. For example, Blayney J. said:

> *"Where a person who is compos mentis has a condition which, in the absence of medical intervention, will lead to death, such person has a right in law to refuse such intervention"* (at p. 142).

Hamilton C.J. stated:

> *"A competent adult if terminally ill has the right to forego or discontinue life-saving treatment"* (at p. 125).

O'Flaherty J. said:

> *"There is an absolute right in a competent person to refuse medical treatment even if it leads to death"* (at p. 129).

162. Since Mr. F. does not have capacity to give or to refuse his consent to the amputation, the court has to make that decision for him, taking into account what the court believes to be in his best interests.

163. Second, the fact that a person has lost capacity does not meant that they have lost the benefit of the personal rights guaranteed under the Constitution. In *In Re A Ward*, Hamilton C.J. said:

> *"The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution, including the right to life, the right to bodily integrity, the right to privacy, including self-determination, and the right to refuse medical care or treatment…*

> *The ward is entitled to have all these rights respected, defended, vindicated and protected from unjust attack and they are in no way lessened or diminished by reason of her incapacity."* (at p. 126)

This fundamental principle was stressed by Kelly P. in *In Re J.M.*

164. As I noted earlier in this judgment, Mr. F.'s personal constitutional rights are heavily engaged by the application before the court, including, but not limited to his right to privacy and self-determination.

165. Third, there is a strong presumption in favour of maintaining life, and of taking all necessary steps to do so. This fundamental principle was referred to by a number of the judges *In Re A Ward*. In his judgment, Hamilton C.J. stated:

> *"The nature of the right to life and its importance imposed a strong presumption in favour of taking all steps capable of preserving it, save in exceptional circumstances."* (at p. 123)

166. Denham J. referred to the *"constitutional presumption that the ward's life be protected"* (at p. 167). This fundamental principle was explained by Kelly P. in *In Re J.M.* where he said: *"There is a very strong presumption in favour of taking all steps which will prolong life"* (at p. 714). However, it is clear that that presumption can be rebutted, and the court may not be obliged in all cases to take such steps. Kelly P. went on to state:

> *"But in exercising its jurisdiction the court is not precluded in principle from finding that in the circumstances of a particular case it is in the ward's best interests that the court should refuse to give consent to a particular course of medical treatment, even treatment which might become necessary or desirable in order to prolong or to attempt to prolong the ward's life. There is no absolute duty imposed on the court to consent to medical treatment on behalf*

of a ward of court in order to attempt to prolong life at all costs and without regard to any other consideration or circumstance of the ward's best interests. Neither is there any absolute duty on a doctor to provide, or on a patient to consent to, medical treatment in order to attempt to prolong life at all costs and without regard to other matters concerning the patient's best interests." (at p. 714)

167. Those observations are particularly relevant to this case. I completely accept that there is no absolute duty imposed on the court to consent to medical treatment in the form of an amputation on behalf of Mr. F. in order to attempt to prolong his life at all costs, without regard to other considerations or other circumstances relevant to his best interests.

168. The existence of the rebuttable presumption in favour of sustaining life-prolonging treatment was recently considered by Irvine P. in *In Re C.* Having referred to the observations of Kelly P. in *In Re J.M.*, Irvine P. stated:

"59. Therefore, whilst the court, in the exercise of its discretion as to whether to give or withhold consent to a medical intervention, must take as its starting point a presumption that the ward's life should be maintained, this may be rebutted.

60. Such rebuttal is justified where the court is satisfied that it is in the best interests of the ward to give or refuse any such consent. And, in determining what is in the ward's best interests, the court is required to have regard to all the circumstances of the case."

Irvine P. held that the presumption was rebutted on the facts of that difficult and tragic case.

169. The constitutional right to life and the constitutional presumption that a ward be protected was also recently considered by Hyland J. in *Health Service Executive v. Ms. A.* [2021] IEHC 836. In that case, the HSE sought orders from the court permitting the doctors treating Ms. A., a severely anorexic woman, not to use coercive nasogastric feeding, without which the ward would probably die. In applying the best interests test, the court concluded that it was in the ward's best interests that no further coercive treatment should be provided to her. She held that, on the evidence, having regard to the seriousness of the ward's condition, it was highly unlikely that coercive treatment would be of any enduring benefit to the ward and also had its own risks. She found, therefore, that:

> *"The right to life does not necessarily point exclusively in the direction of the provision of coercive treatment: the coercive treatment itself may negatively impact upon the right to life"* (para. 65).

170. Fourth, as is clear from the authorities, including *In Re A Ward*, that several other constitutional rights are engaged in a case such as this, apart from the constitutional right to life. In *In Re A Ward*, Denham J. listed among the factors to be considered in determining the best interests of the ward the constitutional rights to privacy, bodily integrity, autonomy, equality and dignity in life and in death. Mr. F. possesses all of these constitutional rights as well as the constitutional right to life.

171. With respect to his right to bodily integrity, a right arising under Article 40.3 of the Constitution, Kenny J. in the High Court in *Ryan v. Attorney General* [1965] I.R. 294, described the right to bodily integrity as meaning:

> *"no mutilation of the body or any of its members may be carried out on any citizen under authority of the law except for the good of the whole body…"* (p. 313-314)

Clearly, Mr. F's constitutional right to bodily integrity is engaged in this case.

172. Mr. F.'s constitutional right to equality is also engaged, in that if Mr. F. were of full capacity he would be required to consent to the proposed treatment but because of his lack of capacity, he is unable to do so. Article 40.1 of the Constitution provides that: "*All citizens shall, as human persons, be held equal before the law*" but that *"*[t]*his shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function"*. As Denham J. explained in *In Re A Ward*:

> *"Due regard may be had to differences. It may be that in certain instances a person may not be able to exercise a right. But the right exists. The State has due regard to the difference of capacity and may envisage a different process to protect the rights of the incapacitated. It is the duty of the Court to uphold equality before the law. It is thus appropriate to consider if a method exists to give to the insentient person, the ward, equal rights with those who are sentient."* (p. 159)

173. Mr. F. does have a right to equality before the law under Article 40.1. The court is obliged to uphold that right, and to consider how best to do so in the particular circumstances of Mr. F's case. The court does so by taking into account all the circumstances in determining what is in Mr. F's best interests.

174. Mr. F. also enjoys a constitutional right to privacy, an unenumerated right under the Constitution: *Kennedy v. Ireland* [1987] I.R. 587. Denham J. in *In Re A Ward* discussed the right to privacy enjoyed by a ward in the context of proposed medical treatment. She said:

> *"Part of the right to privacy is the giving or refusing of consent to medical treatment. Merely because medical treatment becomes necessary to sustain*

> *life does not mean that the right to privacy is lost, neither is the right lost by a person becoming insentient. Nor is the right lost if a person becomes insentient and needs medical treatment to sustain life and is cared for by people who can and wish to continue taking care of the person. Simply it means that the right may be exercised by a different process. The individual retains their personal rights."* (at p. 163)

175. She further noted that the right to privacy is not absolute and has to be balanced against the State's duty to protect and vindicate life. However, Denham J. observed that an individual's right to privacy *"grows as the degree of bodily invasion increases"* (*In Re Quinlan* [1976] 355 A. 2d 647). Denham J. explained:

> *"The increasing personal right to privacy in such a situation is consistent with the defence and vindication of life being 'as far as practicable' (Article 40, s. 3, sub-s. 1) and the protection being 'as best it may' (Article 40, s. 3, sub-section 2)."* (p. 163)

Denham J. continued:

> *"A constituent of the right of privacy is the right to die naturally, with dignity and with minimum suffering. This right is not lost to a person if they become incapacitated or insentient."*

176. A further related unenumerated right enjoyed by Mr. F. is his right as a human person to be treated with dignity. Mr. F. has a right to dignity: see, for example, *M.X*. That right to dignity encompasses a right to live with dignity and a right to die with dignity.

177. The court must, as best it can, respect and vindicate all of these constitutional rights enjoyed by Mr. F. while at the same time acknowledging the strong presumption in favour of taking such steps as may be necessary to preserve Mr. F's life.

178. Fifth, as noted earlier, the clearly and consistently expressed wishes of Mr. F. must be given considerable weight, notwithstanding his lack of capacity. While those wishes are not necessarily the determining factor in a decision as to what is in Mr. F's best interests, they are particularly significant in this case, having regard to the evidence as to the likely effect on Mr. F's mental and physical welfare in the event that the amputation was to go ahead notwithstanding Mr. F's opposition.

179. Sixth, the views of Mr. F's family are also important and considerable weight should be attached to those views. In *In Re A Ward*, Denham J. considered the weight to be given to the views of the family of the ward. She referred to the special position of the family in Article 41.1 of the Constitution. She noted, however, that the jurisdiction to make the decision in a case such as this lies with the court and not with the family. However, she continued:

> *"The family's view as to the care and welfare of its members carries a special weight. A court should be slow to disagree with a family decision as to the care of one of its number if that decision has been reached bona fides after medical, legal and theological advice and careful consideration."* (at p. 164)

180. Denham J. then stated:

> *"In this case, the family is united in its view of what decision should be made. While that view does not determine the issue before this Court it is a factor to which the Court should give considerable weight."* (at p. 164)

181. I agree with this. I have given considerable weight to the views of Mr. F's family which, as noted earlier, have evolved as the evidence has become clearer.

182. These are the principles which I have applied in reaching my decision in this case.

10. Application of the Relevant Principles

183. I will now set out my conclusions based on the facts as I have outlined them and by reference broadly to the factors identified by Denham J. in her judgment in *In Re A Ward*. I will focus on those factors which are most relevant to the facts of Mr. F's case. I do so in order to explain how I have come to the clear view that, in all of the circumstances, it is clearly in Mr. F's best interests that his right leg should not be amputated and that he should receive the type of palliative care referred to and favoured by the consultant geriatrician, consultant psychiatrist and the palliative care consultant.

184. In reaching these conclusions, I have accepted the submissions advanced on behalf of the HSE and on behalf of Mr. Bardon, the guardian *ad litem*. I have also very much taken on board the clearly and consistently expressed wishes of Mr. F. that his leg not be amputated and that he should be permitted to go home. I have also given considerable weight to the views of Mr. F's family, as they have evolved during the course of the application. They are now very supportive of the decision to discharge Mr. F. from the hospital to allow him to return home under the care of his family, with the benefit of the extensive care provided by the palliative care team, his GP, the public health nurse, and the community social work team.

11. Application of the Facts to the Denham J. Factors outlined in *In Re A Ward*

185. (i) Mr. F's current condition is as outlined earlier. His right lower leg has significant wounds which were described by the consultant vascular surgeon. They are infected. There is an imminent risk of major life-threatening haemorrhage and sepsis.

(ii) At the time of this application, Mr. F. was under the care of the consultant

vascular surgeon's team in the hospital. He was receiving treatment in the form of antibiotics for the infection and pain relief. Despite considering all possible alternatives, nothing can be done to address the risk of a life-threatening haemorrhage in his leg apart from amputation. The alternative to amputation is discharge home from the hospital with extensive palliative and other care arrangements in place.

(iii) The degree of *"bodily invasion"* which an amputation of his right leg would involve is enormous. An amputation, while addressing the imminent risk of a life-threatening haemorrhage, has a very significant mortality risk itself, with a 50% mortality risk within 30 days of the operation), and would have several adverse consequences for Mr. F. Apart from the significant mortality risk, there is also the real risk of post-operative delirium, post-traumatic stress (described as *"severe psychological distress"* by the consultant geriatrician and *"catastrophic mental distress"* by the consultant psychiatrist). A real likelihood of reduced mobility resulting in him being bed-bound or chair-bound, resulting in an almost complete loss of independence.

(iv) In order for the amputation of his leg to proceed, the court would have to provide its consent to the procedure being carried out. In order for the court to provide that consent, it would have to be satisfied that the amputation is in Mr. F's best interests. Before the court could reach that decision, it would have to hear from the relevant clinicians and from the legal and other representatives of Mr. F. and his guardian *ad litem*. The court would also have to give Mr. F's family an opportunity to be heard. That is what has happened in this case. Having heard all of that evidence and having heard legal submissions on behalf of the HSE and the hospital and on behalf of Mr. F., I am in a position to decide what I believe to be in Mr. F's best interests. That is the legal and constitutional process by which the decision has been

reached in this case.

(v) Mr. F's life history, insofar as is relevant to the issues which arise on this application, has been described earlier in the judgment and it is unnecessary to repeat that here. Mr. F. suffers from dementia and significant cognitive impairment. He has severe peripheral vascular disease. He was admitted to the hospital with right lower limb-threatening ischaemia and required urgent surgery to bypass the damaged area of his right leg. This required a graft. He has interfered with that graft as a result of which it has become badly infected and is exposed to a risk of life threatening haemorrhage. There has been adequate time to achieve an accurate diagnosis. There is disagreement among the clinicians as to the treatment course to pursue, so, therefore, the court has to make the decision.

(vi) The prognosis on medical treatment is as outlined earlier when discussing the risks and benefits of amputation, as against palliative and other care.

(vii) In terms of current and previous views, Mr. F. has consistently and repeatedly expressed the view that he does not want to have his leg amputated. It is the view of his family that this would always have been Mr. F's view prior to the onset of his dementia, and that he would, in all probability have expressed exactly the same views then as he is expressing now.

(viii) Mr. F's family have been wonderful. He has a loving and caring wife and son. Their sole interest has been to try and achieve what is in Mr. F's best interests. They were initially in agreement with the view of the consultant vascular surgeon that the amputation should succeed and they were very concerned about their ability to care for Mr. F. at home if he were discharged with the ongoing risk of life threatening haemorrhage and infection. However, they carefully and diligently attended and followed the progress of this case. They listened intently to the evidence and, during

the break in the hearing to facilitate the obtaining of evidence from the palliative care consultant, they met with that consultant and assessed the additional information obtained during the course of the evidence and at that meeting. Having done so, they have come to the position that they would welcome Mr. F. home without him having to undergo the amputation, and would work closely with the care arrangements that will have to be put in place. They are supportive of those care arrangements and of Mr. F's wish not to have his leg amputated. I have given considerable weight to the family's views.

(ix) The medical opinions are divided, as is clear from my account of the evidence earlier. The consultant vascular surgeon favours proceeding with the amputation, while acknowledging some of the risks involved. His view was supported by a second opinion from another consultant vascular surgeon, albeit that that consultant also recognised the centrality of Mr. F's autonomy and the likely serious impact on the quality of his life if the amputation were to proceed. The consultant geriatrician and the consultant psychiatrist were opposed to amputation for all the reasons outlined earlier. I am satisfied that all of the clinicians involved have acted in good faith and entirely in accordance with the ethical guidelines set out in the Guide to Professional Conduct and Ethics for Registered Medical Practitioners (amended) (8th edn, 2019). I am quite satisfied that each has acted properly and professionally and in a way in which he or she sincerely believes to be in Mr. F's best interests. It is understandable why the consultant vascular surgeon and his team took the view which they did, focusing on the surgical approach to try to eliminate the imminent risk of life threatening haemorrhage. The other clinicians involved, the consultant geriatrician and the consultant psychiatrist, while acknowledging the potential benefit of amputation, have stressed the likely negative consequences and risks, and have

focused on the wider picture for Mr. F. As I have explained earlier, I believe that their approach, supported by the approach taken by the palliative care consultant, is more consistent with Mr. F's overall best interests when consideration is given to the overall quality of life which Mr. F. would have in the event that his leg were to be amputated.

(x) The views of relevant carers are, I think, reflected in the views of Mr. F's family as outlined at para. (ix) above and in the evidence given by the palliative care consultant.

(xi) In reaching my decision I have adopted the approach set out in the leading case law in this area and have proceeded on the basis that there is a presumption that Mr. F's constitutional right to life should be vindicated and that all steps should be taken to save his life. However, that presumption is a rebuttable presumption, and the court is not under an absolute duty to consent to a medical procedure on behalf of Mr. F. in order to attempt to prolong his life at all costs, without regard to other matters relevant to his best interests. Those other matters include the powerful evidence of the consultant geriatrician and the consultant psychiatrist of the severe distress which would be caused to Mr. F. were he to discover that his leg had been amputated against his wishes. I have, as suggested by Denham J., taken into account as part of my decision on what is in Mr. F's best interests, the many other constitutional rights which he enjoys, including his rights to privacy, bodily integrity, autonomy, and self-determination, equality and dignity in life and death. Having done so, and having considered the evidence, I am absolutely satisfied that the presumption in favour of life-sustaining treatment has been rebutted in this case. What has been put forward as the life sustaining treatment, namely the amputation itself, has very significant risks, including the risk of death. Those risks are, in my view, too great to take in light of

all of the adverse consequences an amputation would have for Mr. F. and in light of all his other underlying medical conditions.

(xii) In reaching my decision, I have carefully considered and taken into account in the context of all of the evidence, the constitutional requirement that Mr. F's life be (a) respected, (b) vindicated, and (c) protected. I have done so in the context of all of the other constitutional rights which Mr. F. has, and in light of all of the evidence in the case.

(xiii) As already noted, I have adopted the constitutional presumption that Mr. F's life be protected and have scrupulously considered whether there is clear evidence to rebut that presumption. I am satisfied that there is, for the reasons already mentioned.

(xvi) While I have referred earlier to a difference of opinion in the authorities as to the question of the burden of proof and the standard of proof, I have proceeded on the basis proposed by Denham J., and have not drawn any conclusions reaching my decision lightly or without due regard to all of the relevant circumstances. I am satisfied that there is clear and convincing evidence to support my conclusions.

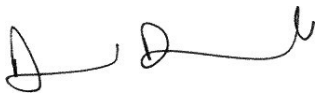
Part C: Conclusions and Decision

186. For all of these reasons, I reached the clear conclusion at the end of the hearing on 11 May 2023, that it was not in Mr. F's best interests that his right leg should be amputated. I was satisfied that it was in his best interests that, when clinically appropriate, he should be discharged from hospital without having his leg amputated and on the basis of the extensive palliative and other care arrangements outlined in evidence by the consultant geriatrician and the palliative care consultant. That, in my view, is what is in Mr. F's best interests, having regard to all of the circumstances of the case and the totality of the evidence available to me. Therefore, I refuse to

provide my consent to the amputation and instead consent to the alternative form of treatment proposed namely Mr. F's discharge home with the palliative and other care arrangements outlined in evidence.

187. In conclusion, I want to sincerely thank all of the doctors who gave evidence during the course of these proceedings and those who have been involved in Mr. F's care while in the hospital. I also want to thank the solicitors and counsel for the parties, namely, the HSE and Mr. Bardon, the guardian *ad litem* for the high quality of the work involved in this complex and difficult application, and for the clarity of their submissions. I particularly want to thank Mr. Bardon for taking on the onerous role of guardian *ad litem* in this case and for discharging that role with great skill, tact, and diligence. He played a central role in liaising with Mr. F's family and in ensuring that they understood the evidence given in the course of the proceedings. I am very grateful to Mr. Bardon for his efforts in that regard. I want to recognise also and thank Mr. F's family for the approach which they have taken and for carefully and diligently following the proceedings and taking on board the difficult evidence which they have had to hear in the case. I am quite sure that Mr. F. is being discharged into the care of a very loving family.

188. Finally, while I only had the opportunity of speaking very briefly with Mr. F. himself over a remote a link during the course of the hearing, it was clear from what I saw and from the evidence I heard in the case that Mr. F. is a very likeable man with a great sense of humour. He has had a very difficult time but has been extremely well cared for in the hospital. I am certain from what I have heard that he will continue to be very well cared for at home.



APPENDIX

[redacted]

16:33

[redacted]

16:33

[redacted]

16:34

[redacted]

16:34

RULING BY THE PRESIDENT

16:34

[redacted] I will try not to go into too much detail, but I am *ex temporising* at this point because obviously we have

heard more evidence. We have heard more evidence today.

As I have just mentioned, what I am going to do now is to give my decision on the HSE's application in relation to [redacted] case. I will give it in as concise a manner as I possibly can, so this decision will not contain the sort of analysis and discussion of all of the evidence that one might see in a detailed written judgment of the Court. I do intend to produce a written judgment and will do so as soon as absolutely possible. 16:34 16:34

But I understand, and it is has been confirmed to me today that for obvious reasons both the doctors and Mr. [redacted] family would like to know what my decision is on the application as soon as possible. Since I have reached a decision on the application it seems to me that I should inform the parties of that decision and I will do so now. 16:35 16:35

As everybody knows, the centre of this application and the most important person for present purposes is Mr. [redacted], and I had the privilege of having the opportunity to speak with Mr. [redacted] during the course of this Hearing under perhaps somewhat unusual conditions in that he spoke to all of us and to myself from his bed in the hospital and had the assistance of a solicitor for the HSE while he did so. 16:35

But I have to say, what struck me from that discussion what Mr. [redacted] said and how he behaved and chimed with almost everything that had been said in all of the expert reports that I had the opportunity to read before the Hearing and in all of the evidence given by the various experts during the course of the Hearing. 16:36

There is no doubt that Mr. [redacted] is very, very, likeable man. He has got a very good sense of humour. He is clearly a sociable man and he is a man who knows his mind, notwithstanding the uncontradicted evidence and the clear evidence that he lacks capacity for the reasons outlined in evidence. But what was extremely informative for me was actually to see and hear from Mr. [redacted] who, as I say, is the most important person in this case. 16:36

The application is one by the HSE which concerns Mr. [redacted] As we know is a man who is almost 75 years-of-age and who was very, very, seriously ill when he was admitted to the hospital back in June of 2022 and he underwent a very serious operation as a result of vascular disease, as a result of which he obtained a graft. While initially the operation was successful, as a result of various factors the wound, the graft has run into big difficulties. The would is infected and there is on, again, the uncontested medical evidence in the case, a real and very serious risk of a catastrophic haemorrhage or a very serious infection, 16:37

each of which would or could be fatal within a very short period of time. In the case of a haemorrhage, the uncontested evidence is that that could happen at any time and if it did happen it could lead to almost instant death for Mr. [redacted] 16:38

So for that reason and for that understandable reason the surgical team, the Consultant Vascular Surgeon and his team, that is [redacted] and his team, formed the view that the most appropriate action to take was 16:38 to amputate his right leg above the knee. That, they say, would solve the haemorrhage problem and would solve the risk of infection from the wound. They were not so focused on the other consequences of an amputation, because of their particular disciplines, 16:38 obviously their main focus was on trying to clear up the immediate problem, to avoid the haemorrhage and to avoid the risk of fatal infection.

On the other hand, the various other disciplines 16:39 involved, the Consultant Geriatrician, [redacted], the Consultant Psychiatrist, Dr. [redacted] in particular, were both very focused on the consequences of such an operation taking place, both on various different fronts in terms of the impact it would have 16:39 on Mr. [redacted] in circumstances where he has on every single occasion when he was asked expressed a very clear and consistent position that he did not want to have his leg amputated, that he would rather die than

have his leg amputated, that he needed two legs, and if he didn't have two legs he would rather be dead, he would rather be thrown in the sea and so on.

We have all heard during the course of the Hearing the vehemence with which Mr. [redacted] expressed those views. Indeed, he expressed similar views in the course of his discussion with us on Tuesday. 16:39

The Consultant Geriatrician, [redacted] and the Consultant Psychiatrist, Dr. [redacted] were and are both of the view that the negative consequences of an amputation would greatly outweigh the benefits of the amputation. I am not going to get in, for the purposes of this Ruling, to discuss all of the advantages and disadvantages and all of the risks involved. Obviously there has been extensive evidence in relation to that. But there are some factors that I am just going to mention in the course of this short Ruling. 16:40 16:40

In deciding on the HSE's application, I have certainly found this a difficult case, it is a complex case, but one of the things that is very clear is that all of the doctors who have given evidence, both in the form of reports and in the form of the oral evidence to the Court, it is quite clear they were faced with a very, very, complex situation. I am quite satisfied and I do think I should make this clear that all of them have done their very, very, best. All of them have acted 16:41

with the utmost proprietary and in accordance with the highest ethical and professional standards.

Everyone agrees that whatever decision, whatever view the doctor has taken on either side of the debate, each view is a perfectly ethical approach to take and there is nothing unethical in the views adopted by either side, in fact quite the contrary. 16:41

So I am faced with; and [redacted] who has strongly advocated an amputation from a medical and surgical perspective and it is something that that is what he does, I am quite satisfied that he is acting absolutely properly and professionally and in what he believes to be the best interests of Mr. [redacted]. 16:41 16:42

Equally, I am satisfied that the other doctors' involved, [redacted] are doing precisely the same. They are just looking at it from a different perspective. [redacted] I think is focusing primarily on the physical and surgical aspects of it. He wishes, he says, and he wishes to try and save Mr. [redacted]'s life. 16:42

[redacted] and [redacted] are looking at it from a slightly different perspective and they say when one has to consider the best interests of Mr. [redacted] you have to look at what sort of life is being saved, what will the overall quality of life be, how will an 16:42

amputation affect Mr. [redacted] how will he react to it in light of his underlying dementia and in light of the severe vascular disease that he has, and in light of the very type of person he is. We know he is an outdoor person living in a remote location, there is farms, fishes, he likes to move around. He is a very sociable person. He knows his mind. He is fiercely independent, although as I say, obviously he is a person who, the evidence establishes lacks capacity. But lacking capacity doesn't mean that he cannot and shouldn't have his views respected. He has consistently said, as I have indicated, that he does not want to have his leg amputated. 16:43 16:43

In considering this application I have to consider what is in the overall best interests of Mr. [redacted]. On the basis of all of the evidence that I have heard I am quite satisfied that the best interests of Mr. [redacted] are served by not amputating his leg. I have absolutely no doubt about that for all of the reasons I will set out in my judgment. I am persuaded, whilst I entirely accept what [redacted] has said about the desire to preserve life and to save life and that is obviously, in any situation that is the first thing that a doctor will do, it is the first and paramount consideration, but the consequences of potentially saving the life, and I will come to the risk, the very stark piece of evidence that we heard on Tuesday. The consequences of doing so I think will and could be very 16:43 16:44 16:44

extreme for Mr. [redacted] himself.

I am persuaded very much by the views of [redacted] and [redacted] n terms of my view that the overall best interests of Mr. [redacted] are not to proceed with the amputation but to proceed along the lines that would allow a discharge by the hospital of Mr. [redacted] to his home in accordance with a carefully planned and well-worked plan, the detail of which we heard in evidence this afternoon from [redacted] [redacted]

It seems to me, having re-read [redacted]'s evidence again on the transcript in advance of the Hearing today, [redacted] sees that as a perfectly ethical alternative situation, it is just not the one that he has advocated for, but ultimately he is prepared, as one would entirely expect, prepared to abide by the Courts or my ultimate Judgement on the issue. It seems to me that that is very much in Mr. [redacted]s best interest, namely that he would not have the amputation, that he would, when it is appropriate to do, and hopefully that is in the very near future, be discharged from the hospital to his home where he will be cared for by his family and by those assisting in that care in accordance with the well-worked-out Palliative Care Plan which would involve obviously the Palliative Care Team, those working in the community, Mr. [redacted]'s General Practitioner, the Public Health

Nurse and a range of multi-disciplinary people that we have heard discussed in evidence.

I want to say something about Mr. [redacted]'s Family because I think they have been absolutely wonderful in all of this. All that they have been interested in, and I am absolutely certain about this, is what is in Mr. [redacted]'s best interests. They have carefully and diligently followed the progression of this case. They attended in court in person on Tuesday. They are, I know, participating remotely in the Hearing today. 16:46

When they have had the opportunity of discussing the matter with the doctors, with the experts, their views have evolved. Whilst initially they were supportive of the suggestion that Mr. [redacted]s leg would be amputated on the basis that they felt they would not be able to cope with him at home if he didn't have an amputation and would be unable to cope in the event of a discharge home with the enormous risk of haemorrhage and infection. But having reflected on the evidence that they heard on Tuesday and having considered the matter with the doctors again, in particular with Professor [redacted] and her palliative care colleagues, their position has evolved now to a situation where they would welcome Mr. [redacted] home without him having to undergo an amputation and would work closely with palliative care arrangements that will be put in place. So I really want to commend and thank them for the 16:47 16:47

very, very, responsible and loving way in which they have handled all of this.

I also want to thank Mr. Bardon, the Guardian ad Litem, who I think has been really quite central in drawing all of these things together and ensuring that the Family's voice has been heard and ensuring that Mr. [redacted]'s voice has been heard, although, of course as I mentioned we have heard directly from Mr. [redacted] himself. But I have derived great assistance from the approach taken by Mr. Bardon, the careful considered approach he has taken and ultimately the evolution in his own view as well. So I have derived great assistance from that. His view as Guardian ad Litem appointed by the Court to represent effectively the interests of Mr. [redacted] and also to express his own professional judgment on the issue, his view is, is the view that I have ultimately come to which is that I should not provide consent to an amputation, but should consent to the alternative plan which would involve a discharge to home on the basis that I have mentioned. 16:48 16:48 16:48 16:49

In reaching that decision a number of legal principles have been outlined to me and I believe the decision I am taking is consistent with those legal principles. I will discuss those in detail in the written judgment I will deliver. Many authorities have been opened to me and they demonstrate, I don't need to go into the detail, but they demonstrate that the first and 16:49

fundamental thing that the Court would seek to do is to ensure that life is preserved, but it doesn't do so at any cost, much will depend on the circumstances of the case.

16:49

There are often competing constitutional rights involved. In this case there are many competing constitutional rights: Mr. [redacted]'s constitutional rights to bodily integrity, not having his leg amputated, to autonomy, to privacy, to equality, all of 16:50
these constitutional rights must on the basis of the case law be taken into account and I have done that in reaching my decision.

Equally, what must be taken into account is the views 16:50
of the doctors and I have certainly done that. The expressed views of Mr. [redacted] himself, and I agree with Mr. O'Donnell that the list of factors to be considered which was set out by Ms. Justice Denham in the Ward case I think perhaps needs to be supplemented 16:50
by making reference not only to any previously expressed wishes of the person, the subject of the application, but also any currently expressed wishes. That is why much will depend on the facts. That is why in this case I think that the consistent clear manner 16:50
in which Mr. [redacted] has expressed his strong objection to an amputation is a factor that I have taken into account, as is the attitude and the position adopted by his Family which has been quite properly an evolving

position.

I also consider all of the evidence I have heard in relation to the sort of quality of life that Mr. [redacted] would have if he proceeded to have the amputation. I take into account the fact that his mobility is likely to be severely restricted and mobility is something which he attaches, certainly is very important to him, and that is clear on the evidence. He is a very sociable man and the fact that he can move around where he is and greet and meet people is a significant factor. I think all of those would be severely interfered with if he had the amputation. 16:51 16:51

I don't think he - accept the evidence that he is not a candidate for a prostheses and he would have severe difficulty I think coping with, adapting to wheelchair use largely because of his dementia and the likely psychological of an amputation on him. In that respect I have considered ultimately that the burdens and disadvantages of an amputation greatly exceed, in this particular case, the advantages and benefits to Mr. [redacted] 16:52

I was particularly struck, as I think many of us were, by [redacted] estimate that even with an amputation there would be a mortality risk of 50% within 30 days and that means that there is a 50% 16:52

chance of Mr. [redacted] not surviving within that 30-day period. Obviously there is a 50% chance of him surviving, but 50% is a very, very high, 50% mortality rate is a very, very, high risk and I have no doubt that struck everybody and it seemed to me that that is a very significant factor as well. 16:53

So I have obviously considered all of the evidence that I have heard. I noted that mortality risk obviously. I have noted what I think is the very clear and convincing and persuasive evidence of [redacted], the Consultant Geriatrician, and Dr. [redacted] the Consultant Psychiatrist, where they used very strong terms as to the slightly impact of an amputation on Mr. [redacted] described it as likely to give rise to catastrophic mental distress. [redacted] referred to severe phycological distress. I could can't get away from that. I think that is very compelling evidence in my view, very, very, compelling evidence in my view. 16:53 16:54

So obviously as I mentioned at the outset of this Ruling my task, which is a difficult one, is to try to identify what, on the basis of all of the evidence I have heard, what do I think is in the best interest, the overall best interests of Mr. [redacted]? 16:54

I have concluded, and ultimately whilst the case is a very difficult one and it is a very complex one,

ultimately I have concluded that on the evidence I am very clear that the Applicant, that is the HSE, has established that the best interests of Mr. [redacted] are served by my decision to refuse to consent to an amputation of his right leg, and instead, to consent to the treatment plan which would involve a discharge from hospital to home which is appropriately and properly planned with all of the arrangements that are set out in the reports of [redacted] and as were discussed by [redacted] in the course of her evidence this afternoon. 16:54 16:55

I was also persuaded, having heard from [redacted] and also having heard what the attitude of Mr. Bardon, his Guardian is, and that attitude of the HSE is, that it would be appropriate in terms of any Order that I would expressly make clear that there should be a provision not to resuscitate Mr. [redacted] in the event of a catastrophic bleed. Having regard to, and in light of all the evidence I have heard, I think that would be appropriate and I am persuaded that that is the right thing to do in the circumstances. 16:55 16:55

So this obviously is a case where what I am effectively being asked to do is to give my consent to what is in Mr. [redacted] best interests, I have indicated what that decision is. So for all of the reason I will in due course set out in my written judgment, which I have attempted very imperfectly to do I think in this short 16:55

decision this afternoon, that my view is that it is in Mr. [redacted]'s best interests that he not have the amputation and that the plan would be, as discussed, by [redacted] and by the other experts, which is the discharge to home as I mentioned. 16:56

END OF RULING BY THE PRESIDENT

[redacted] 16:56

[redacted] 16:56

[redacted] 16:57

16:57