EDITORIAL NOTE: CHANGES MADE TO THIS JUDGMENT APPEAR IN [SQUARE BRACKETS].

IN THE FAMILY COURT
AT TIMARU

I TE KŌTI WHĀNAU
KI TE TIHI-O-MARU

FAM-2022-076-000003
[2022] NZFC 771

IN THE MATTER OF	THE PROTECTION OF PERSONAL AND PROPERTY RIGHTS ACT 1988
BETWEEN	[JH] Applicant
AND	[LN] Respondent
AND	[RH] Person In Respect Of Whom the Application Is Made

Hearing: 26 January 2022

Appearances: J Johnson for the Applicant
S Jamieson for the Respondent
C Clifford for the Subject Person

Judgment: 28 January 2022

RESERVED JUDGMENT OF JUDGE D P DRAVITZKI

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[1] These are proceedings under the Protection of Personal and Property Rights Act 1988 in relation to [RH] (known as “[RH]”).

[2] On 19 January 2022, [JH], who is a daughter of [RH], filed an application to remove [LN] as [RH]’s enduring power of attorney for personal care and welfare. [LN] is another daughter of [RH] and is [JH]’s sister.

Proceedings

[3] The application is made under s 105 of the Act. [JH] alleged that [LN] was:

(a) not acting in the welfare and best interests of [RH];

(b) failing to comply with obligations of consultation and disclosure under ss 99A and 99B of the Act; and

(c) making decisions that are outside the scope of the enduring power of attorney and are unlawful.

[4] [JH]'s application is opposed by [LN]. She opposes removal.

Background

[5] [RH] is suffering from progressive dementia. In June 2021, he was assessed as wholly lacking capacity to make or communicate decisions in relation to his personal care and welfare and the power of attorney which he had given to [LN] many years previously was activated. It is in force.

[6] [RH] is currently cared for as a resident at [a Health Care facility] in [location deleted]. In fact, as part of the wider dispute, [JH] would like him to live with her and says that would better meet [RH]'s needs and wishes. [LN] rejects that.

[7] There is evidence of long-standing and bitter dispute between [JH] and [LN]. Those relate to care of [RH] but also to wider family and financial issues.

[8] [RH] and his late wife had five children – [JH] and [LN]; as well as [OH]; [GH]; and [SH].

[9] [GH] and [OH] have both filed affidavits in this matter. They are fully supportive of [LN] and opposed to what [JH] is seeking. A letter from [SH] was attached to [JH]'s affidavit. She supports [JH].

[10] The family is deeply divided and, it seems, has been for a number of years.

[11] The substantive proceedings will require consideration but those are not the subject of this decision.

Urgent application

[12] At the same time as she made her substantive application, [JH] also applied for an interim injunction seeking specific remedies in relation to medical treatment for [RH]. The injunction is filed in reliance on r 182 of the Family Court Rules.

[13] In the alternative, an interim order is sought by [JH] with the same effect as the injunctions under s 102(2)(c)(iv) of the Act.

[14] The specific injunctive relief sought by [JH] is:

(a) A mandatory injunction requiring [LN] and health practitioners to reinstate the medicines regime and all medical interventions [RH] was receiving as at 20 December 2021 until further order of the Court.

(b) A mandatory injunction requiring [LN] to revoke any decisions that limit the provision of life-saving medical treatments to [RH] (or any that would prevent serious damage to [RH]'s health). That includes but is not limited to a "Not For Resuscitation" directive for [RH].

(c) An injunction preventing [LN] and health practitioners from taking any steps that are not "consistent with object of preserving [[RH]'s] life and ensuring his ongoing survival".

[JH]'s position

[15] [JH]'s allegation is that as [RH]'s health has deteriorated recently, [LN] has actively made decisions to withdraw medication [RH] was receiving and that decision could have adverse effects on [RH]'s health and hasten his death.

[16] [JH] also alleges [LN] completed a "Not for Resuscitation" document.[1]

[17] That document is a direction that [RH] is not to be resuscitated or offered CPR.

[18] [JH] says these steps were taken by [LN] without consultation with her or the rest of the family.

[19] [JH] alleges this is specifically a breach of the terms of the Power of Attorney. That document was exhibited to [JH]'s affidavit of 19 January.[2] It provides, in clause 3:

> The attorney cannot act for you on certain matters. These are:
>
> (c) the refusal of consent to any standard medical treatment or procedure intended to save your life or to prevent serious damage to your health.

[20] That limitation is specific recognition of the legal position set out in s 98(4) and s 18(1) of the Act. Section 98 provides that an attorney shall not act in any way which would be a breach of s 18 if the attorney was welfare guardian for the person.

[21] Section 18(1)(c) provides that:

> No court shall empower a welfare guardian, and no welfare guardian shall have power, …
>
> (c) to refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health.

[LN]'s position

[22] [LN] opposes the injunction sought. Firstly, she notes that the power of attorney does not include any express obligation to consult with anybody or provide information to any person (other than, of course, with [RH] to the extent that is possible). On that basis, she says there is no breach of ss 99A or 99B of the Act.

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[1] This document was produced in evidence and is formally titled "Resuscitation Status Decision Form" but it is referred to by the parties and in the evidence as a "not for resuscitation" or "NFR" order and I therefore use that term throughout this decision.

[2] [JH]'s affidavit 19 January 2022w OP.J.00I.

Notwithstanding that, [LN] says she has endeavoured to consult with her sisters and her brother about care arrangements for [RH] and to advise them of decisions made.

[23] More fundamentally, [LN] denies she has initiated or driven any active decisions to cease medication for [RH]. She says what she has done is to follow medical advice about the right course of care for him. She says when recommendations have been made that medication is of no benefit to [RH] or is likely to be detrimental to his health, she has accepted that advice and the course of action [RH]'s doctors recommend.

[24] She says at no time has she pursued or initiated a Not For Resuscitation "NFR" directive in respect of [RH].

[25] [LN] frankly acknowledges that she did not know there were specific restrictions on what she was able to agree to on [RH]'s behalf as his attorney. In particular, she did not know that she was prohibited from refusing any standard medical treatment intended to save [RH]'s life.

Evidence

[26] These issues were canvassed in the affidavit evidence filed by the parties, memoranda of counsel, submissions filed by the parties and in oral submissions.

[27] I was invited by Ms Jamieson (for [LN]) and Ms Clifford (as counsel appointed by the Court to assist for [RH]) to hear from Dr [Fuller], the consultant geriatrician who has had responsibility for care of [RH] recently.

[28] Mr Johnson, for [JH], said that if I did hear from Dr [Fuller], I should also hear from Dr [Robles], a consultant cardiologist who had previously treated [RH].

[29] In the brief time available to Ms Clifford, she had liaised with both Dr [Fuller] and Dr [Robles] about [RH]'s medication regime and had provided their written responses to her queries to the Court.

[30] I eventually determined to hear briefly from both Dr [Fuller] and Dr [Robles]. They were sworn and answered questions from counsel and from the Court. The information provided was helpful and I am grateful to the two doctors for making themselves available at short notice.

[31] One document that had given [JH] particular concern was a discharge summary from [the Hospital] when [RH] was discharged [in early] January 2022.[3] It recorded [RH] was discharged on that day on a number of medications including bisoprolol and furosemide which are heart medications. The discharge also noted the following medication changes:

> "Started: Augmentin" for further 10 days to treat "UTI" [urinary tract infection]. Stopped aspirin, citalopram, and digoxin as no benefit at this stage of life.

[32] Under the heading "Advanced Care Planning" the discharge noted the following:

> Seen by geriatrician, Dr [Fuller], who the patient is known to. Advised that we are likely seeing a progression of [RH]'s dementia which is now at an advanced stage. Evaluated to show his quality of life is poor in his current state and this will likely only get worse in the future. Mr [Fuller] discussed this with EPOA who agreed the patient would just want comfort cares if he goes to this stage. NFR signed. Also discussed would not benefit from aspirin or citalopram at this stage these have been ceased. Digoxin too – given CKD and rate controlled during admission.

[33] The focus at the hearing was on the medications [RH] had been receiving – bisoprolol and furosemide. Dr [Fuller] had ceased the prescription for furosemide. He said he did so because it had diuretic properties and had some risk of [RH] becoming dehydrated and eventually of kidney damage.

[34] Dr [Fuller] expanded on that when he gave evidence. He said that he did not think the furosemide prescribed to [RH] was giving significant benefit. He maintained that there was some risk of continuing to administer it, particularly of dehydration and the damage that could cause. He also noted if [RH] showed signs of deterioration in his heart condition, furosemide could easily be re-prescribed to him.

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[3] [JH]'s affidavit OP.1.016.

[35] Furosemide manages atrial fibrillation. If removed that could result in fluid backing up behind the heart and congesting the lungs. That, in turn, leads to discomfort and shortness of breath and risk of pneumonia. Dr [Robles] referred to the risks of removing furosemide in the written information he provided to Ms Clifford. He expanded on that when he gave evidence. He acknowledged there may be some risk of dehydration from furosemide but said that was really only if a patient was not able or willing to eat and drink. Dr [Robles] considered withdrawal of the medication did give rise to a real risk of fluid build-up and shortness of breath.

[36] Dr [Robles] agreed with Dr [Fuller] that if medication was discontinued and [RH]'s heart health deteriorated, it would be possible to reintroduce furosemide. He noted that given [RH]'s permanent loss of capacity, it may be difficult for [RH] to communicate that he was suffering from those symptoms.

[37] Both doctors talked about the difficulty of managing patients at the end of life and with irreversible and severe dementia. Decisions about the level of intervention into their care were made with input of family members. The difficulty, of course, is where family members disagree about the appropriate approach to take.

[38] Dr [Fuller] spoke from his long history of treating geriatric patients and particularly patients suffering from dementia.

[39] Dr [Robles] noted he had not seen [RH] since 2019 and was not able to speak to his current condition. He was aware though that [RH] was suffering from dementia and had lost capacity. Dr [Robles] said he would not regard the removal of furosemide as particularly concerning in all the circumstances.

[40] Both accepted there were matters to be weighed and "pros and cons" of the administration of furosemide to [RH].

[41] Another heart medication prescribed for [RH] is bisoprolol. That is used to control heart rate. It was established during the hearing that is still being prescribed to [RH].

[42] Digoxin was ceased but Dr [Robles] agrees, in the material provided to Ms Clifford, that was unlikely to have a material impact.

[43] Aspirin was accepted as having a very minor reduction in stroke risk and, again in written material provided to Ms Clifford, Dr [Robles] agreed a decision to maintain or stop aspirin would be expected to have little, if any, impact on [RH]'s longevity.

[44] Another medication discussed was Augmentin. That is an antibiotic that is used to treat [RH]'s urinary tract infection (UTI). It now appears to be accepted, because of his age and health, [RH] will never be entirely free of urinary bacteria. As such, Augmentin has been discontinued. However, if [RH] displays symptoms of discomfort or renewed UTI, Augmentin would be prescribed again.

[45] To the extent that the doctors disagreed at all, it was a minor difference on the clinical approach to take, taking into account all of [RH]'s circumstances. Both spoke carefully and obviously knowledgably about their areas of expertise and the benefits and risks of administering medication. I did not sense from either of them that they were saying that their approach was the "right" or "only" way.

Injunctive relief

[46] I am not determining the substantive issues in these proceedings. I am required to determine whether the specific injunctive relief sought by the applicant is appropriate pending the resolution of these proceedings.

[47] For interim relief to be granted, the applicant is required to establish that:

(a) there is a serious question to be tried in the proceedings;

(b) the balance of convenience favours an injunction; and

(c) the overall interests of justice require it.

[48] To summarise the effect of the injunctions sought, they are:

(a) A direction that [RH] must receive all medications and medical interventions he was at a certain date (20 December 2021) from now, indefinitely into the future, until the Court makes a further direction.

(b) A requirement to revoke any decisions limiting the provision of life-saving medical intervention.

(c) A prohibition on taking any steps that are inconsistent with preserving [RH]'s life and ensuring his ongoing survival.

[49] Submissions by Mr Johnson, on behalf of [JH], focussed on [RH]'s medication, the NFR and any direction that [RH] be provided with "comfort cares" only rather than active medical intervention.

[50] Mr Johnson submitted that there is no clear evidence of what [RH] wanted in terms of the level of medical intervention at this stage of his life. He noted [RH]'s strong Catholic faith and submitted that had a focus on sustaining life. In those circumstances, a conservative approach should be adopted by the Court and the Court should ensure all and every life-preserving and sustaining step available is pursued for [RH].

Determination

[51] The appropriate medications to prescribe a patient are clinical decisions made by doctors in conjunction with their patients on a daily basis. They after that having considered all the medical issues and circumstances of their patient and the discussion with their patient. When their patient lacks capacity to be consulted on their wishes, doctors consult with their personal representative, in this case [LN] as [RH]'s power of attorney.

[52] Dr [Fuller] has far more recent experience of treating [RH] than Dr [Robles]. Dr [Fuller] provided clinical reasons for the decisions made in relation to what medications to prescribe [RH].

[53] All of these decisions are the type of decision that are made daily by treating doctors in a clinical setting.

[54] The initial relief sought by [JH] is a direction that all of the medications [RH] was receiving prior to the specified date in December are to be reinstated. That would amount to substituting the Court's decision as to the appropriate medical treatment for [RH] for that of his treating clinicians. That would be entirely inappropriate.

[55] I do not overlook that [JH] has made a complaint to the health and disability commissioner about Dr [Fuller]. However, as I have noted, I did not sense a substantial dispute between him and Dr [Robles] as to the appropriate approach to [RH]'s heart medication. There was a subtle clinical difference of opinion. That can always arise between professionals.

[56] In relation to the medications administered to [RH], I do not consider there is any evidence [LN] has directed the removal of life-preserving medication or that she has breached the terms of the power of attorney, and the law, in that way. The evidence simply does not support that. It is quite clear that medication decisions have been led by [RH]'s doctor based on his clinical opinion. That is an ongoing process and will continue as [RH]'s condition develops.

[57] It would be quite inappropriate for the Court to effectively freeze matters at a point in time (December 2021) and order that [RH] continue to receive medication he was receiving then. That pays no regard to the ongoing process of clinical assessment of [RH]. It effectively imposes on [RH]'s clinicians a medication regime without regard to their ongoing assessment of his situation. I do not think that can be the correct approach. I do not consider that injunctive relief is warranted or permitted. Decisions about the medication [RH] is to receive must be made by his clinicians in consultation with [LN] as the appointed power of attorney for personal care and welfare.

[58] However, there are limits as to what [LN] is able, as attorney, to agree to. Those are set out in ss 17 and 98 of the Act. She must not withhold her consent for

any standard medical treatment intended to save [RH]'s life or prevent serious damage to his health.

NFR order

[59] The NFR order requires discussion in that context. [LN] deposes that when [RH] was in [hospital] in January, she spoke to a doctor who she now knows to be Dr [Frimmer]. [RH] was particularly unwell. She said to Dr [Frimmer] [RH] was not normally as unwell as he appeared that night.

[60] [LN] then says:[4]

> The doctor brought up the subject of the non-resuscitation order. I certainly didn't. The first time I saw the resuscitation status decision form was yesterday when I asked [the healthcare facility] to send me any documents relevant to this issue after I was served with the Court papers. I couldn't even tell you the doctor's name until I saw the form.

[61] She exhibited the NFR as an attachment to her affidavit.[5] The form is dated 2 January 2022.[6] It is signed by Dr [Frimmer] and by a confirming senior medical officer. It is not signed by [LN]. It records that:

(a) [RH] is "not for CPR".

(b) The decision is "medically initiated".

(c) There was no discussion with [RH] about it on the basis that he "lacks capacity".

[62] It then goes on to note: "In care plan already. EPOA [LN] in full agreement".

Orders For Life Sustaining Treatment

[63] There is a further document titled Orders for Life Sustaining Treatment ("OFLST"). That document is also not signed by [LN]. It is dated 2 November 2021.

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[4] Paragraph 44-45 of [LN]'s affidavit.
[5] Exhibit AMA – 2.
[6] Formally titled Resuscitation Status Decision Form.

It is signed by [RH]'s regular general practitioner, Dr [Holman]. The document records that [RH] is: "Not for resuscitation/do no intubate".

[64] In terms of medication interventions, it says [RH] should receive: "Limited treatment: consider all medical interventions (unless excluded below) to reverse acute illness excluding transfer to hospital".

[65] Under the heading "Antibiotics", it says: "use antibiotics when indicated to reverse illness with intention to prolong life".

[66] The form says this is the "known preference" of [RH] and that "the principle diagnosis and prognosis of the patient" was discussed with [LN] on 27 October 2021.

[67] In relation to the OFLST, [LN]'s affidavit states the form was given to her by [the health care facility] and she told them she would think about it. She then states:

> When I read the document that the rest home gave me in October, I understood what decisions it was asking me to make. I didn't want to make those decisions. I didn't want to lose my father. I sat on it for about a month and then I took to Dad's GP [Edwin Holman].

[68] She notes that she considered Dr [Holman] a long-time and trusted medical advisor in relation to her father's care. She continues:[7]

> Dr [Holman] said to leave the form with him. I didn't see him complete it. I have not signed that form, it was signed by Dr [Holman] and must have been returned to the rest home. I have seen the completed form for the first time yesterday when I asked [the health care facility] for it.

[69] [LN] goes on to say she accepts Dr [Holman]'s assessment of the care [RH] should receive as reflecting her father's wishes as she understood them.

[70] [LN] also accepts that, to the extent she was involved in the creation of both documents (neither of which she has signed), that exceeds her authority, and breaches the restrictions placed on her, by the power of attorney and by the law.

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[7] Paragraph 46-47 of [LN]'s affidavit 26 January 2022.

[71] She refers to it in this way in her evidence:[8]

> I had no idea that the power of attorney document that Dad signed in 2001 did not allow any decisions to be made about non-resuscitation. My lawyer has told me that is what it says today. Of course if that is what it says, then I will abide by that. Both with Dr [Holman] and with the discussion I had with the doctor in [the Hospital] I just followed their advice. No one has ever told me this is what I can or can't do as a power of attorney. It just seems to be expected that I know what I can and can't do.

[72] The second injunctive relief sought by [JH] is a mandatory injunction requiring [LN] to revoke "any decisions, orders or directives made concerning the care of [RH] that may have the effect of "limiting the provision of life-saving medical intervention or intervention that would prevent serious damage to his health, including but not limited to, the NFR directive".

[73] I am not prepared to make the injunction on these general terms. Other than in relation to the NFR and the OFLST document, I do not consider there is evidence of any decisions made or directives given by [LN] to limit standard life-saving care being provided to [RH].

[74] However, in relation to those two documents, I consider an injunction should issue. I accept there is a question to be tried whether [LN] was involved in making decisions which were outside her power under the enduring power of attorney in agreeing to the NFR and the OFLST in that they might lead to standard life-saving medical treatment (for example, CPR) not being offered to [RH]. I accept that the balance of convenience favours an injunction and damages are an inappropriate and inadequate remedy. I accept that the overall justice of the case favours the granting an injunction in relation to those documents.

[75] That position is not contested by [LN]. Her evidence which I have referred to, expressly accepts that these documents were outside her authority. She says she did not know her authority was limited in that way.

[76] Ms Jamieson invites me to deal with the matter by way of a direction that those documents are a "nullity" and of no effect. She submits that an order, which could be

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[8] Paragraph 49 of [LN]'s affidavit.

made by consent, would be served on [RH]'s health providers with direction that those documents are to be of no effect in his care and are to be destroyed.

[77] I consider it is more appropriate to deal with matters by injunctive relief because:

(a) I consider an injunction is available and should issue.

(b) I am uncertain of the jurisdiction for making the orders in another manner.

(c) The order is made on the basis that there is a serious question to be tried.

[78] That does not finally determine the issue of whether the NFR and the Orders for Life-Sustaining Treatment are in breach of the terms of the power of attorney and the Act. I acknowledge [LN] accepts they are. I have not, however, heard detailed argument about it.

[79] I expect there could be situations where a patient's dementia was so advanced and their general health otherwise so poor that it would not be "standard medical treatment" to offer them a life-saving intervention or procedure such as CPR or life-prolonging medications. In those circumstances, an NFR may not breach the power of attorney and Act. I do, though, accept that is a serious question to be argued.

[80] The third injunctive relief sought is an injunction preventing [LN] and health practitioners from taking any and all steps that are "not consistent with the objective of preserving [RH]'s life and ensuring his ongoing survival".

[81] I do not consider that necessary or appropriate. A literal reading of an injunction in those terms would require all and every step available to be taken by [RH]'s carers to preserve his life and "ensure his ongoing survival". That would include medical treatments which, while available, would be seen by many people are artificially prolonging the natural end of [RH]'s life. An example would be a requirement to place [RH] on an artificial ventilator if his lung function deteriorated

to the point that was necessary. That would preserve [RH]'s life and "ensure his ongoing survival" but it may be entirely inappropriate given the other aspects of his condition including its progressive and terminal nature.

[82] This part of the injunction suffers from the same difficulties as the direction sought that [RH]'s medications be reinstated as at 20 December. An injunction that requires medical intervention on an indefinite basis with the stated aim of preserving [RH]'s life and ensuring his ongoing survival usurps the crucial, dynamic and ongoing process of clinically assessing [RH]'s condition as it develops and recommending appropriate care for him in light of those circumstances. It is a matter for ongoing clinical assessment by his doctors and consultation with [LN] as his power of attorney.

[83] I note again there is a baseline, however, for [LN]'s decision-making. She must not contravene the law and, as such, must not refuse life-saving medical treatment for [RH].

[84] She will of course be guided by [RH]'s clinicians and their recommendations as to the appropriate treatments and intervention for [RH]. Those recommendations will no doubt take account of his advancing and irreversible illness.

[85] I am mindful that Dr [Fuller]'s involvement is controversial to [JH] and, I understand, [SH]. I have already referred to the complaint that [JH] has made to the health and disability commissioner about Dr [Fuller].

[86] If [LN] had any concerns about the medical advice [RH] is receiving, it is of course open to her to obtain a second opinion from an independent clinician reviewing [RH]'s medication regime and the level of medical intervention recommended. I do not require that or even suggest that. Nor do I suggest I have any concerns about Dr [Fuller]'s clinical judgements. I raise the possibility for consideration because confirmation from an independent clinician of the medication regime and level of medical intervention being provided for [RH] as appropriate and within the range of "standard" treatments and procedures may assist in allaying the concerns [JH] has.

Orders

[87] I make the following orders:

(a) I am not satisfied the applicant is entitled to and I decline to issue an injunction requiring the reinstatement of [RH]'s medicines regime and all medical interventions he was receiving at 20 December 2021 (paragraph 1(a) of the interlocutory application for injunction).

(b) I am satisfied that the applicant is entitled to relief and issue an injunction that:

i. The Not For Resuscitation Order (Resuscitation Status Decision Form dated 2 January 2022) in relation to [RH] is of no legal effect and is not to be taken into account in any way in care decisions or medical interventions for him.

ii. The Orders For Life-Sustaining Treatment document dated 2 November 2021 is of no legal effect and is not to be taken into account in any way in care decisions or medical intervention for him.

[88] In all other respects, I am not satisfied that the applicant is entitled to and decline to issue an injunction in the form sought in paragraph 1(b) of the interlocutory application for injunction.

(c) I am not satisfied the applicant is entitled to and decline to issue an injunction requiring [LN] and [RH]'s healthcare providers to take all steps to preserve his life and ensure his ongoing survival (paragraph 1(c) of the interlocutory application for injunction of the relief sought).

(d) For the reasons given, I am not satisfied it is appropriate to make an alternative order under s 102(2)(c)(iv) of the Protection of Personal and Property Rights Act 1988.

Costs

[89] [JH] has succeeded on a limited basis in these proceedings in relation to the injunctions issued concerning the Not For Resuscitation order and the Orders for Life-Sustaining Treatment document. She has failed on the other injunctive relief sought.

[90] [LN] has properly conceded the position in relation to the two documents in respect of which injunctions have issued. She said she immediately did so as soon as she received legal advice on the limitations of her authority.

[91] I am conscious of the fact the parties, and all of their siblings, remain in a family relationship, albeit that is clearly fraught with difficulties.

[92] In all of the circumstances, I am not satisfied that this is an appropriate matter for costs to be awarded. There shall be no order for costs.

D P Dravitzki
Family Court Judge

Released on 28/1/2022 at 4.45 pm