NSW Civil and Administrative Tribunal

New South Wales

Case Name:	GMI
Medium Neutral Citation:	[2020] NSWCATGD 6
Hearing Date(s):	23 April 2020
Date of Orders:	23 April 2020
Decision Date:	29 April 2020
Jurisdiction:	Guardianship Division
Before:	M D Schyvens, Deputy President Dr M J Wroth, Senior Member (Professional)
Decision:	The Tribunal consents to the following medical treatment being provided to GMI: Percutaneous tracheostomy under general anaesthetic and any necessary treatment that would normally be provided in association with or directly consequent upon the above treatment. This consent is effective for a period of seven (7) days from the date of this order.
Catchwords:	CONSENT TO MEDICAL TREATMENT – application for consent to major medical treatment – COVID-19 – pandemic – foreign national – subject person a crew member on Ruby Princess Cruise Ship – subject person in an induced coma and intubated – no person responsible available – subject person being treated for severe respiratory failure secondary to COVID-19 infection – real risk to life – proposed treatment percutaneous tracheostomy under general anaesthetic – proposed course of treatment preferred course of treatment – optimal means of removing ventilation – consent to treatment given.

Legislation Cited:	Guardianship Act 1987 (NSW), ss 33(1)(a), 33A, 33A(4)(b), 34(1), 42 of Pt 5, 42(2), 44(1), 44(2)(a)(i), 44(2)(a)(iii), 45(1)
Cases Cited:	Nil
Texts Cited:	Nil
Category:	Principal judgment
Parties:	001: Consent to Medical or Dental Treatment GMI (the person) Dr BNH (applicant)
Representation:	Nil
File Number(s):	2020/00121254
Publication Restriction:	Decisions of the Guardianship Division of the Civil and Administrative Tribunal have been anonymised to remove any information that may identify any person involved in the Tribunal's proceedings (s 65, Civil and Administrative Tribunal Act 2013 (NSW)).

REASONS FOR DECISION

1 The matter listed before us was an application under s 42 of Pt 5 of the *Guardianship Act 1987* (NSW) ("the Act"), seeking the Tribunal's consent for medical treatment to be carried out on GMI (the patient) as permitted by s 44(1) of the Act.

2 The applicant was Dr BNH (the applicant), an advanced trainee in Intensive Care based at [a public hospital] (the hospital). The proposed treatment was percutaneous tracheostomy under general anaesthetic and any necessary treatment that would normally be provided in association with or directly consequent upon the above treatment (the proposed treatment).

Background to the application

3 The applicant filed her application with the Tribunal on 23 April 2020 and the matter was heard later that same day given the urgent nature of the application. Given the social distancing requirements in place as a result of the COVID-19 pandemic, the hearing was conducted entirely by telephone.

4 Only the applicant participated for the entire duration of the hearing. We had the benefit of the participation for part of the hearing of Mr Z, the Consul General of [another country], and Mr Y, [senior executive] at P&O Cruises.

5 We understood the factual circumstances that led to the application as provided to us by the applicant as follows:

(1) The patient is a 38-year-old [foreign national] who as at the date of the hearing is an inpatient at the hospital being treated for severe respiratory failure secondary to COVID-19 infection and is currently sedated in an induced coma as he is intubated;

(2) The patient had been an inpatient at the hospital for 25 days as at the date of the hearing. He had been sedated and intubated for 30 days in total, however, as he was first intubated onboard the cruise ship "Ruby Princess" (the ship) and then subsequently transferred to the hospital. The patient is an employee of the company that operates the ship;

(3) It was reported that the patient had a "difficult airway" to intubate on the ship and that it then took approximately 72 hours for him to be extracted from the ship and transferred to the hospital;

(4) Attempts have been made to reduce the patient's sedation but each time he regains some consciousness he becomes distressed and attempts to remove the breathing tube. Consent was sought to perform a percutaneous tracheostomy to endeavour to liberate the patient from sedation safely and to gradually wean him from ventilation to aid his recovery.

Person Responsible

6 Consent for the treatment proposed could be given by the patient's person responsible as defined in s 33A of the Act. This would include a spouse who is in a close and continuing relationship with the patient: s 33A(4)(b) of the Act. In considering the application before us we were required to take account of the views of any person responsible for the patient: s 44(2)(a)(iii) of the Act.

7 The application indicated that the patient has a wife named Ms X and provided a telephone number which the Tribunal's Registry used prior to the hearing, unsuccessfully, to attempt to contact the patient's wife.

8 The applicant informed us that it was her understanding that the patient's wife could only be contacted using "WhatsApp" and so far no contact had been able to be made by the hospital.

9 We contacted Mr Y during the hearing. He advised us that he was [a senior executive] of P&O Cruises and was currently onboard the ship assisting in its departure from Australia. He said that since the Tribunal's Registry had contacted him prior to the hearing he had made some investigations and was advised that the patient did indeed have a wife and her name was Ms X. He understood that she lived in a remote village in [another country] which most likely had poor mobile communications and that she could only be contacted through "WhatsApp". Attempts had been made unsuccessfully to contact her and further attempts were to be made using agents in [that country].

10 We also contacted Mr Z, the Consul General of [another country], during the course of the hearing as we had been advised by the Tribunal's Registry that they in turn had been advised by the Legal Branch at the Ministry of Health that the Department of Foreign Affairs (Cth) had been liaising with the Consul General in relation to the patient. Mr Z informed us that he did not have any direct knowledge of the patient or any attempts to contact his wife. He did, however, offer his services in any way he, or his staff, could assist to facilitate communication with the patient's wife.

11 It was proposed that the treatment, if consented to, would optimally occur in the next 24 to 48 hours. Accordingly, we decided it was appropriate to proceed to hear the matter in the absence of the patient's wife. We had no means of contacting her during the hearing and no certainty that contact could be made even if the hearing was delayed.

Evidence and Findings

12 In order for us to make the orders sought we needed to be satisfied of two preliminary matters: that Pt 5 of the Act applied to the patient, that is, that he was incapable of giving his own consent (s 34(1) of the Act); and that the treatment proposed was medical treatment: s 33(1)(a) of the Act. Neither of these issues were in doubt. The patient had predominantly been in an induced coma for the previous 30 days and remained so as at the time of the hearing and accordingly was incapable of providing his own consent to treatment. Similarly, the procedure proposed in the application was the surgical insertion

of a tracheostomy tube under anaesthetic, clearly a procedure within the definition of medical treatment as provided in the Act.

13 Turning to the actual proposed treatment, we could consent to such treatment if we were satisfied that it was appropriate that it be carried out: s 44(1) of the Act. We could not consent unless we were satisfied that the treatment was the most appropriate form of treatment for promoting and maintaining the patient's health and well-being: s 45(1) of the Act.

14 In reaching our decision we were required to have regard to the views of the patient (s 44(2)(a)(i) of the Act) and any person responsible for the patient: s 44(2)(a)(iii) of the Act. Due to the prevailing circumstances as at the time of the hearing, neither of these views were available to us (see [11] and [12] above).

15 We were also required to have regard to the views of the applicant as well as the matters referred to in s 42(2) of the Act and the objects of Pt 5 of that Act. Once we had received the applicant's evidence, in terms of s 42(2) of the Act, this meant that we needed to take account of: the patient's particular condition that required treatment; any alternative course of treatment; the general nature and effect of each course of those courses of treatment; the nature and degree of the significant risks (if any) associated with each of those course of treatment; and the reason why a proposed course should be carried out. As to the objects of Pt 5 of the Act, they are as follows:

> **32 Objects**
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> The objects of this Part are:
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> (a) to ensure that people are not deprived of necessary medical or dental treatment merely because they lack the capacity to consent to the carrying out of such treatment, and
>
> (b) to ensure that any medical or dental treatment that is carried out on such people is carried out for the purpose of promoting and maintaining their health and well-being.

16 The applicant provided clear and uncontradicted evidence to us. The patient, having been diagnosed with COVID-19, had suffered severe respiratory failure which had required him to be ventilated for the last 30 days. He had been sedated for this entire time and it was important that steps be taken to remove him from the ventilator. She described the patient's condition as improving and

that the proposed procedure was “advisable and preferred” to safely wean him from ventilation.

17 On more than one occasion sedation had been reduced to the patient, however, each time, he became quite distressed and would try to remove the breathing tube from his mouth, no doubt due to the irritation/gagging effect the tube has.

18 It was hoped that once the breathing tube was inserted through his anterior neck rather than his mouth, there would be a much greater prospect of reducing the patient’s sedation, essentially waking him up and liberating him from ventilation in a calm manner, whilst still having recourse to ventilation if required due to the level of secretions remaining on his lungs and the weakness of his respiratory muscles that has developed. Whilst the expected outcome for the patient was currently a full (but long and slow) recovery, he would be critically weak for some time and he would need significant medical support and physiotherapy in the weeks ahead, all of which would be promoted by the proposed procedure.

19 As to the risks associated with the treatment, the applicant noted that as it was a surgical procedure, it has all associated risks such as bleeding and scarring at the site. There was also the possibility with a tracheostomy that there could be narrowing of the airway at the site of insertion which could make any future need for the insertion of an airway difficult. Further, there was the potential for nerve damage to the vocal chords, but the applicant noted this risk was the same for the current airway. There are normally risks associated with anaesthetic. In this case the patient is in effect already under general anaesthetic in order to maintain his ventilation, so these are not risks in addition to his current care.

20 In the applicant’s view, the proposed treatment was the optimal means of treating the patient, it would be conducted by two consultant COVID-19 intubators, and there was real risk to his life if he was not removed from the current method of ventilation. The applicant informed us that, after 30 days of intubation, there had to be an emergency replacement of the airway tube the night before the hearing because the cuff of the endotracheal tube had “burst”

as it had not been replaced since first inserted on the ship. This placed both the patient and the intubators at significant risk. Steps needed to be taken to support and promote the patient's general liberation from ventilation and rehabilitation generally.

21 We accepted the evidence of the applicant. That evidence satisfied us that the proposed course of treatment, whilst not without associated risks, was the preferred course of treatment for the patient. It was appropriate in his current circumstances and it was the best means of promoting and maintaining his health and well-being.

22 The patient, due to the significant and not yet fully understood ramifications of COVID-19 infection, had been the subject of severe respiratory failure requiring ventilation for a long period. We accepted the well-articulated position of the applicant that putting in place a percutaneous tracheostomy was the optimal means of taking steps to gradually and safely remove the patient from sedation and ventilation to aid his recovery. We were satisfied that to grant the consent sought would, in the circumstances of the patient, promote the objects of Pt 5 of the Act.

23 Accordingly, we consented to the carrying out of the proposed treatment on the patient within the seven (7) days following the order at the hospital. It was expected that the procedure would be carried out within 24 to 48 hours of the hearing.

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I hereby certify that this is a true and accurate record of the reasons for decision of the Civil and Administrative Tribunal of New South Wales.
Registrar

Amendments

01 May 2020 - Correction, [20]