Neutral Citation number: [2023] EWCOP 43

Case No: 1405715T

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29 September 2023

Before :

MR JUSTICE PEEL

- -

Between :

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

Applicant

- and -

(1) SUDIKSHA THIRUMALESH
(by her litigation friend, the Official Solicitor)
(2) THIRUMALESH CHELLAMAL HEMACHANDRAN
(3) REVATHI MALESH THIRUMALESH

Respondents

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Victoria Butler-Cole KC (instructed by **Bevan Brittan LLP**) for the **Applicant**
Katie Gollop KC (instructed by the Official Solicitor) for the **First Respondent**
Bruno Quintavalle (instructed by **Andrew Storch Solicitors**) for the **Second and Third Respondents**

Hearing date: 22 September 2023

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Approved Judgment

This judgment was handed down remotely at 10.30am on 29 September 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE PEEL

The judge has given leave for this judgment to be published

Mr Justice Peel :

Introduction

1. I shall refer to the First Respondent, the subject of these proceedings, as ST. This is for convenience only. She is named, as are the other parties, in the heading to this judgment.

2. In immensely sad circumstances, ST died on 12 September 2023.

3. The family of ST have concerns about the care provided to ST by some of her treating team, but they have expressed in evidence their gratitude to the Hospital staff as a whole. I make no comment on the specific allegations by the family, but my reading of the voluminous evidence suggests to me that overall, the multiple clinicians, nursing staff and others charged with caring for ST have done so with dedication, conscientiousness and sensitivity.

4. The issue before me is whether to lift in whole or in part a Transparency Order made by Francis J on 14 March 2023 which, in summary, prohibits the publication (by any means, direct or indirect) of the names of, or any information that would identify, ST, the family of ST, the applicant Hospital Trust, the hospital(s) attended by ST, experts, treating clinicians and any health/care professional engaged with ST. That wide-ranging order was expressed to last "until further order of the court". However, as the parents, who were acting in person, opposed the order, the judge provided that it should be considered at the next hearing. The judge also ordered that all future hearings should take place in public, but subject to the Transparency Order.

5. On 4 April 2023 the parents applied for discharge of the Transparency Order.

6. On 15 May 2023, by way of a consent order to which the parents had agreed through their legal representatives, the Transparency Order was varied by Judd J to last until 13 November 2023, or earlier order.

7. At no court hearing was the application to discharge the Transparency Order substantively considered until it came before me at this hearing. I have little doubt that the courts (myself included), when faced with complex and wide-ranging issues about capacity and best interests at hearings with limited court time, followed the usual practice of continuing the anonymisation at least until conclusion of the proceedings at which point fuller consideration could be given to the issue.

8. In considering the application I have read:

    i) An extensive bundle including two witness statements of particular relevance to the application, one by ST's father and one by a critical care nurse manager employed by the Trust;

    ii) Position statements on behalf of the parents, the Trust and ST through the Official Solicitor.

9. I have also had the benefit of oral submissions from counsel on behalf of the parents, and leading counsel on behalf of the Trust and ST.

10. In a sense, the issues between the parties are relatively limited, but nevertheless important:

    i) It is agreed that the restrictions on identifying ST, her family and expert witnesses should be immediately lifted.

    ii) In respect of identification of the Trust, the hospital(s) attended by ST, and clinical/nursing staff:

        a) the family seek an immediate discharge of reporting restrictions;

        b) the Trust proposes a continuation of such restrictions for 8 weeks from 22nd September 2023, at which point the provisions shall stand automatically discharged;

        c) the Official Solicitor is neutral;

        d) two members of media organisations at my request addressed me informally (not being parties to the proceedings), and indicated that they support an immediate lifting of restrictions as to ST, her family and the Trust, but are neutral otherwise.

The background

11. The background is set out in the decision of Roberts J pursuant to a judgment handed down on 25 August 2023 and reported as **A NHS Trust v ST and Ors [2023] EWCOP 40.** That judgment should be taken as read.

12. ST at the time of the hearing before Roberts J was 19 years old. She had spent about a year as a patient in intensive care. She had a rare, progressive mitochondrial disease with a number of health problems including impaired sight, hearing loss, gait disorder, muscle weakness, bone disorder, kidney disease and lung damage. On 14 and 17 July 2023, ST had two episodes of hypoventilation, becoming unconscious and seriously ill. She stopped breathing. Her blood oxygen fell to dangerously low levels. She required life-saving interventions.

13. The evidence of her treating clinicians was that she was "actively dying" with a life expectancy measured in weeks. They stated that there was no cure.

14. Court of Protection proceedings had started in February 2023 with a challenge to a Lasting Power of Attorney granted by ST on 20 November 2022. On 20 July 2023, the Trust applied for authorisation to move to a treatment plan of palliative care, involving a much less invasive treatment regime. Life-saving treatment would be withdrawn by removal of the dialysis, and there would be no further attempt to resuscitate in the event of a major respiratory arrest.

15. The application came before me on 26 July 2023. It became apparent that there was a substantial issue about ST's capacity to litigate and to make decisions

about her medical treatment. ST herself was expressing opposition to the Trust's proposed care plan and withdrawal of treatment. She supported exploring experimental treatment potentially available in Canada, an option strongly advocated by her family, but which was considered by the Trust and the Official Solicitor on ST's behalf not to be realistic.

16. Accordingly, I gave directions for the capacity issue to be determined before any consideration of best interests. That issue came before Roberts J on 7 August 2023. Her decision was reached after careful consideration of the voluminous papers, hearing oral evidence from four medical witnesses, and hearing extensive submissions from expert legal teams. The judgment itself is comprehensive.

17. Roberts J concluded that ST did not have the relevant capacity. She accepted that ST was aware of the nature of the disease, that it was progressive, and that she was likely to die of it. But she determined that ST did not understand the precariousness of her position. ST did not believe the doctors who told her that she might have only have days or weeks to live. She was, on the judge's findings, unable to weigh the information because (as set out at para 86 of her judgment): "(a) she does not believe what her doctors are telling her about the trajectory of her disease and her likely life expectancy and (b) she does not fully comprehend or understand what may be involved in pursuing the alternative option of experimental nucleoside treatment". The judge considered, as part of an assessment of capacity, that ST was not able understand properly the option of treatment in Canada: it was unlikely to provide ST with any material benefit, the trial itself had been paused, the journey would be extremely risky and there was considerable doubt about whether she would be eligible for it even if it was available.

18. The decision was about capacity only. It was not a determination of what was in ST's best interests in terms of medical treatment. The judge made clear that she was not authorising or approving the Trust's proposed treatment plan. That was for another day, but in the event, ST sadly died before the next hearing to make those decisions.

19. I am told that the family intend to appeal the order, notwithstanding the death of ST since then. They will contend that the capacity decision was wrong and should be reversed.

The law

20. The general position in the Court of Protection is that proceedings take place in private: COP rule 4.1(1).

21. The court has the power to direct that proceedings take place in public; COP rule 4.3(1).

22. The court has the power under COP rule 4.3(2) to make an order restricting of the identity of any party, P, any witness or any other person. Such an order should be made "only where it appears that there is good reason for making the order": COP rule 4.4(1)(a).

23. COP PD4C at 2.1 provides that:

"The court will ordinarily (and so without any application being made)-

a) Make an order under rule 4.3(1)(a) that any attended hearing shall be in public; and

b) In the same order, impose restrictions under rule 4.3(2) in relation to the publication of information about the proceedings."

24. Such orders are referred to as Transparency Orders. In practical terms, there is little difference between Transparency Orders and Reporting Restrictions Orders ("RROs"), and I tend, tentatively, to the view that it would be desirable to have uniform terminology.

25. When considering what Transparency Order to make, or whether to vary or discharge such an order, the court is required to balance Article 8 and Article 10 considerations.

26. In the recent case of **Abbasi & Anor v Newcastle Upon Tyne Hospitals NHS Foundation Trust [2023] EWCA Civ 331**, the Court of Appeal considered two conjoined appeals (to which I will refer as "the Abbasi case" and "the Haastrup case") and addressed the modern practice of granting indefinite anonymity orders in end of life proceedings to a wide range of medical and non-medical carers.

27. In the Abbasi case, the original RRO prevented naming of the Trust until conclusion of the proceedings at which point that protection fell away subject to further order; no such further order was sought or made, and the identity of the Trust therefore became a matter of public knowledge. The same order prevented identification of the subject of the proceedings, Zainab, who was 6 years old, any member of his family, and specific members of the clinical team. During the proceedings a variation was made by consent to permit the naming of Zainab and the parties to the proceedings, which included the family; the anonymisation of treating staff was left undisturbed until further order.

28. In the Haastrup case, an indefinite RRO was made preventing publication of the clinical and non-clinical staff involved in Isaiah's care, including before and after birth. It did not encompass the identity of Isaiah, his family, or the Trust, because details had earlier been reported in a local newspaper.

29. In both cases, the families applied for discharge of the RROs. The President refused the applications and ordered continuation of the RROs. It is those orders against which the families appealed to the Court of Appeal.

30. The Court of Appeal concluded that the President was wrong so to order and discharged the RROs, save that the orders for discharge were stayed pending applications for permission to appeal. At the risk of oversimplification of the ratio decidendi, it seems to me that the core conclusions, so far as relevant to this case, can be summarised as follows:

i) The Court of Appeal acknowledged that a short term RRO preserving anonymity to protect the integrity of the proceedings may be justified, and indeed in the Abbasi case it was not suggested otherwise (para 69). The real issue before the Court of Appeal was such orders extending beyond the end of proceedings.

ii) Although there is no hierarchical primacy between Articles 8 and 10, "….the practical realities of the balance in such cases will be that evidence of a compelling nature is needed to curtail the legitimate exercise of free speech" (para 78).

iii) In so far as article 8 is engaged on one side of the balance there must be a careful analysis of the risk (para 88). The threshold required to be met is that "the publication in question had constituted such a serious interference with his private life as to undermine his personal integrity".

iv) Article 8 cannot be deployed to protect professionals from criticism unless that criticism reaches the threshold identified in the Strasbourg caselaw and summarised by Lord Rodger in the *Guardian* case, namely that "the publication in question had constituted such a serious interference with his private life as to undermine his personal integrity" (para 91).

v) Experience of other cases may be relevant, particularly if the application is being considered at a date reasonably proximate to the end of proceedings:

> "The Trusts place considerable reliance on the events surrounding the end-of-life proceedings of Charlie Gard and Alfie Evans. They certainly provide clear evidence of the real possibility of conduct impinging on the article 8 rights of staff before, during and immediately after end-of-life proceedings. It was part of the firm foundations for the making of RROs at the time. They do less to inform an assessment of article 8 risks associated with lifting the RROs at a later date" (para 101).

vi) The article 10 rights of parents who wish to exercise the freedom of expression are strong and would be seriously compromised by the continuation of the RROs (paras 104 and 114).

vii) In weighing the competing Article 8 and Article 10 considerations, a generic class of anonymisation for swathes of professionals engaged in this work, based on systemic concerns about general morale, recruitment and well-being of health staff, but which is divorced from the individual circumstances of a particular case, is not appropriate (paras 116 to 129 generally).

viii) "Conferring lifelong anonymity through indefinite orders irrespective of the individual circumstances of those protected…is something which the courts should do only in "the most compelling of circumstances"" (para 119).

ix) Each individual case requires "careful scrutiny, clear evidence and an intense evaluation of competing interests" before continuing an anonymity order beyond the end of the proceedings (para 121).

x) "Where the publication concerns a question "of general interest", article 10(2) scarcely leaves any room for restriction on freedom of expression" (para 123) and, having considered the meaning of general public interest, "The issues arising from end-of-life cases fall into this broad category (para 124).

31. On 27 July 2023 the Supreme Court granted the hospital trusts permission to appeal against the order of the Court of Appeal. The orders of the Court of Appeal are stayed pending the Supreme Court decision.

The parents' submissions

32. In this case, the family seek immediate discharge of the entirety of the Transparency Order. They give a number of reasons:

i) First, the order as drafted is so restrictive as to prevent them from even telling extended family or friends about ST's involvement in the proceedings.

ii) Second, there has been a considerable level of media interest in the case, and they would wish, on behalf of ST and themselves, to thank those who have offered support.

iii) Third, they wish to publicise their concerns about how ST's case was handled by both the NHS and the court system. Essentially, they would like to tell their story, be free to give interviews to the media, publish photographs and contribute to the debate about end of life/serious medical treatment cases. In particular, they would like to be able to discuss the potential treatment in Canada to which I have referred.

iv) Fourth, they wish to identify individuals who they believe made errors during ST's treatment. They refer to what they term an error during a PICC line insertion on 29 October 2022, and a second incident in May 2023 when a doctor used what they say was a tube of the wrong size when replacing ST's tracheostomy. They intend to explore a clinical negligence claim and have, I understand, made a formal complaint to the GMC about one clinician.

v) Finally, they say that the restrictive nature of the order has compounded their anxiety, with the threat of contempt in the event of saying anything to anyone which might contravene the order.

33. Counsel on their behalf submits that the Article 8/Article 10 balancing exercise falls firmly in favour of immediate discharge of the Transparency Order. He submits that the Trust has not established a clear evidential basis for the order which would represent a disproportionate interference with the family's Article 10 rights.

34. He also raised a question about the jurisdiction to make Transparency Orders which I am told may be considered by the Supreme Court. He did not press the point too strongly upon me, correctly in my judgment. The Court of Appeal expressly held that the court has the jurisdiction to make such orders, and to set them aside (see the conclusions at paras 66-68 of the judgment), and I see no reason to depart from that clear statement of principle, which accords with long established practice.

The Trust's submissions

35. The Trust does not object to lifting the anonymity provisions in respect of ST and her family. It suggests that the balance of the Transparency Order should remain in place for 8 weeks, at which point it would stand discharged. That would allow any renewed interest upon publication of the identity of ST and her family to abate, so as to reduce the risk of abuse directed towards staff.

36. The Trust points to its own evidence that relations between staff and parents during the care of ST was not always good. The witness statement in support expressly refers to "nurses and clinical staff". The parents made numerous complaints, which staff felt were unjustified. They "harassed" nurses and tried to interfere with care. Many clinical staff and nurses are extremely worried that they will now be named publicly, including in respect of criticism about care. The parents recorded a number of videos on mobile phones of staff working with ST, and staff are concerned that such videos may be released and might lead to adverse public reaction directed towards them. During the proceedings, media reporting, although anonymised, was perceived by staff to be negative, and two examples are attached to the statement. It is extremely difficult for staff to defend themselves against adverse reporting of this sort, and they would not want to comment publicly in any event. The witness statement prepared on behalf the Trust states that the author is "confident" that staff who cared for ST are likely to take time off work due to stress.

37. Further, the Trust points out that the applications for discharge in the Abbasi and Haastrup cases were made long after the proceedings had ended; respectively, 18 months and 3 years.

The Official Solicitor's submissions

38. The Official Solicitor adopted a neutral stance.

Decision

ST

39. In my judgment, the competing Article 8 and Article 10 rights clearly come down in favour of identifying ST, and that restriction in the Transparency Order should be lifted forthwith. The points made by the family are compelling. Now that the proceedings are over, there is no justification for not being able to name her. The Trust, in my view correctly, does not oppose this relaxation of the Transparency Order.

ST's family

40. The same, in my judgment, applies to naming members of ST's family, and, again, no objection is raised by the Trust.

Clinical and nursing staff

41. I do not accept, as counsel for the family submitted, that there is insufficient evidence before me to weigh materially in the balance the Article 8 rights of clinicians and nursing staff. The witness statement to my mind sets out the anxieties clearly. Nor do I accept, as was suggested, that each individual member of staff should apply separately to be anonymised by a Transparency Order or, at the very least, put in their own statement justifying being included within the Transparency Order. It is acceptable for a statement to be adduced in evidence which encompasses the views of all those affected. That is what took place here. To require dozens of members of staff to set out their own cases would be impractical.

42. I also take the view that when considering the evidence put forward on behalf of the Trust, I am entitled to place it in the context of the Court of Appeal's dicta at para 101 of **Abbasi,** quoted above**:**

> "The Trusts place considerable reliance on the events surrounding the end-of-life proceedings of Charlie Gard and Alfie Evans. They certainly provide clear evidence of the real possibility of conduct impinging on the article 8 rights of staff before, during and immediately after end-of-life proceedings. It was part of the firm foundations for the making of RROs at the time. They do less to inform an assessment of article 8 risks associated with lifting the RROs at a later date."

In my judgment, the fact that improper conduct directed towards clinicians has taken place in other cases can in principle be taken into account in the intense balancing exercise, particularly where, as here, the court is considering transparency issues before, during or immediately after the proceedings. Such previous cases are informative of the potential risks run by hospital staff.

43. In respect of the identification of clinicians, the family allege failings on the part of certain individuals, stating in terms that this amounted to negligence which led to the death of ST. Although the family, I accept, have no intention to take any steps which might lead to harassment of named staff, the harsh reality of modern methods of communications, particularly by social media, is that they will have no control over the narrative. The publicity generated by this case has been heated in some quarters. There is likely to be heightened interest in the coming days as a result of my intention that the restrictions on identifying ST and her family should be immediately lifted. If anonymisation of clinicians is lifted, the consequences are unpredictable, but there is in my judgment a risk that abuse and harassment may follow, particularly as they may be reported by the family as having given ST inadequate care. Were that to come to pass, I would regard it as a very considerable interference with their Article 8 rights. That risk is likely to be at its most acute in the next few weeks and I consider that there should be a "cooling off period" measured in weeks. That would be a

proportionate interference with the family's and the media's Article 10 rights, given the potential interference with the clinical/nursing staff Article 8 rights.

44. This hearing is taking place only a matter of days after the tragic death of ST. That is factually different from the circumstances in both the Abbasi and Haastrup cases where, as para 1 of the Court of Appeal judgment says, "These appeals concern the principles to be applied when a court considers an application to vary or discharge a Reporting Restrictions Order ("RRO") **made long before in end-of-life proceedings in the High Court"** [emphasis added].

45. Where an application is heard long after the conclusion of proceedings, it is easy to see why there may be little justification for continuation of a Transparency Order. Media and public interest may have diminished. There may have been no improper conduct (of any nature, to any person) in the interim which would indicate a continuing concern about improper conduct towards as yet unnamed clinicians or other staff. The raw emotions upon or shortly after the death of a much-loved person may have dissipated.

46. But in this case, at this point in time, so close to the tragic death of ST, the likelihood is that interest in the circumstances leading to her death will be at its highest, and the risk of improper conduct is similarly at its highest. It seems to me that what is needed here is a relatively short elapse of time to allow matters to settle and reduce the risk of inappropriate secondary activity of the sort described by the Court of Appeal. I do not read the Court of Appeal as determining that the strength of the case for lifting such orders long after the end of proceedings would be the same as immediately after the end of the proceedings, and it seems to me that there is a very considerable difference between the circumstances before the Court of Appeal and the circumstances here.

47. It is further submitted on behalf of the family that the potential clinical negligence claims which they are exploring demand an immediate lifting of the Transparency Order in respect of identifying individual doctors. Counsel relies on para 114 of **Abbasi** in which it was said that:

> "Those involved in clinical negligence claims resulting in death would need a factually quite exceptional case to secure anonymity in civil proceedings or at an inquest touching the death".

48. However, in this case clinical negligence proceedings are simply being considered. Unsurprisingly, given that only a few days have passed since death, no claim has been instituted. I understand that the family, sensibly, intend to take time to consider their position. It is accepted that were such proceedings to be instituted before discharge of the order anonymising clinicians (or were formal complaints to regulators or the like to be brought)), it would be appropriate to vary the order permitting the lifting of restrictions for the purpose of such proceedings.

49. I have therefore concluded that I should leave in place the Transparency Order insofar as it relates to the non-identification of clinicians/nursing staff for a limited period of time before automatic discharge. In my judgment, 8 weeks

from 22 September 2023 is a proportionate and appropriate timescale. For the avoidance of doubt, this does not prevent the family from discussing or reporting openly their perception of failings by the Trust and its staff, but they are not permitted to identify any treating clinicians/nursing staff as part of any such discussions or reporting.

50. I decline to require that the order identifies each member of staff within these two categories, as was commended in **Abbasi**. The numbers would run into dozens, and there is a risk of not capturing all the relevant names. At the risk of repetition, my approach might have been different if this application was being considered long after the event; by then, it might be easier to identify if any particular individuals or individuals were at greater risk.

51. I shall also provide that any videos or photographs which the family may have taken of clinical and nursing staff should not be published, as they could lead to identification of individual clinicians/nurses. Again, this will be discharged in 8 weeks, although there may be separate written agreements in place between the family and the Trust which would in any event govern publication.

The Trust and its hospitals

52. I will provide that the Trust can immediately be identified, but the identity of any hospital attended by ST should not. The issue raised by the Trust is jigsaw identification; the concern that if the Trust and relevant hospitals are named, clinicians will be identifiable.

53. The Trust is a public body responsible for looking after ST and which brought Court of Protection proceedings. Once ST is identified, it will swiftly be known where she lived, and the Trust will be easily identifiable. To retain the provisions of the Transparency Order in respect of the Trust would be futile.

54. However, I consider that to identify specific hospitals attended by ST would carry a risk of jigsaw identification of the clinicians. I accept that as there are only four hospitals run by the Trust, there is inevitably a risk of identification even if a specific hospital is not named, but (i) the order will prevent naming of clinicians/nursing staff, and (ii) the fact that a particular person may know of the identity of the Trust does not lead automatically to identification of the particular clinicians who treated a particular patient at a particular time.

Experts

55. I will lift the anonymity in respect of expert witnesses. I have not read or heard any compelling reasons to continue the Transparency Order in respect of the identity of experts. The high threshold for anonymity required by **A v Ward 2010 EWHC 16 (Fam)** has not been met.

Final comment

56. I express my sincere condolences to the parents of ST. As they sat courteously in court, the distress of ST's mother in particular was palpable. The events of the last few months must have been harrowing. I sincerely hope that they will

find the strength to move forward, comforted by their many happy memories of their much-loved daughter.