

ENGLAND AND WALES / JUDGMENT

RS (Best Interests: Surgery and Intensive Care), Re

COURT
IN THE COURT OF PROTECTION

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IN THE COURT OF PROTECTION
Case No COP 20001522
Date: 05/11/2025

Before :

MR JUSTICE POOLE
Re RS (Best Interests: Surgery and Intensive Care)
GH
-and-
The Applicant
(1) RS (By his litigation friend, the Official Solicitor)
(2) ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
(3) CITY OF WOLVERHAMPTON COUNCIL
(4) BIRMINGHAM WOMEN AND CHILDREN'S HOSPITAL TRUST
The Respondents

Victoria Butler-Cole KC (instructed by Irwin Mitchell) for the Applicant
Eliza Sharron (instructed by Star Legal) for the First Respondent
Sophie Hurst (instructed by Mills and Reeve) for the Second Respondent
Mr Ahmed, in house solicitor for the Third Respondent represented by Mr Ahmed
on
the First Day of Hearing Only
Adam Fullwood (instructed by Weightmans) for the Fourth Respondent
Hearing dates: 3-5 November 2025

This judgment was delivered in public but a transparency order is in force. The judge has given leave for this version of the judgment to be published, on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the RS and members of their family must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly

complied with. Failure to do so may be a contempt of court.

JUDGMENT

MR JUSTICE POOLE Approved Judgment Mr Justice Poole:

Introduction

Re RS (Best Interests: Surgery and Intensive Care) 1. In Applications Relating to Medical Treatment, 17 January 2020, [2020] EWCOP 2, the then Vice President of the Court of Protection, Hayden J, gave guidance as to the procedure to be followed where a decision relating to medical treatment arises and where thought was required to be given to making an application before the Court of Protection. The starting point for the making of medical treatment decisions in relation to those lacking decision-making capacity is the Mental Capacity Act 2005 (“MCA 2005”) s5 which provides a defence against liability for medical professionals who do an act in connection with the care or treatment of a person where they reasonably believe that the person lacks capacity in relation to the matter and that it will be in the person’s best interests for the act to be done. If the provisions of the MCA 2005 are followed and professional guidance and any guidance in the Code of Practice followed, then if there is agreement as to decision-making capacity and best interests, then in principle the treatment may be provided or withdrawn or withheld without application to the court. However, if, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is: “(a) finely balanced, or

- (b) there is a difference of medical opinion, or
- (c) a lack of agreement as to a proposed course of action from those with an interest in the person’s welfare, or
- (d) there is a potential conflict of interest on the part of those involved in the decision-making process (not an exhaustive list) Then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration must always be given as to whether an application to the Court of Protection is required.” The guidance then makes it clear that where any of those matters arise and the decision relates to life-sustaining treatment an application to the Court of Protection must be made. 2. In the present case the person with whom I am concerned is RS. The treatment under consideration is surgical correction to curvature of his spine. RS lacks capacity to consent or to refuse consent to the treatment. Notwithstanding a long and detailed medical decision-making process, concerns remain that the way forward in RS’s case is finely balanced. In fact there is a broad measure of agreement between RS’s mother, GH, the surgeon who would carry out the operation, independent expert witnesses, the providers of a second opinion to the treating clinicians, and the Official Solicitor, acting as RS’s Litigation Friend. No party contends that the proposed treatment is contrary to RS’s best interests. However, all involved agree that the decision is finely balanced and the healthcare professionals who would provide the post-

operative treatment are particularly anxious for confirmation from the Court that it will be in RS's best interests. MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) The Parties and Background Information

3. RS is the First Respondent. He is 18 years old. He has complex learning disabilities, epilepsy, ADHD, Duane Syndrome (a congenital eye movement disorder), dysmorphism, a congenital cardiac anomaly, and progressive scoliosis. He has limited communication with a small range of phrases. He uses visual prompts to express his wishes. Attempts have been made to assist him to understand the nature of the proceedings but he was unable to engage and became distressed when shown a video of a judge in a court room. All parties agree, and it is quite clear to the Court, that RS lacks capacity to make a decision about his medical treatment including the proposed surgery and post-operative care.
4. RS is said to be cheeky and engaging. He lives at home with his mother, GH, and three younger siblings. They are visited frequently by the maternal grandparents. This is a close family unit. RS attends school. GH receives a package of 3 hours of care a day on weekdays at home funded by the Third Respondent Local Authority, and respite care is provided on nine nights each month. GH has experienced numerous problems with the package of domiciliary care and has asked the Local Authority to look into supported living options for RS.
5. RS's scoliosis has worsened such that on the most recent formal assessment in June 2024, his spinal curvature was measured as being 115°. In 2020, x-rays had shown a curve of 60°. GH believes that his curvature has progressed further since it was last measured. It could now be as much as 130° to 140°.
6. The treatment under consideration is surgical correction of the curvature. Investigations earlier this year showed that the spinal cord functioned well in the transmission of both sensory and motor signals. The traction x-ray revealed reasonable flexibility, which is a good indicator for a successful operation, and that to achieve a reasonable correction of RS's spine, an anterior release via a thoracotomy (an incision made in the chest, removal of a rib and deflation of a lung to allow access to the spine inside the chest) followed by posterior screws and fusion will be required. The expectation is that the curvature would be reduced by about 50% to, at most, 70°. The Second Respondent would be the provider of the surgery, to be performed by Professor Gardner and the surgical team at the Second Respondent Trust but it has been agreed that the optimal location for the surgery and post-operative care would be at Birmingham Children's Hospital operated by the Fourth Respondent Trust. The anaesthetist would be Dr Jepson from the Fourth Respondent Trust. RS would be treated in the paediatric intensive care unit ("PICU"). The usual peri- and post-operative care for paediatric patients undergoing surgical correction of scoliosis would be immediate extubation and transfer to a High Dependency Unit. Due to his learning disabilities and ADHD, RS would not be able to cope with the pain and immobility he would experience in the post-operative period. He would be likely to pull out monitoring devices and lines delivering drugs, tear off dressings, and might well pick at his wounds. Accordingly, as all

agree, the only option for post-operative care would be heavily to sedate him and to maintain mechanical ventilation for a period likely to be two to three weeks. He would receive passive physiotherapy during that period. Once it was considered safe to do so, he would be extubated. At that point, a team of five assistants from a specialist provider, would be on hand to provide any physical restraint necessary MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) to keep RS safe. Ultimately, RS would be discharged home with a package of professional care provided by the Third Respondent Local Authority. On the first day of the hearing, the Third Respondent was directed urgently to file a statement as to the steps that will be taken to assess and provide for RS's care needs upon discharge from hospital after the operation. The subsequent statement provides some reassurance to the Court but preparatory work will need to be done prior to RS's admission to ensure that a suitable, funded package of care will be in place on time.

7. Dr Tremlett is the Consultant Paediatric Intensivist at the Birmingham Women and Children's Hospital who would lead RS's post-operative care. If the operation is undertaken then he and his team will have many challenges in the post-operative period, not least deciding on the optimal time to attempt extubation. Too soon and RS's actions might compromise his health and safety. Too late and it might not be possible to wean RS off ventilation. 8. I have heard oral evidence from Professor Gardner and Dr Tremlett, and from independent experts Dr Ross Russell, Honorary Consultant in Paediatric Respiratory Medicine, and Professor Playfor, Consultant Paediatric Intensivist, both of whom have considerable experience in the post-operative care of children who have undergone scoliosis correction and in the administration of mechanical ventilation to children with respiratory compromise. I also have the benefit of written evidence of second opinions from specialists at Great Ormond Street Hospital, as well as statements from GH, Dr Jepson, social workers, and from the solicitor instructed by the Official Solicitor detailing her discussions with RS. Medical Evidence
9. Helpfully, there has been a minuted professionals' meeting attended by Dr Ross Russell, Professor Playfor, Professor Gardner, Dr Tremlett, and Dr Jepson. The meeting was described to me as being open and frank. There is clearly a great deal of mutual respect amongst the professionals, expert witnesses and treating clinicians alike. In what follows I set out the consensus opinions but highlight some differences of emphasis.
10. The proposed operation is not urgent or life-saving but RS's scoliosis has already progressed beyond the point at which the great majority of patients would have undergone surgery. Whilst his scoliosis does not imperil his life presently, one of its consequences is that it has reduced his lung function. It is difficult to assess RS's current lung function. At the joint meeting Dr Ross Russell said that it could be in the region of 40% but after hearing that RS's mother had observed further curvature since the last measurement in June 2024, he has suggested it might even be as low as 20%. His experience is that young patients with lung function below 30% can tolerate scoliosis surgery and anaesthesia very well. Of course, in

the present case RS would have to survive a period of mechanical ventilation as well.

11. Curvature of the spine can only progress so far before the pelvis resists any further significant progression, but an uncorrected curvature of the kind RS now has, is likely to lead to deteriorating lung function, perhaps a loss of 1-2% per year, and difficulties with MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) cough and clearing secretions, leading to more frequent infections. His uncorrected scoliosis will continue to cause back pain, trunk imbalance, causing difficulties walking and sitting straight, and possible flank pain where, due to the deformity, the ribs and pelvis contact when sitting.
12. The proposed surgery would aim to prevent further progression but also to attain correction to at most about 70° (maximum 50% correction), and to improve mobility and pain by equalising body shape.
13. There are risks involved in the proposed surgery itself which would be common to all patients undergoing it. They include anaesthetic risks and risks of bleeding and blood clots, nerve damage, including paralysis and blindness, and infection. There would be a risk of chronic post-operative pain and of the surgery failing and the need for further surgery.
14. Notwithstanding that a number of children with co-morbidities and challenging circumstances undergo surgical correction of scoliosis, and some suffer physiological derangement during surgery so as to require post-operative care in the PICU, it is very unusual to plan for post-operative mechanical ventilation in the PICU. Professor Playfor told the Court that elective use of mechanical ventilation happens at his unit for no more than one patient every one to two years. That is for all patients, not just those undergoing scoliosis correction. Dr Tremlett works at the biggest PICU in Europe and says that he has no experience of such planned post-operative treatment. Not only is this planned post-operative care for RS a major intervention in itself, involving intubation and heavy sedation for two to three weeks, and then possible use of chemical and physical restraint after extubation, but it gives rise to risks to RS over and above those to which other patients would be exposed following scoliosis surgery.
15. Dr Ross Russell advised that, "I would anticipate that RS's lung function would dip in the months following surgery, mostly in the first weeks when he would be getting intensive care support, but by around 3 months post-operatively would be back to his current levels."
16. Dr Tremlett expressed concern that this impact on lung function of the surgery combined with a period of two to three weeks on mechanical ventilation could mean that it would not be possible to liberate RS from ventilation. A period of even two to three weeks on mechanical ventilation would lead to loss of muscle including the muscles needed for respiration. Dr Ross Russell was more optimistic: in his considerable experience, even children with significantly compromised lung function do well and he believes that the strong probability is that RS will be weaned off ventilation. Professor Playfor was also more sanguine than Dr Tremlett. He put the risk of RS not being weaned off mechanical

ventilation at below 1%.

17. There are risks from mechanical ventilation and heavy sedation other than the inability to be weaned off ventilation, such as ventilator associated pneumonia and pressure sores.
18. Whilst the risk of infection exists for all patients undergoing scoliosis correction surgery, RS's particular circumstances affect that risk in his case. Firstly, consideration has to be MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) given to the risk of infection arising due to faecal contamination of wounds. RS will be lying still on his back for two to three weeks at least. Heavily sedated, he will lose functional continence. However, in his case the incision will not extend far down and not close to the natal cleft. Innovative techniques will be considered to mitigate the risk of faecal contamination of the wound. Overall, the evidence was that RS would not be at a significantly lesser or greater risk of infection than any other patient. Professor Gardner put the risk of deep wound infection likely to require wash out and vacuum dressings to be about 5 to 10%. Of those patients, about 10% ultimately require removal of infected metalwork. However, such an infection would be extremely difficult to manage for RS. Typically a patient requiring washout and vacuum dressings will need to be returned to theatre on about four to five occasions over a period of about four weeks. RS would not be able to tolerate such a course of treatment and so he would have to be kept under heavy sedation and probably mechanical ventilation. Professor Gardner and Dr Tremlett agreed that in that event, the combined effect of the infection and very prolonged ventilation post-operatively would almost certainly be fatal for RS. Their evidence which is that there is a 5-10% risk that RS could suffer post-operative infection causing or contributing to his death. Professor Gardner told the court that overall the mortality risk for RS was 10% to 12%, taking into account the risk of infection and other risks associated with the operation and planned post-operative care. Dr Tremlett was inclined to view this as the minimum risk but he did not put forward a higher figure. Professor Playfor and Dr Ross Russell have not put the mortality risks so high. Professor Playfor has put the overall risk of death associated with the surgery and elective mechanical ventilation at less than 5%. Doing the best I can I proceed on the basis that the proposed treatment will create a 10% risk of mortality.
19. There are however a host of risks and complications from elective mechanical ventilation, short of death, that are agreed by Professor Playfor. He sets them out in detail in his expert evidence and says that there is a 50-60% chance of RS developing some complication or complications but that most are likely to be trivial or mild. Nevertheless, there is a 30-40% chance that he will develop a more serious complication mandating significant extra investigation and management and a significant increase in the length of stay in PICU and/or the duration of mechanical ventilation.
20. One risk is that RS will suffer psychological harm when heavy sedation is ended. As he becomes aware he may become very distressed by finding himself in the PICU with a large surgical wound, probably with pain and discomfort, and with lines and tubes in situ. Dr Tremlett told the Court that he would endeavour to reduce the number of lines and tubes

just prior to extubation and that lighter sedation would also be used to bridge the gap between intubation and eventual transfer from the unit and discharge home. Nevertheless, it is likely that the post-operative process and period of recovery from the operation will be very distressing to RS.

21. Dr Ross Russell gave important evidence as to RS's life expectancy in the event that the surgery is not performed. Assuming a curvature of 140° he posits current lung function at about 20% and a life expectancy of 5-7 years only. Unfortunately, RS's curvature has not been measured since June 2024 when it was 115°. GH believes that his curvature has worsened since then and there is no reason to doubt her, but there is no recent, accurate measurement. His curvature might be less than 140° and his lung function better than 20%. At the joint meeting, Dr Ross Russell thought that lung function was better than 20%. Nevertheless, even taking a more optimistic view of the current degree of curvature MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) and lung function, but remaining reliant on Dr Ross Russell's reasoning, it is unlikely that, absent the scoliosis correction, RS will live beyond the age of 30. If Dr Ross Russell's most recent view that lung function may be as low as 20% is accepted, then RS may very well not live beyond the age of 25 without the corrective surgery being undertaken.
22. Dr Ross Russell also opines that successful scoliosis correction surgery would extend RS's life by 5 to 10 years beyond his life expectancy in the absence of such surgery. No other expert or professional disagreed with that evidence. In the context of RS's life expectancy absent the operation, that would be a very significant extension of the likely duration of his life.
23. Both Dr Ross Russell and Professor Playfor recognised the concerns of the treating clinicians but were of the view that it was in RS's best interests for the surgery to be performed with post operative care to include elective mechanical ventilation and heavy sedation in the PICU.
24. Professor Gardner's view was that, were it not for the need for post-operative mechanical ventilation the surgery itself would clearly be in RS's best interests. He could not think of a case in which someone of RS's age, with his curvature of the spine but without his learning disabilities and particular behavioural traits, would not be suitable for surgery. Even taking into account the risks involved in RS's post-operative care, Professor Gardner was content to conclude that it was in his best interests for the surgery to be performed.
25. Dr Tremlett was more cautious. He purported to speak on behalf of a large number of his intensivist colleagues who have considered RS's case at MDTs. He frankly told the Court that over the past year to 18 months he has oscillated between believing that the operation is in RS's best interests to believing it not to be. His ultimate position, having heard the evidence of the other medical professionals, was that this was a finely balanced decision and one primarily for the family, here GH, because they would know what RS's quality of life was like and the importance of extending his life. He would be fully supportive of the decision to

proceed with the surgery and he and his team would do everything they could do to support RS through his post-operative care.

26. In 2023 the Fourth Respondent sought second opinions from specialists at Great Ormond Street Hospital whose opinion was that it was in RS's best interests to proceed with the surgery.
27. At some point – the date is unclear – referral was made to the Ethics Committee at the Fourth Respondent Trust. They identified a third option other than proceeding to surgery with elective sedation and ventilation, which they rather ambiguously described as “perform surgery using boxing gloves...” The use of devices such as gloves to prevent RS removing dressings is not now regarded as a realistic option. The Committee's conclusion was, “If surgery cannot be safely conducted for P ... then it is not ethical or in P's best interests to offer surgery.” Unsurprisingly, this advice was not considered particularly helpful by the treating clinicians wrestling with the difficult balance of all the possible risks and benefits.
28. Internal discussions and multiple MDTs have not resolved doubts within the teams who MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) would be responsible for delivering the care to RS, as to whether the proposed treatment is or is not in his best interests. Regrettably, the prolonged decision-making process and then these proceedings have caused delay during which time RS's curvature has probably deteriorated giving rise to poorer lung function and therefore, if anything, greater risk to him in the post-operative period. This delay has been frustrating to GH and led to Counsel for the Official Solicitor voicing criticism at the hearing. I need not carry out a forensic examination of the process leading to this point: this has always been a difficult decision and the anxious consideration of the responsible clinicians will mean that very detailed planning will have gone in to any surgery and treatment given. However, even difficult best interest decisions require prompt resolution or, if that is not possible, timely application to the Court.
29. Detailed plans for RS's pre-operative care, surgery, nursing care, post-operative care and the use of physical restraint, have been drawn up with the utmost care. They were commended by the independent experts and they reassure the Court that if the surgery were to go ahead, RS is in very capable hands and his care has been very carefully thought through. GH's view
30. I heard brief oral evidence from GH, RS's mother who attended the hearing remotely. She had listened to the oral evidence of the professional witnesses. She told the Court that RS was an active young man and full of life but he had struggled in recent months with coughing up green phlegm and was now finding it difficult to maintain a position for more than five minutes without discomfort. He can walk but not over distance. He has used a wheelchair for longer distances for a number of years but now he cannot sit comfortably or upright in a wheelchair or any other chair because of his scoliosis. He has not had any lung infections requiring treatment but he seems to get out of breath more easily. He particularly loves spending time with his family. He seems to be a happy person. I asked to see a

photograph of him and GH kindly sent to the Court a recent photograph showing a young man with short curly hair and a slightly mischievous glint in his eye. She told me that he has had general anaesthesia before and came round from it rather like a child waking from sleep, not distressed. When he has been ill and in bed at home, he has not shown particularly challenging behaviour. However, she agreed with the assessments that he does not like things on his skin and would therefore be prone to tear off dressings or remove tubes and lines.

31. Having listened to the professionals' oral evidence, GH told me that she thought it was in RS's best interests to proceed with the surgery. She is very aware of the risks of complications, even of death during or following the operation, but regards the shortening of RS's life in the absence of the surgery as a "guarantee" rather than a risk, and one which should be avoided.

Legal Framework

32. MCA 2005 s1(4) provides that "an act done, or decision made, under this Act for on MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) behalf of a person who lacks capacity must be done, or made, in his best interests". MCA 2005 s4 provides that any person determining a person's best interests for the purposes of the Act must consider all the relevant circumstances. Amongst other things, they must consider, so far as is reasonably ascertainable, the person's past and present wishes and feelings and the views of anyone engaged in caring for the person or interested in his welfare as to what would be in the person's best interests.
33. In *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591, Lady Hale said at [39]: "The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."
34. Although the proposed treatment is not life-sustaining or life-saving, the decision under consideration does have implications for RS's life expectancy. The authorities clearly establish that there is a presumption that steps should be taken to preserve life but that presumption may be rebutted if in all the circumstances it is not in P's best interests for treatment to be given or continued. Analysis and Conclusions

35. RS lacks capacity to make a decision about his own medical treatment and so, faced with a choice as to whether to proceed to major surgery with highly interventionist post-operative care, a decision has to be made on his behalf in his best interests. Here there is a stark choice. There is no conservative treatment that will help RS's scoliosis. There is no safe way of offering him surgery without the elective post-operative intensive care under heavy sedation, intubation and mechanical ventilation. He either has the corrective surgery and post-operative mechanical ventilation or he has no treatment for his scoliosis at all.
36. Medical professionals are much more experienced than judges in making decisions about whether a particular treatment or operation is in a patient's best interests but in this case, as Dr Tremlett put it, after months of intense assessment and discussion, he and other professionals of enormous experience have oscillated. They regard this as a finely balanced decision. In accordance with the guidance referred to at the outset of this judgment, the decision has properly been brought to Court of Protection for resolution.
37. Whilst NHS Trusts and clinicians have to take into account other matters such as the MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) allocation of resources and the impact on others of providing or not providing the proposed treatment, the Judge in the Court of Protection is required by statute only to consider the subject individual's best interests. The Court cannot require resources to be allocated or force clinicians to provide treatment they are not willing to provide, but when there are choices to be made between available options, then the entire focus is on the individual's interests.
38. The assessment of best interests includes, but is not limited to, consideration of the risks and benefits of proceeding with the planned treatment, and of not doing so. Evidence about risks and benefits requires careful consideration. Unavoidably, the evidence before the Court tends to focus on numerical assessments of risk and benefit, such as a 40% chance of a risk occurring, or a 5 year extension of life expectancy. In many cases, including the present case, such evidence has to be treated with caution. Predictions cannot be made with precision when they are based on very limited data. There are no large studies of 18 year olds having elective heavy sedation and mechanical ventilation for two to three weeks after corrective surgery for scoliosis. If not unique, the plan for RS is extremely unusual. The Court relies on expert and professional opinion evidence but in this case much of that evidence is based on personal experience.
39. Decision-makers have to look forward and so have to deal with uncertainty. It is a frequent mistake to believe that if something goes wrong after a decision then the decision must have been wrong. If a decision-maker chooses option X over option Y because X has a 90% chance of success and Y has only a 50% chance of success, and X fails, it does not mean that they made the wrong choice. There is rarely a risk free option, and there certainly is not one for RS. Where there is risk, there is the possibility of a poor or even a fatal outcome, but risk is inevitable, in particular when the decision to be made is finely balanced.

40. When choosing to take a course of action that carries risk over a course of inaction, a decision-maker may feel personally responsible for every risk that then occurs. That may be especially so for clinicians and family members closely connected to the individual concerned. But they would have been equally responsible for the consequences of not acting. A decision-maker may feel a greater sense of responsibility for the consequences of a decision to act as opposed to a decision to do nothing, but for the person who suffers the consequences there is little difference.
41. Judges are not inherently better at assessing risks and benefits than those intimately concerned with a person's care and treatment, including parents and medical professionals, but there are differences: 41.1. Judges have some distance from the person whose treatment is under consideration. Unlike those intimately involved with the individual's care, judges will not have responsibility for carrying out the treatment, dealing with complications, or living with the direct consequences of the decision. 41.2. Judges can hear evidence from key witnesses, including independent experts, scrutinised by experienced Counsel, in a formal court setting to assist them to assess risks and benefits and to assess best interests. 41.3. Judges can take a neutral overview having taken into account the family's MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) perspective and the clinicians' perspective.
42. It might be argued that some of these differences place judges at a disadvantage. Some would say that fundamental decisions about a person's medical treatment should be made by those who know them best and who will be living with the consequences. However, the law requires that when disputed or finely balanced decisions regarding medical treatment of this kind are brought before the Court, it is the Judge who makes the decision as to what is in the person's best interests, applying the principles and provisions of MCA
2005. Court procedures are designed to ensure fairness to all the parties involved. The process requires the judge to be objective. Responsibility for the decision is taken away from the family and the clinicians who may find objectivity difficult to achieve and is placed in the hands of the Judge. Precisely because the Judge is one step removed from the day to day care of the individual, they may find it easier to take a balanced overview than those with a particular, personal perspective.
43. In RS's case, a successful outcome of the proposed treatment would be that his scoliosis will be reduced by 50% to about 70°. His thoracic cage would once more sit upon his pelvis, balancing his body and enabling him to be more mobile and to sit in a more upright position. His progressive scoliosis would be arrested and, after recovery from the operation, his lung function would be unlikely to deteriorate further or at least at the same rate. His life expectancy would be prolonged by some 5 to 10 years compared to his likely life expectancy absent the surgery. He is a happy young man, deeply cared for by a loving family. He currently lives at home and whilst that might not always be the case, he will never be without his family's close care and support. With greater mobility and comfort he will be able to be more active. He enjoys activity and, despite his many difficulties, he enjoys life.

The proposed treatment is more likely than not to be successful and so to achieve significant benefits for him.

44. If the surgery is not performed his scoliosis may well worsen and his lung function will deteriorate further. His life expectancy will be limited such that he will be unlikely to live into his 30's. On Dr Ross Russell's more bleak prediction based on a pessimistic view of RS's current lung function, he would be unlikely to live beyond the age of 25. The last two years of his life would be characterised by increasing pain and distress with recurrent lung infections requiring in-patient treatment.
45. The proposed treatment involves significant risks. Although the independent experts are more optimistic, for present purposes I accept that, taken together, the peri-surgical and post-surgical risk of mortality may be as high as about 10%. There are smaller risks of significant complications such as nerve damage. There is a small risk of RS not being weaned off ventilation (even without a deep wound infection prolonging the need for continued heavy sedation and mechanical ventilation). There is a 40% risk of significant complications from heavy sedation and mechanical ventilation leading to a prolonged period in the PICU beyond three weeks.
46. RS will be unable to understand and comply with the treatment. He would have to make a significant sacrifice to have the chance of benefiting from the surgery. He will be heavily sedated, intubated and mechanically ventilated for two to three weeks and possibly longer. There is a very substantial risk that he may be in the PICU for several weeks. Even if all goes well, he will have to bear many burdens with post-operative scarring, immobility, reduced lung function for a period of up to three months, pain and MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) discomfort. He is likely to require further sedation after extubation and very possibly physical restraint to prevent him from causing himself damage for example by pulling out important lines, removing dressings or interfering with his wounds. He may become very distressed and suffer psychological damage.
47. Hence, the benefits of the surgery have to be sufficient to justify these significant burdens on, and risks to, RS.
48. I take into account that the second opinion from GOSH and the two independent experts instructed for the purpose of these proceedings, concur that it is in RS's best interests to undergo the proposed treatment. Professor Gardner is of a similar view but Dr Tremlett and his intensivist colleagues at Birmingham are more cautious. Nevertheless the Fourth Respondent Trust does not make a positive case that the proposed treatment is contrary to RS's best interests and the Second Respondent, the Official Solicitor, and GH all submit that the proposed treatment is in RS's best interests.
49. RS himself cannot give an opinion or express his wishes and feelings about the proposed surgery because of the level of his incapacity in this area of decision-making. However, he clearly enjoys life and I believe he would want to continue living and enjoying the love and

company of his family for as long as he could and provided he was not in too much pain or distress. A successful operation would give that to him. It is likely that he will have a very difficult but finite period of suffering in order to achieve that goal, but he will have excellent care and the loving support of his family.

50. GH has cared for RS at home all his life, even when bringing up three other children. Her devotion to him is inspiring. She knows him better than anyone else and she has respectfully engaged with clinicians and social workers when considering the decision whether or not to proceed to surgery. She has given the Court an insight into family life with RS. She is realistic about the risks that the proposed treatment brings. Her son could die as a result of taking a course of action intended to help him and to prolong his life. But she recognises that the option of doing nothing carries with it the probability of deterioration and premature death. She is willing to put her much loved son through the surgery and post-operative care, believing it to be in his best interests and that is a view that weighs heavily with the Court.
51. The responsibility for this decision is now the Court's. I was told that GH did not want to bear the weight of responsibility herself. She wanted all the clinicians to agree. That has not quite been achieved but she should know that whilst her evidence is of considerable assistance, the decision is not hers and the responsibility for the decision lies with the Court. Likewise, the treating clinicians, including those with doubts about the merits of the decision, can focus on giving RS the best possible care without worrying that they made the wrong call.
52. Having considered all the circumstances, including the views of those concerned with RS's welfare, I have concluded that it is in his best interests to undergo the proposed surgery and post-operative care in accordance with the various plans provided to the court, notwithstanding the considerable risks to and sacrifices required of RS to ensure the treatment has the best possible chance of success.
53. The surgery is currently planned to take place in January 2026. My best wishes go to RS, MR JUSTICE POOLE Approved Judgment Re RS (Best Interests: Surgery and Intensive Care) his family, and all those involved in his treatment and care.

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