Neutral Citation Number: [2020] EWCOP 37

Case No: 13617268

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/07/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

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Between :

(1) AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP **(2) NORTH BRISTOL NHS TRUST**	**Applicants**
- and -	
(1) WA **(2) DT**	**Respondents**
- and -	
THE OFFICIAL SOLICITOR	**Advocate to the Court**

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Ms Fiona Paterson (instructed by Bevan Brittan) for the 1st **Applicant**
Mr Neil Davy (instructed by DAC Beachcroft LLP) for the 2nd **Applicant**
Ms Katie Scott (instructed by Miles and Partners) for the **Respondent**
Ms Emma Sutton (instructed by the Official Solicitor) as **Advocate to the Court**

Hearing dates: 6th, 7th, 8th, 9th July 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered following a remote hearing conducted on a video conferencing platform and was attended by members of the public and the press. 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judgment) in any published version of the judgment the names and addresses of the parties and the protected person must not be published. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. This application is brought by both the Avon and Wiltshire Mental Health Partnership (AWP) and the North Bristol NHS Trust (NBT). The first applicant is primarily concerned with questions relating to capacity, they provide a psychiatric liaison service to the relevant hospital, which is run by NBT. The second applicant presents for the court's scrutiny a Clinical Treatment Plan, which it contends is in the best interests of WA, the protected person at the centre of this litigation.

2. In 2009 WA claimed asylum in the United Kingdom. Notwithstanding a substantial and compelling body of evidence in support of his application, it was initially refused. However, an appeal to the First Tier Tribunal reversed the decision and WA was permitted to remain, initially as a refugee, for 5 years. Thereafter, he was granted indefinite leave to remain (23rd July 2009). WA had escaped from his native Palestine where he reports having suffered sustained physical abuse by members of Hamas in consequence of his refusal to act as a suicide bomber. It is said that his Grandmother had been able to provide a bribe to a Hamas soldier to facilitate WA's escape. His Grandmother was also able to finance and arrange for WA to leave the country. He travelled to Italy, where he initially claimed asylum. In Italy, WA and one other boy were allocated a foster carer. That proved to be a disastrous placement, both boys were physically and sexually abused and the other boy was ultimately killed, having been kicked to death by the foster carer. There is a good deal of corroborative material to support these accounts, not least evidence of extensive injury, including stab wounds and a crudely amputated index finger. WA has suffered post-traumatic stress disorder and depression. It is important that I record that I find his account of his early life substantially reliable. To the extent that there may be any inconsistences I do not consider that is a consequence of any dishonesty. I find WA to be open, sensitive and honest.

3. In 2009 WA was placed with foster carers in the United Kingdom. The carers, Mr and Mrs DT are a West Indian couple in their mid-fifties. It seems to me that they bonded almost immediately with WA and welcomed him to their family as a member of their family. WA still lives with them, now eleven years later. He refers to them as "Mum" and "Dad." Their own birth children he regards as his siblings and his two Grandmothers take obvious delight in him. They are a close and supportive family and the love, commitment and patience shown by Mr and Mrs DT is both impressive and humbling. During the course of evidence Mr DT described an incident which plainly remains vivid to him, though it occurred shortly after WA joined the family. He told me how WA had been a little slow to come to the dinner table when called. Mr DT used a stronger voice than his usual one to call WA again. He was not shouting or angry, but firm. Nonetheless, this was sufficient to cause WA to dive under a coffee table, curl into a foetal position and urinate. Though he had no real cause to, I sensed Mr DT still felt guilty about this incident. The couple told me that it was a turning point for them. They realised that they would have to treat WA with heightened sensitivity and care.

4. At some point after his arrival in the United Kingdom, WA was referred to the local Children and Adolescent Mental Health Services (CAMHS) who diagnosed Post-Traumatic Stress Disorder (PTSD) and depression. Those diagnoses have been

modified and refined in the years that followed. The labels are probably irrelevant, what is clear though and was surely inevitable, is that WA continues to suffer significant psychological distress from the awful traumas that he has endured.

5. WA believed that he was 14 when he was placed with his carers. An initial age assessment undertaken by Gloucestershire County Council confirmed this. However, it was considered that the assessment had not been sufficiently rigorous and two further age assessments were commissioned. WA had been told by his Grandmother before he left Palestine that his date of birth was 29th December 1994. The subsequent age assessments concluded that WA was five years older than he believed himself to be. The Home Office determined that WA's date of birth should be 19th April 1989. It is this date that now appears on WA's biometric records.

6. From one perspective it might be thought that the impact of this bureaucratic decision might have diminished in WA's thoughts over the last decade and perhaps become little more than a frustrating and upsetting irritation. That has not happened. For WA the removal of his date of birth is perceived as a fundamental violation of his own rights and an assault on his identity. As a prisoner in Palestine and a victim of physical and sexual abuse in Italy, WA experienced the complete negation of his autonomy at a stage in his childhood and adolescence where he might otherwise have started to explore it. Having listened to him, his parents, the psychiatrists and psychologists, during the course of this hearing, it is clear that WA experienced the change of his date of birth as effectively abusive. It triggered, I have been told, the vivid memory of his powerlessness in the instances of childhood trauma that I have summarised above.

7. Professor Jennifer Wild, whose evidence I will consider below, was of the strong view that the child sexual abuse is the prevailing trauma for WA. She told me that in the context of his life in Gaza, WA knew and understood Hamas to be his enemy who might oppress and torture him. By contrast, the physical and sexual abuse in Italy was perpetrated by somebody who had been trusted to nurture and protect him. The violation in these circumstances was compounded by the breach of trust. WA was entirely powerless. Paradigmatically for victims of such abuse, WA coped by disassociating himself from his circumstances. The psychological trauma which though abated still continues, does not centre upon violent assault or the physical pain which WA undoubtedly suffered and which the scars on his body are ever present reminders, it is his sense of powerlessness and loss of autonomy in the face of forces which he could do nothing about and which continue to compromise his psychological wellbeing. All the psychologists agree with this analysis.

8. Mr and Mrs DT communicated what I consider to be an identical perspective, expressed in the simple and clear language of instinctively good parents. Each in their different ways emphasised WA's challenges when he confronts controlling individuals or bureaucratic institutions which are, perhaps necessarily, inflexible. When she began her evidence in chief Mrs DT asked if she might read a short statement she had prepared. She told me that she wanted me to understand WA *"as a person."* I consider it appropriate to set this short statement out in full:

> *"[WA] is a kind and gentle man, who is considerate, thoughtful and endearing.*

> *He puts other people before himself, sometimes I wonder who is looking after who.*
> *He has helped many people in the community, helping where he can, small jobs etc.*
> *He is someone that holds and stands by his beliefs and values.*
> *He works hard at anything he sets out to do, doing well and putting great effort into it.*
> *He is honest and does not like dishonesty, he is clear on what is right and what is wrong.*
> *He does not cope well with overbearing controlling people, who come across as threatening or want to impose their will or dominance on him.*
> *He does not like discrimination in any form.*
> *We do not want [WA] to be stuck in a system when he has the ability to recover and move on in his life.*
> *We do not want [WA] to be treated at any cost.*
> *We believe that [WA) will be able to go on and lead a full and fulfilling life.*
> *[WA] has great potential.*
> *We also believe that a DOB is everyone's right of passage."*

9. The Court of Protection is a senior court of record, regulated by the Mental Capacity Act 2005 (MCA). Manifestly, it does not have the power to review the fairness or rationality of decisions taken by public bodies. During the course of this hearing, a significant number of members of the public have been sitting in, remotely. By this I mean they have applied and been granted entrance to the video conferencing platform on which this court now conducts its daily business. It is important therefore that I emphasise that I have not investigated in anyway the circumstances in which the decision was taken in relation to determining WA's date of birth. The objectives at this hearing are to identify whether WA has the capacity to take decisions relating to his medical treatment and, if he does not, what treatment plan is in his best interests.

10. For completeness I record that WA has issued Judicial Review proceedings in the Upper Tribunal and an initial order has been made by the Upper Tribunal judge directing evidence to be filed by WA and on behalf of the Secretary of State.

11. Mrs DT told me that WA is simply not able to accept his assigned date of birth. From what she said and as others have commented, the use of it is experienced by him as some kind of a betrayal. This is, in part, rooted in the fact that it was his Grandmother who gave him written confirmation of his date of birth. She was a very significant person in WA's life. WA continues to grieve for her. Perhaps even more significantly, he believes that using the date of birth is corrosive of both his integrity and his humanity. WA reverts, I have noticed, to comparing this forced identity, as he believes it to be, to the treatment of animals. "*This would not happen to a puppy"*, he told me.

12. Mrs DT considers that WA will not allow himself to remember his assigned date of birth. Whenever he is asked for it, he gives the date of birth he believes to be true. Though he is an intelligent and articulate man, Mrs DT tells me that WA does not do this to be obstructive or to make a point, he does it because it is his verification of his own identity which he simply cannot let go. It causes endless practical bureaucratic problems and a great deal of distress, not only to WA but to Mr and Mrs DT, particularly Mrs DT. There are countless examples of this distress over the years but a recent incident illustrates the challenges faced. WA applied to help out in the

Nightingale Hospital. It is easy to see from his temperament and personality that he would have been able to make a real contribution. His calm and sensitive nature could have been harnessed in all manner of different circumstances. On the application form he did not give his biometric birth date. His application was rejected and Mrs DT, who recognised immediately what had happened had to explain to him why he was rejected. Whenever WA is asked for his date of birth on the telephone, he simply hands the telephone to Mrs DT. In a very real sense this percolates through every aspect of WA's life and has gradually become intolerable to him.

13. It appears that earlier this year WA may have been given some negative advice in the context of his application for Judicial Review. I emphasise again, that I have no way of evaluating the strength of that application. It appears however, that at this point WA began to feel that his situation was hopeless and he started to refuse food and drink.

14. Eventually, WA was admitted to Southmead Hospital on 20th April 2020. He had been restricting his intake of fluids and food, at this stage, for a number of weeks and had lost approximately 10kg of weight since March 2020. At hospital WA was initially given IV fluids but he refused nasogastric ["NG"] feeding.

15. On 30th April 2020 a decision was made that WA should be detained under Section 3 of the Mental Health Act 1983 ("MHA"). At this hearing there has not been time, nor would it have been appropriate, to consider whether that order was properly made. There is no doubt that WA was extremely distressed. An NG tube was inserted on 4th May 2020 but WA found it to be intolerable and removed it after the feed had been given. The evidence of the doctors at this hearing highlights how this process might easily have been retraumatising for WA. An attempt to replace the tube was made on 5th May 2020 but it could not be sited satisfactorily and so it was removed. Eventually, it was replaced but it was then then removed again by WA on 7th May 2020. Thereafter, he refused to have it replaced.

16. Following this, WA intermittently accepted IV fluids, one nutritional drink, some yoghurt, some dates and an antidepressant tablet. On 5th June 2020 his detention under Section 3 of the MHA was rescinded.

17. Between 23rd May 2020 and 16th June 2020 apart from IV fluids containing dextrose WA accepted only half a cup of milk, a spoon of yoghurt and two dates. WA's ideal weight is 68kg, his weight in August 2019 was 63.5kg and between April and June 2020 his weight fell from 52.5kg to 48kg. This indicates that by 7th June 2020 his weight had fallen to 48kg (i.e. a 24.4% weight loss from his August 2019 weight and a 29.4% weight loss from his ideal weight).

18. WA's current weight, as at 1st July 2020 is 47.7kg and his BMI was now precariously 14.7kg/m2. Since 16th June 2020 WA has agreed to try to take some nutrition by mouth with additional nutritional support by NG tube and IV fluids. He reports pain when eating and consequently the vast majority of his nutrition has been administered via NG feed and IV fluids which comprises of 1 litre of dextrose (which provides approximately 200kCal and 600kCal of NG feed per day). WA has refused any more intake than that.

19. On the current level of nutrition, the rate of WA's weight loss has decelerated but it is important to highlight that it continues to decrease. His most recent blood tests are stable and, if he continues the current level of intake, it is not considered that there is any immediate risk to his life. He is bedbound and very weak.

20. If WA were to refuse NG tube feeding and return to the position which pertained during the period between 23rd May 2020 and 16th June 2020 (when he was essentially receiving only IV fluids) his nutritional intake would not be sufficient to sustain life. The risk of death would increase substantially as his body mass index falls. Dr R told me that death could occur suddenly through organ failure.

21. Against this background, the following issues have been identified for this court to address:

    i) Whether WA lacks capacity to conduct these proceedings.

    ii) Whether WA lacks capacity to make decisions about his nutrition and hydration; and if not

    iii) Whether WA is a vulnerable adult to whom orders could and should be made under the inherent jurisdiction (and in particular whether the Court can make an order for forcible feeding that involves a deprivation of WA's liberty.)

    iv) Whether, if ii) or iii) applies, what approach to nutrition and hydration would be in WA's best interests.

22. Though the Official Solicitor has accepted the invitation of the court and has been represented, by Ms Sutton, she acts as Advocate to the Court to assist in the complex moral, ethical and legal issues the case presents. She does not represent WA. There has, in the end, been no significant dispute as to whether WA has capacity to conduct these proceedings. I am entirely satisfied that he has. Whether he has the capacity to take decisions regarding his nutrition and hydration has, however, proved to be an extremely difficult question. Before I turn to the evidence on this issue it is helpful to contextualise it in the context of the many assessments of WA's capacity that have been undertaken and which have reached differing conclusions. Ms Sutton has prepared an extremely helpful chronology which is accepted by all as being entirely accurate and complete. I adopt it:

20.04.20	**Capacity assessment (1):** 21.30: *'MH nurse came to see [WA]. He assessed him. [WA]* ***has capacity*** *don't need to put under section. MH nurse will come back tomorrow morning to see him. Unfortunately [WA] has come to bad decision'*
21.04.20	**Capacity assessment (2):** by SM regarding WA's capacity *'around*

	declining to eat' *'[WA] does appear to place an overvalued sense of identity around his need to have his perceived date of birth rather than this allocated one, which he does appear to hold with almost delusional intensity. However, [WA's] beliefs ..... appear to be in keeping with his background and cultural experiences of having been a refugee escaping from Palestine as a child having been given a possibly doctored birth certificate by his Grandmother ……* ***I think that [WA] is making capacitous decisions*** *about his treatment regarding his dietary intake and mental health care'*
29.04.20	**Capacity assessment (3):** by RH (trainee psychiatrist) in the presence of Dr G. *'**He seemed to have capacity** to make decisions around his care …. No evidence of acute psychopathology and current presentation seems to be a result of a capacitous decision related to psychological distress related to significant traumatic life and loss of identity related to Home Office decision'*
29.04.20	**Capacity assessment (4):** by Dr G (consultant psychiatrist) A full assessment of WA's mental state was undertaken and the current impression was of *'significant trauma' but [WA] '**appear[ed] to have the capacity** to make the decision'*
30.04.20	**Capacity assessment (5):** by Dr G (consultant psychiatrist). Form A8 (medical recommendation for admission for treatment) confirms that *'on interview he has some symptoms of PTSD, and low mood, but **retains capacity** to make decisions regarding his care and treatment'*
09.05.20	**Capacity Assessment (6):** Dr C (liaison psychiatrist) recorded that WA was **not able to demonstrate capacity** and vocalise his ability to weigh up the options of treatment and no treatment. WA agreed

	to some IV fluids
09.05.10	**Capacity assessment (7**): the RMN (name illegible) within the day report stated that WA *'engaged very well [and]* ***lacking nothing at all in terms of capacity'***. Noted that WA will continue to be nursed at 1:1 level at all times
11.05.20	**Capacity assessment (8**): night SHO noted that WA was refusing all treatment, but having assessed him, considered that WA *'understands the consequences of his decision, can weigh this up, can remember them and has communicated his decision so* ***he has capacity*** *to refuse treatment currently'*
29.05.20	**Capacity assessment (9):** Dr BD (consultant psychiatrist); second opinion assessment. WA's foster mother also in attendance for part of the assessment Concluded that: • WA's thoughts regarding the Home Office to be *'rigid and overvalued, not delusional'* • *'[WA] has been a victim of many injustices, therefore it is not surprising that he has developed a heightened sense for injustices against him'* • *'he appears to be a highly principled young man who focuses on and responds to actual or perceived unfairness and discrimination against him. His ideas and thoughts regarding this are set and rigid with determination not to change his attitude or position, in spite of good arguments or reasons from carers to do'* • *Initially [WA]'s thoughts regarding his change of DOB appear overvalued and unreasonable – however if understood within the context of his history, they can be interpreted as a means of protecting and exercising control'* • *'[WA] does not represent with major cognitive impairment, his thoughts are ordered and he does not harbour*

	*delusions. It is therefore **improbable that the trauma associated impairment or disturbance of his mind is sufficient that [WA] lacks the capacity** to make decisions regarding his care and treatment'* • *'My impression is that [WA's] presentation can be understood in the context of his adverse and highly traumatic childhood and adolescence''*
10.06.20	**Capacity assessment (10)**: second opinion in dietetics and capacity assessment regarding decisions about nutritional intake undertaken by BW (gastroenterology specialist dietician (with a background in mental health). Dr G was present as was LH (dietician) and WA's parents Concluded that WA **had capacity**. He could understand, retain and communicate the decision, and in relation to his ability to use and weigh the relevant information, the assessment concludes that '*he demonstrated that he was able to weigh up the information given, including weighing up the risk of death and his desire to end his life. He did relate his desire to end his life to past traumatic experiences, but was clear that his desire to end his life would change if the home office were to make a decision to change their documented date of birth for him'*
10.06.20	**Capacity assessment (11)**: WA was assessed by Dr MC (community consultant) who concluded that WA *'**had capacity** to make decisions around his care and treatment'* stating that there was *'no evidence of severe mood disorder or a psychotic disorder, and [WA] appeared to be capacitous'*
11.06.20	**Capacity assessment (12):** Dr B (SHO) considered that WA *'appears to **have capacity** to decide on whether he is to continue his hunger strike with the significant risks that this poses'*

15.06.20	**Capacity assessment (13)**: Dr V (gastroenterologist) assessed WA's capacity '*regarding feeding issues'* *'in my mind today, the patient has been able to understand the information relevant to not being fed, has retained most of it, is able to weigh up the information available and communicate, therefore **he has capacity** to receive oral or enteral feeds'*
18.06.20	**Capacity assessment (14)**: Dr C (expert instructed by the applicants) attends upon WA to undertake a capacity assessment - concludes that WA **lacks capacity** to make decisions regarding his nutrition and hydration and **lacks capacity** to conduct these proceedings
19.06.20	**Capacity assessment (15)**: Dr C (consultant psychiatrist and medical director within the mental health trust) attended upon WA at 11.15 for 1 hour 15 minutes in the presence of Dr G to undertake a capacity assessment - concludes that WA **lacks capacity** to make decisions regarding his nutrition and hydration Highlights that there has been *'considerable uncertainty'* amongst the treating psychiatric staff who have cared for WA since 20 April 2020 as to whether he has capacity or not [**B/29**]
19.06.20	**Capacity assessment (16):** within her witness statement Dr G highlights that *'it extremely difficult to assess his capacity. However, having reflected carefully, I consider that on balance, his capacity to decide whether or not to accept nutrition **could be impaired**. That said, I accept that other clinicians may have a different view'* During Dr C's discussion with Dr G, she *'admitted that she was finding it difficult to commit to whether or not he had capacity to make decisions around nutrition and hydration'* [**G/14** §3.44]

03.07.20	**Capacity assessment (17)**: Dr W (expert instructed by WA) concludes that WA **has capacity** to conduct these proceedings and **has capacity** to make decisions regarding his nutrition and hydration.

Before I analyse the evidence on this question it is necessary to set out the legal framework.

Legal Framework

23. The applicable law in this sphere is relatively easy to state. Its application to the individual facts of the particular case can nonetheless be challenging. It is important to preface my analysis of the law by stating the uncontroversial fact that there is no obligation on a patient with decision-making capacity to accept life-saving treatment, and doctors are neither entitled nor obliged to give it. As set out by Lord Brandon in **Re: F (Mental Patient: Sterilisation) [1990] 2 AC 1**:

> " '*a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force ... without their consent'*, and if he were to do so, he would commit the tort of trespass to the person [**55**].

24. As Lord Goff thereafter observed in **Airedale NHS Trust v. Bland [1993] AC 789 at [864]**:

> *' ... the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so'.*

25. Additionally, as Lord Browne-Wilkinson said in Bland (supra) at [**877**], the questions for the court are questions of law:

> *'[b]ut behind the questions of law lie moral, ethical, medical and practical issues of fundamental importance to society'.*

26. The right to self-determination was expressed succinctly by Judge LJ (as he then was) in **St George's Healthcare NHS Trust v S [1999] (Fam) 26**:

> *'Even when his or her own life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it'*

27. As set out by Baker J (as he then was) in **An NHS Trust v A [2013] EWHC 2442 (COP) at [30]**:

> *'There is no doubt that this principle applies in the context of choosing whether to refuse food and drink (see, for example, Secretary of State for the Health Department v. Rob [1995] 1 All ER 677 and A Local Authority v. E and Others. [2012] EWHC 1639). Thus, if Dr. A. has the capacity to make decisions as to whether to take food and drink, he is entitled to starve himself to death if he so chooses. The question is: does he have the capacity?'*

28. Additionally, at para 47, Baker J observed:

> *'it is not uncommon for people to go on hunger strike in the hope that the Government will be forced to change its policy. Hunger strikes are a legitimate form of political protest. Not all hunger strikers are suffering from a mental disorder .....'*

29. In **London Borough of Tower Hamlets v PB [2020] EWCOP 34** I recently reviewed the applicable law which can, conveniently, be reprised here. The MCA provides a specific statutory definition of mental capacity which is termed to be "decision specific", predicated on a "functional approach", evaluated in the framework of a "diagnostic threshold". Thus, at the core of the Act is a central distinction between the inability to make a decision and the making of a decision which, objectively, would be regarded by others as unwise. Fundamentally, the Act emphasises the right of the individual, in exercising his or her personal autonomy, to make bad decisions even extending to those with potentially catastrophic consequences (see **Barnsley Hospital NHS Foundation Trust v MSP [2020] EWCOP 26**).

30. The presumption of capacity, Section 1(2), is the bench mark for decision makers in this sphere. The Act reinforces this by requiring that a person is not to be treated as unable to make a decision unless *"all practicable steps to help him to do so have been taken without success."* The scope of these unambiguous provisions must be fully recognised and vigilantly guarded. The philosophy informing the legal framework illuminates the point that this case highlights, namely '*a person is not to be treated as unable to make a decision merely because he makes an unwise decision.'* This statutory imperative reflected extensive common law jurisprudence, prior to the Mental Capacity Act, recognising that the law does not insist that a person behaves "*in such a manner as to deserve approbation from the prudent, the wise or the good"*: **Bird v Luckie (1850) 8 Hare 301.** It is the ability to take the decision, not the outcome of it which is in focus: **CC v KK and STCC [2012] EWHC 2136 (COP); Kings College Hospital NHS Trust v C & V [2015] EWCOP 80.**

31. McFarlane LJ made the following observation in **PC v City of York [2013] EWCA Civ 478** at [54], which strikes me as capturing and distilling the true essence of this principle:

> *"there is a space between an unwise decision and one which an individual does not have the mental capacity to take and … it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual's autonomy operates."*

32. It is important to identify and define the issue in question, see **PC v NC and City of York Council [2013] EWCA Civ 478 at [35].** There, the Court of Appeal stated that:

> *"The determination of capacity under MCA 2005, Part 1 is decision specific…. all decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of MCA 2005, ss 1 to 3 which requires the court to have regard to 'a matter' requiring 'a decision'. There is neither need nor justification for the plain words of the statute to be embellished."*

33. It is important to set out Section 3 MCA, which provides:

> *"3. Inability to make decisions*
> *(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—*
> *(a)to understand the information relevant to the decision,*
> *(b)to retain that information,*
> *(c)to use or weigh that information as part of the process of making the decision, or*
> *(d)to communicate his decision (whether by talking, using sign language or any other means).*
> *(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).*
> *(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.*
> *(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—*
> *(a)deciding one way or another, or*
> *(b)failing to make the decision."*

34. Paragraph 4.30 of the Code of Practice also requires to be considered:

> *"Information about decisions the person has made based on a lack of understanding of risks or inability to weigh up the information can form part of a capacity assessment – particularly if someone*

> *repeatedly makes decisions that put them at risk or result in harm to them or someone else."*

35. Intrinsic to assessing capacitous decision taking is the ability to weigh and sift the relevant information. This is the central focus of enquiry in relation to WA's decision to refuse CANH. In **PCT v P [2011] 1 FLR 287, AH and The Local Authority [2009] COPLR Con Vol 956** at [35] Hedley J, with characteristic conciseness, analysed the capacity to use or weigh information thus:

> *"the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another."*

36. In this case it is important to highlight that it is not necessary for a person to use or weigh every detail of the respective options available to them to demonstrate capacity, the salient factors are key: see **CC v KK and STCC [2012] EWHC 2136 (COP)** at [69]. Importantly, it must always be recognised that though a person may be unable to use or weigh some of the information objectively relevant to the decision in question, they may nonetheless be able to use or weigh other elements sufficiently well so as, ultimately, to be able to make a capacitous decision, see **Re SB [2013] EWHC 1417 (COP)**. It is not necessary to have every piece of the jigsaw to see the overall picture.

37. Even where an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself justify a conclusion that P lacks capacity.

38. Whilst the evidence of psychiatrists is likely to strongly influence the conclusion of the Court as to whether there is *"an impairment of the mind"* for the purposes of section 2(1) MCA, the ultimate decision as to capacity is a judgment for the court see (**Re SB [2013] EWHC 1417 (COP)).** In **PH v A Local Authority [2011] EWHC 1704 (COP)** Baker J observed at [**16**]:

> *"in assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P …".*

39. **Best interests**

Where a person is unable to make a decision for themselves there is an obligation to act in their best interests: section 1(5) MCA. Where a decision relates to life-sustaining treatment, the person making the decision must not be motivated by a desire to bring about death: section 4(5) MCA. When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to

the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence their decision if they had capacity, and to the other factors that they would be likely to consider if they were able to do so: section 4(6) MCA. Account must be taken of the views of anyone engaged in caring for the person or interested in their welfare: section 4(7) MCA. Carers, including health professionals, are permitted to carry out acts in connection with personal care, health care, or treatment of a person who lacks capacity to consent: section 5 MCA.

40. The Mental Capacity Act 2005 Code of Practice ('**the Code**') issued under section 42 MCA came into effect in April 2007. Chapter 5 of the Code titled "*How should someone's best interests be worked out when making decisions about life-sustaining treatment?"* includes the following:

> *"5.31 All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment'*
>
> *'5.33 ... Doctors must apply the best interests' checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests. If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide what is in the person's best interests'*
>
> *'5.38. In setting out the requirements for working out a person's 'best interests', section 4 of the Act puts the person who lacks capacity at the centre of the decision to be made. Even if they cannot make the decision, their wishes and feelings, beliefs and values should be taken fully into account – whether expressed in the past or now. But their wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests ..'*
>
> *'5.41 The person may have held strong views in the past which could have a bearing on the decision now to be made. All reasonable efforts must be made to find out whether the person has expressed*

> *views in the past that will shape the decision to be made. This could have been through verbal communication, writing, behaviour or habits, or recorded in any other way (for example, home videos or audiotapes)"*

41. Baroness Hale in **Aintree University Hospital NHS Trust v James [2013] UKSC 67** (at para [26]) described this section as putting an *"emphasis on the need to see the patient as **an individual*** (my emphasis), *with his own values, likes and dislikes, and to consider his best interests in a holistic way."*

42. In **Briggs v Briggs [2017] 4 WLR 37**, Charles J considered that where best interests in respect of life sustaining treatment is in issue the "*default position for incapacitous persons is founded on the sanctity of life and so the strong presumption that lives that have value should be continued by life-sustaining treatment."* However, whilst there is considerable weight or indeed, a strong presumption in favour of the prolongation of life, it is manifestly not an absolute. As Charles J went on to say in *Briggs* (at para 7):

> *"In all the circumstances of this case I have concluded that the weightiest and so determinative factor in determining what is in Mr Briggs' best interests is what I am sure he would have wanted to do and would have concluded was in his best interests. And so, for him, his best interests are best served by giving effect to what he would have been able to dictate by exercising his right of self-determination rather than the very powerful counter arguments based on the preservation of his life."*

43. In coming to this view Charles J was echoing the holistic application of the best interests test, concerned with enabling the court to do for the patient that which he could do for himself if he had full capacity, articulated by Baroness Hale in Aintree (above).

44. Delivering the judgment of the Supreme Court Baroness Hale stated:

> *"[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 towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be."*
>
> *[45] Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say*

> *that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."*

45. When applying the best interests tests at section 4(6) MCA, the focus must always be on identifying the views and feelings of P, the incapacitated individual. The objective is to reassert P's autonomy and thus restore his right to take his own decisions in the way that he would have done had he not lost capacity.

46. The weight to be attributed to P's wishes and feelings will of course differ depending on a variety of matters such as, for example, how clearly the wishes and feelings are expressed, how frequently they are (or were previously) expressed, how consistent P's views are (or have been), the complexity of the decision and **how close to the borderline of capacity the person is (or was when they expressed their relevant views).** I have emphasised this particular aspect of the exercise because, as will emerge below, I consider it to be a significant factor in this case.

47. Munby J (as he then was) made a number of pertinent points in **Re: M, ITW v Z [2009] EWHC 2525(COP) [2011] 1WLR 344** (at para 35):

> *"I venture, however, to add the following observations:*
>
> *(i) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see Re MM; Local Authority X v MM (by the Official Solicitor) and KM [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at paras [121]-[124].*
>
> *(ii) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P's wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P's wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic. Just as the test of incapacity under the 2005 Act is, as under the common law,*

> *'issue specific', so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.*
>
> *(iii) Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to all the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:*
>
> *a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings: Re MM; Local Authority X v MM (by the Official Solicitor) and KM at para [124];*
>
> *b) the strength and consistency of the views being expressed by P;*
>
> *c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again Re MM; Local Authority X v MM (by the Official Solicitor) and KM, at para [124];*
>
> *d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and*
>
> *e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests."*

48. Nothing requires to be added to those very clear observations. In Aintree University Hospitals NHS Foundation Trust v James **[2013] UKSC 67** the Supreme Court made it clear that the court below had been wrong to focus on what *"the reasonable patient"* would decide, and emphasised that the patient's own wishes and feeling must be properly considered: *"the things which were important to him… should be taken into account because they are a component in making the choice which is right for him as an individual human being."*

49. At para [44] of Aintree, Baroness Hale said that *"As was emphasised in Re J (1991), it is not for others to say that a life which the patient would regard as worthwhile is not worth living"*. It is axiomatic that the corollary must equally be true i.e. it is not for others to say that a life they would regard as tolerable would be considered to be so by P. As Jackson J put it in **Wye Valley NHS Trust v B [2015] EWCOP 60** at [9], *"Where a patient is suffering from an incurable disability, the question is whether he would regard his future life as worthwhile."*

50. There are a number of cases decided since Aintree (supra) which have considered the weight to be placed on the wishes and feelings of an incapacitous adult in the best interests' assessment. In **M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group [2015] EWCOP 9**, I observed (at paras 28 & 30):

> *"…where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interests'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them.*
>
> *Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment. Mr Patel, counsel acting on behalf of M, has pointed to recent case law which he submits, and I agree, has emphasised the importance of giving proper weight to P's wishes, feelings, beliefs and values see Wye Valley NHS Trust v B."*

51. Whether or not a person has the capacity to make decisions for themselves, they are entitled to the protection of the European Convention on Human Rights. In the present context, the relevant rights are found in Article 2 (the right to life), Article 3 (protection from inhuman or degrading treatment), Article 5 (right to liberty and security), Article 8 (the right to respect for a private and family life) and Article 10 (freedom of expression).

Analysis

52. On the question of capacity, I heard firstly from Dr C, who is a Consultant Psychiatrist and Medical Director of AWP, I found Dr C to be an impressive witness, entirely open to revisiting her conclusions and prepared fully to engage in a dialectic with her professional colleagues and with the Advocates. She told me that from the psychiatrist's perspective the issue which she identified as giving greatest concern was achieving a balance between care which led to an improvement in WA's condition but did not exacerbate what she saw as the underlying mental health issues. She was anxious that any degree of coercion, albeit motivated to preserve WA's life might have the counterproductive effect of triggering a relapse of the PTSD and depression and serve in effect to retraumatise him.

53. In her report dated 25th June 2020, Dr C makes the following observations:

> *"**9.** WA's history and current presentation are extensively set out in other documentation so I will not repeat it here. Currently, his BMI is 14.7 and has lost 1kg in weight over the last week. He is still at*

> *significant risk even though he is taking some food and fluid. He receives 1 litre of iv fluids with 5% dextrose every 12 hours and Nutrison Protein Plus 500ml (+pre and post flushes of 50ml) at a rate of 25ml/hour every 20 hours.*
>
> ***10.*** *When I saw him he said he was prepared to die from self-starvation, but I am aware that he has told others that he does not want to die. He is currently accepting nutrition via NG feeding sufficient to*
> *prevent further deterioration of his health but not sufficient to improve his condition. This is therefore not a long term option.*
>
> ***11.*** *WA has a fixed date in his mind of 6 July 2020 after which time he has declared he will no longer accept even this limited amount of nutritional support. Without this WA's physical condition will inevitably deteriorate and ultimately lead to his death.*
>
> ***12.*** *WA does not currently exhibit symptoms of depressive illness; he is currently accepting treatment with an antidepressant which should be continued to avoid relapse of depression.*
>
> ***13.*** *There are NICE recommended psychological treatments available to WA as outlined by RP. However, in his current nutritional state it her view that WA is not able to engage in these.*
>
> ***14.*** *It is possible that WA could respond to a Court Order to re-feed him in a somewhat passive way and he may simply accept this decision and become compliant with either oral or NG feeding. He responded in a similar way when he was recently under Section 3 of the Mental Health Act and also when given medical treatment at Southmead. E95 Dr C Dated 3.7.20*
>
> ***15.*** *Of course the opposite reaction is possible and one cannot predict with any certainty how he would respond."*

54. Counsel properly, in my judgement, identify the essence of the question relating to capacity as whether WA has an impairment of the mind or brain which causes him to be unable to use or weigh the relevant information as part of the process of decision taking, as prescribed by Section 3 (1)(c) MCA 2005 (see para 33 above).

55. Dr C made a face to face visit to see WA on 19th June 2020. She selected a time of day (11.15am) and a date when WA had no other specific assessments. She was taking these measures in order to create the best circumstances for P to exhibit the extent of his capacity on the identified issues. Also present at the interview was Dr G, with whom WA is relaxed and familiar and Mrs DT. In her report Dr C records the following features of her discussion with Mrs DT:

> *"32. [DT] told me that she does not agree with WA not eating and drinking but she can understand how he feels about his date of birth. She said that it is fundamental to his identity and although she does*

> *not want him to die she knows this may be the consequence. She would like the Home Office to change the date of birth to the one he had originally and her hope for WA would be for him to be able to live a happy life.*
>
> *33. I explained that WA had refused food in the past. [DT] told me that she thinks he does this because he is able to control this and he has gone lots of times in the past with no food. She said he has always been a fussy eater and joked that he had taught her a recipe for fresh pasta sauce so there are things he will eat. There have been times when upset and he has stopped eating but on previous occasions he has restarted she thinks because she has been able to provide some help.*
>
> *34. I asked what was different this time. [DT] told me that WA had told her in a heart to heart that he was very unhappy and couldn't go on like this. She therefore discussed that they would put money into paying a human rights solicitor to take the case about the Home Office. However, on 5 March 2020 this solicitor said that they would not take the case further as they thought they would not win. It was at this point that WA said he would not eat and drink and wanted to die.*
>
> *35. [DT] became tearful at the end of this conversation. WA said that he and his mum are "tired" and they shouldn't have to go on like this. He was clearly discomforted by her tears and he told her not to cry and gave her a tissue."*

56. Dr C told me in evidence that in her conversation with WA he was explicit that he was not eating because he wants to die. When she pressed him, WA said that *"they"* by whom he meant the Home Office, had taken away his identity. He stressed that his Grandmother had given him documentation relating to his date of birth when he left her in Palestine. WA reminded Dr C that his parents were already dead and this was all he had of himself. He said his date of birth was everything to him and he could not ignore it. Dr C enquired whether this was, in effect, a hunger strike designed to encourage the Home Office to change their decision. I have found Dr C's questions to be perceptive and focused. She strikes me as having made sincere and strenuous efforts to understand her patient. Whilst her questions are challenging, I have no doubt that they were pursued gently and sensitively. In her report it is clear that she has plainly reflected, at some length, on her exchanges with WA and DT. Dr C records that in answer to her question as to whether this a protest of some sort, engineered to pressurise the Home Office, WA said, that *"he didn't know"*. In evidence Dr C said that WA's focus was on *"dying"*. He told her that he wants the Home Office to *"hear my voice"*. I have already stated that I find WA to be intelligent, articulate and honest.

57. In evaluating capacity, Dr C records the following:

> *"42.2. Speech*

> *WA spoke with a soft voice and had a Middle Eastern accent. His English vocabulary was good and he was able to understand most of my questions; occasionally he needed clarification with some more complicated ones.*
>
> *42.3. Thoughts and perceptions*
> *WA was fixed on his view that the Home Office had given him an incorrect date of birth. He was resolute this was the case. He said that he looks a little older because of what he has been through but he believes the date of birth given to him by his grandmother. This view was completely unshakeable but I do not assess this to be of delusional intensity as it has the basis within his cultural belief system.*
>
> *42.4. Mood and affect*
> *WA told me that he feels low in mood because he and his mother are so tired. He fees sad that she is tired. However, he denied feeling depressed and said that he is low because of his current situation. He told me that he wants to die to "be with his parents". He told me that he cannot see how he can live if he does not have his identity which is his date of birth. He became tearful at the end of the interview saying that he wants "the right to die". He told me that he does cry sometimes when he is alone because he feels sad about what has happened to him with the Home Office. He told me that he does have an appetite and feels hungry but he does not eat in order to die.*
>
> *42.5. Cognition*
> *WA was orientated in time, place and person. He was able to engage in conversation and was not at all drowsy during our meeting.*
>
> *42.6. Insight*
> *WA told me that he does not think he has depression. He said that he knows that he has had trauma throughout his life but does not think that is the problem at the moment. He told me that he should have the right to die."*

58. Dr C meticulously followed the two-stage test for assessing capacity, outlined in the Mental Capacity Act 2005 and in the Code of Practice. She identified the "diagnostic test": does WA have an impairment of the mind or brain? She went on to consider the "functional test" i.e. does that impairment or disturbance mean that WA is unable to make the decision in question at the time it needs to be made? She breaks the decision down, as is required, to whether WA is able to understand the information relevant to the decision, retain the information, weigh the information as part of the process of making the decision and whether he can communicate it.

59. In relation to the diagnostic test and notwithstanding WA's history, Dr C did not consider that there is an extant psychiatric diagnosis to explain WA's current attitude. Whilst she identified some symptoms associated with atypical depression, Dr C observed social reactivity. WA engaged with her and appeared happy and enthusiastic

when interested in the topic or responding to good news. WA told Dr C that he was inclined to be low and preoccupied with his date of birth when he was alone. In her assessment Dr C records *"he certainly has sensitivity to interpersonal rejection resulting in social relationship problems."*

60. It is an interesting feature of remote hearings that they have served, in a number of cases, actively to promote the participation of P in the court process. I have visited WA (remotely) in his hospital bed, with his parents in attendance, on two occasions. Firstly, at the directions hearing and again when he gave his evidence. It was possible to set up an arrangement where I could see him but the Advocates and everybody else present in the court could only hear him. He has listened to every word of evidence with keen attention and self-evidently been able to provide full instructions to his legal team, in whom he plainly and rightly has great confidence. There are wider lessons to be learnt from this for the future.

61. At the directions hearing I introduced myself to WA and his family. He was, as I have already foreshadowed, articulate, lively and humorous. He is a keen football fan and his team have recently enjoyed a level of success, domestically, which had become unfamiliar to them. WA quickly realised that I did not share in his unbridled pleasure. He was plainly amused. He also struck me as an interesting person who enjoyed conversation. The nurses have all reported the same.

62. Dr C arrived at the following conclusions:

> *"46. Of current significance is his description of a wish to die. He was clear when speaking with me that he feels that he has suffered pain throughout his life and he now wishes to end that and, in his words, "join my parents". He told me that he took an overdose of medication but he does not think that would work; he knows that starvation will kill him.*
>
> *47. WA is absolutely rigid and preoccupied about his date of birth. He is unable to accept anything other than the date of birth he was given by his grandmother. This is related to his sense of self as being the only thing he had when he came away from Palestine. Despite this fixed belief of this I would not describe this as delusional as it is related to his personal cultural belief.*
>
> *48. I asked if WA is troubled by thoughts of his trauma from the past. He told me that it "is there but number 1 is the Home Office". I explored this with him and asked if before the date of birth decision if he thought about the other trauma. He was able to tell me that he did and he was "badly affected" by it. I asked if it was therefore fair to say that since he had the Home Office decision he has that as number one worry but the other trauma worries have been pushed down. He said that was true.*
>
> *49. I am of the opinion that WA's preoccupation with his date of birth does constitute an impairment of the mind. It is my assessment that in the past he has had complex PTSD related to his trauma experiences. These have been supressed by moving his thinking*

> *entirely to focus on his date of birth. He therefore focusses on this and the Home Office, it serves to displace the thoughts of his trauma. In addition he does have some symptoms of low mood and a wish to die."*

63. There is, I consider, no disagreement amongst the professionals that WA can understand the information relevant to the decision and retain it. There is equally no doubt that he can weigh individual facets of the treatment plan. For example, he recognises that the nasal bridle has the advantage of keeping the NG tubes more securely in place and generally restricts the ease with which he could pull them out. He goes so far as to see the advantage in this as preventing him pulling them out in frustration. The real issue, when it is honed down, is whether WA has the capacity to "weigh information" relevant to nutrition and hydration when considering the decision globally rather than in individual components. Dr C said, in evidence, that she found this case, on this point as well as others, *"extremely difficult"*. She described her opinion relating to capacity as *"on a knife edge"*. She candidly volunteered that her thinking had been dragged both ways. She was entirely alert to contrary interpretations which she regarded as valid and frequently accepted. Nonetheless, she considered the rigidity of thinking and preoccupation in relation to his date of birth occluded WA's capacity to weigh and use the overall information relevant to a decision to accept nutrition and hydration.

64. Dr C, as I understand her evidence, does not consider that WA's rejection of food and hydration is motivated to bring pressure on the Home Office. I agree with her. I detect, as she does, a sense of resignation in WA's manner. The distress caused by the date of birth has regularly intruded into WA's life and provokes a very powerful emotional resistance. DT not only understands it, she has come to experience it herself. As she told me she suffers with him. In her evidence she concentrated on this pain. She is plainly motivated to encourage the Home Secretary not to resist the Judicial Review on entirely compassionate or public interest grounds. Though DT is a powerful voice for WA she is cautious when responding to questions concerning capacity. That said, she has expressed a view, in her oral evidence, that she considers WA has capacity to take this decision. The emphasis however, of her evidence is to highlight WA's determination, courage and single mindedness.

65. WA's parents and the doctors, have all noted that WA will sometimes behave in a manner which can best be described as passively acquiescent. This does not always or necessarily signal agreement. It is more accurately characterised as submission or resignation. All the doctors consider this reflects a coping strategy developed by WA when powerless in the face of his extensive abuse. Whilst there is very much about his life that WA loves, WA told Dr C that he would be *"lying to himself"* if he said he could live without his identity. As I have, with the help of the psychiatrists, drilled down more deeply into WA's thought processes, I have come to the clear conclusion that, it would be entirely wrong to describe his actions as being on "hunger strike". As a judge who sometimes sits in the Administrative Court, I have seen a number of hunger strike cases in the context of applications for asylum. They are predominately motivated to achieve one, entirely understandable objective i.e. leave to remain. WA's situation is different, not least because he already has citizenship. He has partially relented from the full rigour of his refusal to eat and drink at present because, as I see it, he has identified a ray of hope in the Directions made by the judge in the Judicial

Review proceedings. Evaluating his response in the context of Dr C's analysis, I now recognise that WA's actions are responsive not proactive. Additionally, I note that WA has protected his own privacy at this hearing and he has indicated, through his Counsel, that he does not want his name to be in the public domain. He is intelligent enough to know that this reduces the profile of his case and would, objectively, diminish the impact of a protest. He has listened to the exchanges with the advocates regarding publicity where this point was touched upon. WA is not, in truth, protesting. He has all but given up, save for this small window of hope.

66. It is important that I record that if, hypothetically, the date of birth with which WA identifies was restored to him, all the doctors are clear that it would be a significant boost to his psychological well-being.

67. I turn to the evidence of Dr Jennifer Wild. Dr Wild is a Consultant Clinical Psychologist and an Associate Professor and Senior Research Fellow at the University of Oxford. Dr Wild specialises in the research and treatment of trauma related disorders, particularly PTSD, anxiety and depression. Her current research involves developing and evaluating evidence-based interventions to prevent PTSD. Dr Wild was instructed to assess the following:

> *"a. Whether or not [WA] has an impairment or disturbance of mind as a result of his trauma history that would affect his current decision making process.*
> *b. Whether [WA] has capacity within the meaning of the Mental Capacity Act 2005 to conduct the proceedings and to consent to the provision of clinically assisted nutrition and hydration (CANH).*
> *c. The potential impact of Dr Shipway's proposed treatment plan.*
> *d. What psychological treatment, if any, may help [WA] should the Court determine he be provided with CANH against his will."*

68. In her report, Dr Wild states as follows:

> *"In my assessment of [WA], I perceived that he was able to understand information and this included information relevant to his decision. I asked [WA] what he thought would happen if he discontinued the feeding tube and he said 'I will die.' I asked him what he understood would happen were he to die and he said 'I will not be here anymore. My family will suffer.' He said 'I feel badly that my family will suffer but enough is enough.' By 'enough is enough' he explained that he chooses not to lose parts of his identity that remain, such as his age.*
>
> *33. [WA] appeared to be able to retain information relevant to his decision, such as remembering and recalling the consequences of discontinuing his feeding tube.*

> *34. [WA] was clearly able to communicate his decision by talking."*

69. Unlike Dr C and Dr Cahill, to whose evidence I shall turn shortly, Dr Wild concluded that WA does have capacity to consent to clinically assisted nutrition and hydration (CANH). In her report she sets out her reasoning:

> *"39. When I asked [WA] what he thought would happen if his CANH was stopped, he informed me that he would die and that if it were continued, he would live and return to full health. [WA] gives the return to full health little or no weight when it is weighed against other information. That is, the suffering he would endure in living with the Home Office assigned date of birth, which extends his loss of dignity and identity.*
>
> *40. I asked [WA] what his understanding was for why I was meeting him. He told me he had asked for an assessment and his solicitor had arranged this.*
>
> *41. In my view, [WA] has litigation capacity because he evidences the capacity to understand, absorb and retain information, including the advice of Counsel, which is relevant to issues arising in the course of proceedings as to which his consent may be required, such as consenting for his medical records to be shared with independent experts.*
>
> *43. [WA] demonstrates the ability to weigh information (and advice) in the balance as part of the process of making decisions within proceedings, such as weighing the information of consequences of refusing or accepting NG feeding currently. He evidences the ability to communicate these decisions to Counsel, nursing staff and his foster mother."*

70. Dr Wild particularly disagreed with Dr Cahill's view that WA's trauma has '*caused a fragmented sense of self, a lack of emotional resilience, difficulty regulating affect and emotion, difficulty forming and maintaining relationships, lack of trust, failures of self-protection, low self-esteem and self-worth and alterations around how he perceives the world.'* She deconstructed these conclusions thus:

> *"46. There is evidence that [WA] has developed trusting relationships with his foster parents, that he evidences emotional resilience (e.g., he learned to speak English, form warm relationships with 'new' parents, study engineering despite the trauma he has endured). [WA] trusts his foster mother, he trusts himself and appears to have a trusting relationship with Dr G. His decision to restrict food is not a failure to protect himself but a*

> *choice he has made to exercise a sense of agency in a situation where he has lost his sense of identity. [WA] described feeling 'like a dog,' which could be indicative of low self-esteem and he described feeling 'worthless.' Importantly, however, he identified these feelings as being related to the Home Office's decision to assign 5 years to his reported age, which he described as something one might do 'to a stray animal, such as a dog.' He said that the decision of the Home Office causes him to feel worthless because it disregards his age, which forms a part of his identity."*

71. I have already mentioned above that I too was struck by WA referring to himself, in evidence, in animal terms. He did so on more than one occasion. I also agree with Dr Wild's observations as to the warmth and strength of his relationships with his parents and Dr G. Later, in her report Dr Wild observes:

> *"it is my opinion that [WA] does not believe that refusing to eat or drink will solve the injustice with the Home Office but rather that it gives him a sense of control in a situation where control has been taken away from him. The re-assigned age does remind WA of past trauma and in my opinion this does not constitute an impairment of mind (it is a reminder of trauma; he does not disassociate in response to reminders of his past trauma) and has no bearing on his ability to weigh relevant information to arrive at his decision…".*

72. As is clear from my own reasoning above, I very much agree with Dr Wild's view that WA's refusal to eat or drink is not designed to achieve leverage with the Home Office but is a behaviour which gives him *"some sense of control in a situation"* where he perceives *"control to have been taken away from him."* Dr Wild agrees that the reassigned age triggers past trauma but only in the sense that is a reminder of trauma and not a *"dissociated response."* This leads her to assert that it has *"no bearing on his ability to weigh relevant information."* I find this conclusion more difficult to reconcile with the substance of Dr Wild's wider observations and my own assessment of the broad canvas of the evidence, including what WA and DT have told me. By way of completeness I should record that Dr Wild has concluded that WA's mental health is much improved and reveals no evidence of a current diagnosis of major depressive disorder or acute PTSD. This is common ground.

73. It follows that if Dr Wild is correct and WA has capacity to decide on CANH, the court is not required to evaluate his best interests objectively. She was asked in evidence what she considers will be the short and long term psychological impact on WA of being provided treatment that he does not want. Dr Wild was very strongly of the view that it would provoke a deterioration in WA's mental health, retriggering PTSD symptoms by replicating his feelings of subjugation at the hands of his abusers. In this respect Dr Wild considered that it was the trauma of sexual abuse that was most persistent.

74. I found Dr Wild's recommendations for treatment to be thoughtful, well-reasoned and carefully structured. At risk of overburdening this judgment they require to be set out:

> *"53. How can these impacts be minimised? It is difficult to determine how these impacts could be minimised since there would be a potential perception of a loss of control over what happens to him, which overlaps with past trauma. It is possible that trauma-focused treatment could be helpful. In trauma-focused treatment, a tool called stimulus discrimination is used to help patients break the link between triggers in the present and the past trauma. It is possible that trauma-focused treatment could help [WA] to see differences between treatment given against his will and his past trauma. But it is not certain that this would lead to a reduction in any potential increase in PTSD severity. Helping [WA] to identify aspects of his identity which are enduring, such as his name, his genes and his memories of his grandmother, may help to strengthen his self-identity. However, it is unlikely to reduce the sense of loss he experiences in relation to 'losing' his date of birth.*
>
> *54. Compassion-focused therapy may help [WA] to consider alternative ways to be kind to himself other than taking actions which fit with his sense of integrity. However, it should be noted that he currently evidences capacity to be kind to himself, such as making efforts to act in accordance with his values."*

75. Dr Wild also addressed the kind of psychological treatment that should be provided to WA if he is to be provided with CANH against his will:

> *"Trauma-focused cognitive behavioural therapy for Complex PTSD may be helpful to [WA]. Trauma-focused CBT for Complex PTSD is offered over a period of about 24 sessions and can be longer depending on the patient's need. The treatment may help [WA] to separate his past trauma from what he has experienced with the Home Office. [WA] would need to work on finding new ways to preserve his sense of identity and there is no guarantee that this would be successful given that a person's age is part of their identity and given that the treatment does not work for everyone."*

76. In his evidence to me WA said that he had had enough of therapy. He did not think the therapy relating to his PTSD had been helpful or effective. It seems likely that the therapy may have been provided at a time when WA no longer met the strict diagnostic criteria for PTSD and it may, for this reason, not have been sufficiently well focused. The therapy that Dr Wild has identified has conveniently been referred to as "narrative therapy", the objective of which is to develop strategies to enable WA to recover a sense of identity in the context of revisiting the significant relationships in both his present and past. The key to the therapy is identified as kindness, empathy

and cultural awareness. In all this the engagement of DT will be crucial. There is a real risk of potentially retraumatising WA. It is thought to be helpful to focus WA on the identity which he retains such as his name, his genes, his language, his religion, his ancestors and heritage.

77. I turn finally to the evidence of Dr Cahill, a Consultant Psychiatrist. He is the clinical lead for the Cheshire and Wirral Partnership NHS Foundation Trust Eating Disorder Service. He is a member of the Royal College of Psychiatrists, Faculty of Eating Disorders Executive Committee. Dr Cahill was asked, on behalf of AWP to offer an opinion, specifically on WA's capacity to accept treatment, mainly in the form of nutrition and hydration. He has reviewed the medical records extensively and interviewed WA. On the 18th June 2020 WA summarised his current situation to Dr Cahill in these terms: *"they want to take something from me, my date of birth, everything is on my birth certificate. The Home Office says it's copied. I am on hunger strike for my right."* For the reasons I have analysed above I do not consider that WA was truly describing a hunger strike. I note the following in Dr Cahill's report:

> ***"3.12** I asked him about the previous times he had been on hunger strike. He described the time when his grandmother died, and he stopped eating for around two weeks. He said that the reason that the hunger strike stopped was that he realised his parents loved him and when they told him that he 'came back to life'. I asked him why that was different now given that his mum and dad clearly still love him. [WA's] response was rather tangential as he began discussing his date of birth and the Home Office and I was not able get an answer for this question."*

78. It seems to me that, when analysed more closely, two very different concepts have elided here; a "maladaptive relationship with food" and "hunger strike." WA's refusal to eat for approximately two weeks following the death of his much loved Grandmother, I regard as a manifestation of his grief and profound emotional distress. On Dr Wild's analysis, which I accept, this is more likely a strategy for gaining some control in circumstances where, in reality, there could be none. WA told Dr Cahill that it was the realisation of how much he was loved by his English parents that brought him back to life. Later in his discussion with Dr Cahill he said *"enough is enough. I don't want to have to keep pretending every day I will give my life for my right. If I die, mum will put my real date of birth on my stone and that is important to me."*

79. Dr Cahill's conversation with WA elicited a number of significant responses. Again, these require to be set out:

> ***"3.16** I asked him whether he felt that if the Home Office changed to his date of birth to his preferable date of birth would that make all his past trauma better? He said he would manage better. He admitted that he would not forget about everything, but he said, 'it would be one step forward.'*

> ***3.18*** *I asked him how he would feel if they corrected his date of birth. He replied, 'It would make me feel me. It would give me safety and kindness. It will mean I don't have to go back to nightmares. I know they won't stop one hundred percent, but I will try more to go forward. I am trying my best.'*
>
> ***3.19*** *He continued 'I will die for my right. This is my right. What is the reason for my Grandmother spending money to get me out of Palestine if I am still suffering'?*
>
> ***3.20 I asked him to reflect on the times he has been doing well in this country. He answered 'I have found kindness, home, security and study in this country. However, it is also taking something very important away from me. When I went to college, I gave my date of birth but when I have to put in a proper application, things get complicated. It is always there.'*** (my emphasis)
>
> ***3.22*** *I asked him what his religion believed about his current hunger strike. He accepted that in Islamic faith, this is considered wrong, but then he added,* ***'Enough is enough. Hopefully God will forgive me.'"*** (my emphasis)

80. In his evidence Dr Cahill told me that he had found this case to be *"up there"* amongst the most difficult cases that he had been involved in in the last ten years. With candour and great professional integrity, he told me that when he concluded his meeting with WA he was greatly challenged as to the appropriate conclusion but inclined to think WA was capacitous. Following the meeting Dr Cahill discussed WA with Dr G, the Consultant Liaison Psychiatrist with whom WA clearly has a positive relationship. Dr G told Dr Cahill that her relationship with WA has grown because they have found joint interests, and when discussing these he become positive, animated and has positive views for the future. She said that there had been a number of occasions where WA has shown humour and that his mental state improves when his needs are met or when he perceives people taking his side. She considered that he displayed *"learnt behaviours"* with *"underling maladaptive behaviours"* when his needs are not met. I should state that nobody has suggested these behaviours are intended to manipulate events they are maladaptive strategies to achieve emotional respite.

81. In a later discussion with Dr G (24th June 2020), Dr Cahill reports her as saying that if everyone is agreeing with WA or there is a favourable response in the legal proceedings then he becomes more compliant with treatment. She refined this *"when there are gestures of love and kindness he is more amenable to treatment. In contrast, when he perceives someone is persecuting him it has the opposite effect."* Dr G also said that sometimes WA just gets himself in to a *"muddle"*.

82. I have already set out, at paragraph 70 above, Dr Cahill's evaluation of WA as lacking emotional resilience and having a fragmented sense of self. In my judgement Dr Wild's countervailing view on this is more persuasive. However, Dr Cahill goes on to

analyse what is the prevailing view within the treatment team i.e. WA's belief that he has been given an incorrect date of birth is properly to be described as *"an overvalued idea."* From this it is extrapolated that WA is so fixated with this perceived injustice that it overwhelms his ability to weigh CANH as a global decision. Though he can comprehend individual facets of the decision very clearly, the ultimate balancing of the key facts is compromised by the weight WA gives to his assigned date of birth, which he perceives to be the only way that his identity is validated.

83. Dr Cahill, like Dr C, engages fully with Dr Wild's differing perspectives. He acknowledges that even if WA has difficulties with his identity it could be argued that there was no link between this and his decision to refuse nutrition. The reasoning linking these two factors, Dr Cahill also recognised, might well be perceived as too logically structured or calculated to support a conclusion that WA lacked capacity. Indeed, their very complexity might indicate precisely the opposite.

84. Having reflected on this alternative hypothesis, Dr Cahill nonetheless concluded that WA's traumatic past and childhood had severely affected his personality, the way he perceives the world, his self-esteem and his sense of self-worth. He was of the view that WA has become fixated with the assigned date of birth to a degree which overwhelms him and to a point where it dominates his thinking and becomes a conductor for past trauma. Ultimately, he concluded this occludes WA's ability to weigh the relevant information in the context of a global decision as opposed to individual facets of it. Thus, Dr Cahill reasons, this constitutes an impairment of the mind and prevents WA from taking the decision. Dr Cahill plainly considered that Dr G's account of WA, based on her close and comfortable relationship with him, reinforced his view as to WA's fragility and heightened sensitivity to perceived injustice. Dr Cahill would not expect this behaviour in someone of WA's age (whichever might be accurate) and he considers it to be rooted in trauma and the consequent complex PTSD. In response to a question from Ms Scott, on behalf of WA, Dr Cahill agreed that he had reached his conclusion on a fine balance and accepted Dr C's phrase, "knife edge" decision as apposite. Though I was greatly impressed by Dr Wild's powerful analysis of those features of WA's thought processes which point towards his having capacity, I have ultimately come to the conclusion that the view of the clinical team and Dr Cahill is more persuasive.

85. Ms Scott, submitted that in circumstances where the evidence was so finely balanced as to be on a "knife edge", it could not easily be said properly to have rebutted the presumption of capacity enshrined within the framework of the MCA. Though that submission is superficially attractive, Ms Scott agreed, in the course of exchanges, that it did not absolve the court from its duty rigorously to analyse the evidence. The presumption of capacity serves to place the burden of proving incapacity squarely on the shoulders of the applicants. The burden of proof remains the balance of probabilities, nothing more northing less (see **Re: B [2008] UKHL 35**). In some cases, the evidence will tip the balance significantly in one direction. In other cases, such as this, the balance will be more delicately poised, though still identifiably weighted to one side.

86. It is clear from my reasoning, set out above, that I have not adopted the individual reasoning of any of the psychiatrists. I have been able to identify aspects of each of their reports and oral evidence which resonate with my own impression of WA and DT. Though this has been a challenging exercise, it has been made a great deal easier

by the willingness of the doctors to take on board countervailing interpretations and alternative perspectives. In a real sense their evidence, individually and collectively, has been investigative, non-adversarial and entirely free from the defence of amour propre which occasionally casts a shadow over expert opinion. In short, I have heard evidence of the highest quality.

87. The second applicant, NBT, is responsible for devising the treatment plan. Dr R has put very considerable effort into structuring a plan, the implementation of which calls for great sensitivity and discretion. Along with Mr Davy, who acts on behalf of the Trust, Dr R has reworked and restructured the plan during the course of the hearing. I recognise that this has been a very difficult exercise and has required a great deal of work.

88. It is necessary to set the provisions of the plan out in some detail because they envisage treatment options some of which will require WA's cooperation as well as others which it is proposed should be delivered against his expressed wishes. It is important to remember that this plan will be available to all who treat WA in the hospital setting. It begins with the following acknowledgement:

> **Preservation of Life**
> It is acknowledged by the treating team and WA's foster family that WA has expressed a desire to end his life through restriction of oral nutrition and hydration.
>
> It is foreseeable, that WA could suffer catastrophic medical complications of his hunger strike causing irreversible damage to the health. This could occur as a result of refeeding syndrome, severe electrolyte derangement, cardiac arrest, or neurological injury due to vitamin deficiencies causing permanent cognitive and neurological injury. These medical complications have the potential to limit his natural life expectancy, and render him physically disabled and dependent on others for personal care and activities of daily living. They may adversely affect his quality of life.
>
> We consider that WA has reversible *medical* illness (malnutrition), with potential to make a full or near full physical recovery. We anticipate that should his mental state permit him to cease his hunger strike, his nutritional state would be expected to improve and eventually his condition would permit discharge from hospital and return to his previously normal life.
>
> This plan has been developed to set out what treatment should be available to WA, should the Court find that he lacks mental capacity to refuse medical care considered to be in his best interests.
>
> It is the opinion of the treating team and WA's foster family that at the present time, life preserving treatment is in WAs best interests. This plan represents the current consensus opinion of the aforementioned treating clinicians, but may change in the future if no long-term resolution is found.

> **Nutritional Support**
>
> …The overarching aim of the treatment plan is to refeed WA in the least restrictive manner, as set out below, to achieve an improving BMI of over 15 in order to minimize physical risk of malnutrition.
>
> The technical modes of possible nutritional support are discussed below. **Wherever possible**, **WA's cooperation should be encouraged and any interventions should be the least restrictive available to achieve the goal of the intervention. Practically this may require a combination of interventions, and at all times subject to the clinical judgment of the treating team** (my emphasis)**:**
>
> …Any steps that are taken that involve moving from one option to another should involve the input of a senior clinician. For the avoidance of doubt, the objective at all times would be **to attempt to obtain WA's consent through gentle persuasion and explanation**, and if necessary with the involvement of his parents.

89. It is important to highlight that restraint of any kind is not considered to be appropriate. The plan provides as follows:

> Physical restraint:
>
> For the avoidance of doubt, WA has requested that use of physical restraint is avoided due to his history of abuse and torture. No physical restraint would be used for any of the below treatments. Use of elastic wrist ties or mittens would also be extremely distressing for him psychologically, and are therefore not to be used.
>
> Chemical restraint:
>
> For the avoidance of doubt long term heavy sedation or general anaesthesia for the purposes of restraint would not be considered appropriate. Sedation would only be used for the alleviation of distress, and not for the purpose of restraint.

90. The plan is divided into four options. The first two options require WA's consent. I do not propose to replicate them in full in this judgment but to highlight their key components. The emphasis throughout is mine. The first two options or any combination of them may require the use of the NG tube currently in situ:

Treatment Option	Detail	Responsibility

Option 1 – Oral intake supported by IV fluids. To engage WA with a feeding regime supported with IV fluids to improve intake and support nutrition and hydration.	**This option would require the full consent and cooperation of WA.** WA has previously intermittently accepted IV fluids Fortisip, yoghurt, some dates and some milk. **In the event of a Court order permitting nutritional support against his wishes, WA will be offered a period of 24 hours to demonstrate that he is able to cooperate and sustain the required feeding regime as an alternative to more invasive (and inherently restrictive) feeding options.** **In the event that WA's nutritional intake remains inadequate even with his cooperation, he may require artificial feeding (see further below) to supplement that intake. Artificial feeding would be more uncomfortable and distressing for WA**.	Administered by nursing staff in coordination with dietician. Supervised by nursing and dietetics teams, under the supervision of medical consultants.
Option 2: Nasogastric (NG) Feeding (with WA's cooperation) To provide liquid food / administer boluses of medication or fluid. NG feeding would be the treatment of choice to supplement oral nutrition on a short to medium term basis. It can be established quickly and standardised preparations of feeding fluid are available for use 24 hours per day. NG feeding is safe and reversible.	This option would require the full consent and cooperation of WA. **Should attempts to administer oral feeding (option 1) be unsuccessful within the first 24 hours, NG feeding should be offered either to supplement WA's intake or as an alternative to oral feeding.** If WA is co-operating with NG feeding bolus feeds should be provided twice per day. NG feeding has been attempted during WA's inpatient admission following concerted episodes of persuasion. WA has indicated that he would not actively resist or "fight" insertion of a NG tube in the event of a court order requiring it. NG insertion was noted to be distressing for WA due to his past history of torture and abuse. Insertion of NG tubes can be supported by sedation with benzodiazepine (or equivalent sedating drug) on a temporary, short-lived basis. After careful consideration, the	Insertion and NG management by nursing staff; supervision of feeding by dietetics team.

	treating clinicians consider that if required, an NG tube could be inserted under IV sedation with consent, to minimize distress and psychological ramifications to WA given his history of torture and abuse. The NG tube placement should be inserted and confirmed as per trust protocol (CP6a Enteral Nutrition Policy Version 9 April 2018). Ongoing monitoring of the NG tube will also follow standard procedure set out in this policy. Once position of the NG tube is confirmed, NG feeding may commence. Enteral feeding pump should be primed with prescribed feed and commenced at the rate outlined in feeding regimen (see appendix 2). Feed to be run over 20 hours with a 4-hour rest to ensure requirements are met, whilst minimizing complications e.g. abdominal pain, hypoglycaemia. Enteral feed would be commenced at a low rate and volume increased slowly over 5 days to meet requirements whilst reducing the risk of refeeding syndrome, as outlined in appendix 2. WA will require daily refeeding blood tests and either IV pabrinex or NG/PO thiamine and forceval (vitamins) to aid absorption of nutrients and to help prevent consequences of refeeding syndrome. The NG feed will be regularly reviewed and adjusted depending on tolerance, electrolytes and weight. Should the tube become unintentionally dislodged or removed by WA, nursing staff will engage with WA to re-site the tube. It is considered likely that the nutritional support with NG tube feeding may be required for a period of up to 6 weeks to increase his nutritional status to a safe level before being removed / withdrawn. It cannot be	

	considered a permanent or long-term intervention to supplement nutrition. Options to optimize WA's concordance with NG feeding include; • Daily support to WA from the Mental Health Liaison Team (MHLT) • Weekly support via telephone from his Community support worker NJ • His foster mother should be present when the NGT is inserted as this will help manage his distress • The MHLT will support his foster mother who may be able to encourage him to keep in in place. • Offer 2-5mg diazepam TDS (prn up to 20mg/day) In relation to the possible use of a bridle, unless he fully consented and cooperated with the use of the bridle it would not be used. If following explanation WA was willing to fully cooperate, we propose the potential to deploy a 'nasal bridle' fixation at the point of NG tube insertion, which connects the tube directly to the structures of the nasopharynx rendering painless self-removal of the NG tube impossible. The Trust policy would be followed on the care and management of bridles. NG tubes fitted with bridle devices can however be removed. Magnet connection inside the nasopharynx aims to be the point of break, but NG tubes affixed with bridles have been removed previously by patients able to overcome a significant pain threshold. In these instances, trauma to the posterior nasal septum can be seen to varying degrees. This could cause bleeding, pain and discomfort. It would also render repeated NG tube insertion	

	challenging or impossible. WA has expressed concerns that a nasal bridle would risk pain, discomfort and a degree of restriction which he would not find acceptable. This would require further assessment of his perceptions and wishes around a proposed bridle at the time of decision. To prevent removal of NG tube fixed with bridle, WA could be offered 2-5mg diazepam TDS (prn up to 20mg/day) to help with distress or discomfort. This would not however be expected to render him unconscious or physically incapable of removing the NG tube should he decide to do so. Small dose lorazepam or equivalent sedative could be offered to manage outbursts of distress. • 1st line 2-5mg diazepam PO/NG max 20mg/day including regular • 2nd line 25mg promethazine PO/NG max 100mg/day • 3rd line if oral medications not appropriate 1-2.5mg IM/IV midazolam max 5mg/day +/- 25mg IM/IV promethazine max 100mg/day.	
Option 3: NG feeding with sedation for management of distress (without WA's consent)	**If WA is unable to complete his oral diet and he does not consent to accepting NG feeding voluntarily but indicates he will not physically resist and the treatment does not result in distress that cannot be adequately be managed by light sedation, , insertion and maintenance of NG feeding will be considered.** For the avoidance of doubt, no physical restraint would be used. The least restrictive option would be to provide a single	Administered by nursing and dietetics teams, under the supervision of medical and psychiatric consultants.

	daily feed in the evening so that he is not sedated during the day time. This would also maximize his ability to engage in any therapeutic work during the day. However a single daily feed should only be maintained if he is maintaining his blood sugars above 3.5. His blood sugars will need to be tested on a 4 hourly basis. If this is not possible two feed per day will be required. Options to help manage anxiety and distress and to facilitate concordance with NG insertion include; • 1st line medication- PO/NG lorazepam 1mg max 4mg/day +/- PO/NG promethazine 25mg max 100mg/day • 2nd line if not accepting PO- 1-2mg IV/IM midazolam max 5mg/day +/- 25mg promethazine IV/IM • 1:1 support and observation by either a Registered Mental Health Nurse to prepare him for the NG insertion. Ideally this RMN will have spent some time building his trust and has rapport with him. • His foster mother DT should be present when the NGT is inserted as this will help manage his distress • WA has requested that use of physical restraint is avoided due to his history of abuse and torture. This is extremely likely to traumatize him further. The clinical ward team would monitor WA closely following the administration of sedation, continuous oxygen saturation	

	and respiratory rate monitoring for the initial period followed by at 15 min observations for 2 hours. When the sedation wears off, attempts would be made to calm WA with supervision provided by RMN to attempt maintenance of NG tube in situ for feeding. This would allow communication of the benefits of NG feeding, ensuring the tube is secured in a comfortable position as possible and using distraction / relaxation techniques as appropriate.	

91. It is not necessary to set out Option 4 which relates entirely to palliative care, in the event that WA suffered catastrophic medical complications.

92. The plan requires an evaluation of WA's best interests which falls to be determined in accordance with Section 4 MCA 2005, the relevant parts of which provide:

> *"(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*
>
> *(3) He must consider—*
> *(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and*
> *(b) if it appears likely that he will, when that is likely to be.*
> *…*
> *(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*
>
> *(6) He must consider, so far as is reasonably ascertainable—*
> *(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),*
> *(b) the beliefs and values that would be likely to influence his decision if he had capacity, and*
> *(c) the other factors that he would be likely to consider if he were able to do so.*

> *(7) He must take into account, if it is practicable and appropriate to consult them, the views of— . . .*
> *(b) anyone engaged in caring for the person or interested in his welfare, . . .*
> *as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)."*

93. Subsection 6, above, is in concentrated focus in this case. WA has expressed himself in language which not only conveys the depth of his wishes and feelings but also communicates them in terms which permit of absolutely no ambiguity. He has consistently maintained that he has *"had enough"* and does not wish to live with his identity compromised by his bureaucratically assigned date of birth. I have concluded that the rigidity of his thinking in this regard has occluded his capacity, in the sense that its overwhelming importance to him inhibits his ability to weigh the advantages and disadvantages of his decision to reject CANH. This does not mean that I regard WA's reasoning as delusional or even as flawed. On the contrary, I have little difficulty in understanding how important a date of birth is to a young man deracinated from his family and homeland and whose autonomy was, during the course of his childhood and adolescence, crushed by sadistic torture and subsequent sexual abuse. The fact that this aspect of WA's thinking overwhelms all else does not mean that it does not weigh heavily in the balance when determining where his best interests lie. I consider a decision such as this that is, of itself, entirely coherent, clearly articulated and consistently expressed, requires to be given very great weight. In many circumstances such a decision, even where P is incapacitous, would nonetheless be determinative. It is also important to emphasise that all the evidence indicates that the question of capacity is finely balanced. This serves to reinforce the weight to be given to WA's consistently expressed views.

94. In this case there are other factors which also require to be addressed. Firstly, WA has, as discussed above, developed a pattern of passive submission in circumstances where, intellectually and emotionally, he may be profoundly resistant. This strategy was the only way he could survive his abuse. Were he to articulate opposition to Option 3 of the treatment plan i.e. to say "no", there is a very real danger that any failure to resist on his part might be interpreted as tacit acquiescence. Options 3 specifically contemplates the delivery of nutrition and hydration in the face of verbal refusal but perceived compliance. If WA's failure actively to resist was not, in truth, consent, there is, as I have been told, a real risk of reigniting the trauma of past abuse.

95. In some circumstances a plan predicated on compliance without actual agreement may be entirely legitimate. I think, for example, of transfusion cases where Jehovah's witnesses will often indicate that they will submit to an order of the Court in the face of their religious beliefs. Ms Sutton has collated the various phrases that have been used to try to capture the essence of the Treatment Plan which is intended to communicate with clarity what is expected of those charged with providing treatment. She identifies: "gentle persuasion"; "tacitly compliant"; "passive acceptance"; "tacit cooperation" and "acquiescence". Set out in this way they illustrate the complexity of the challenge to the treating clinicians and nurses, particularly to having regard to WA's background. Moreover, looked at collectively, the phrases reveal themselves to be that which they are i.e. euphemisms for force feeding. A plan which stated specifically that WA will be force fed unless he actively resists would, I suspect,

cause most people to recoil from it. It does not become any less disagreeable when dressed in softer language.

96. I have stripped the language down in this way not to be critical of the doctors or the Trust. I am not intending to be critical in any way, quite the reverse. I recognise that intense effort is being directed towards the preservation of a life which is recognised to be ripe with promise. I have already noted the degree to which this well-mannered, urbane and humorous young man has embedded himself in the affections of the nurses who treat him. But, it must be emphasised that loss of capacity does not override respect for personal autonomy. Protecting the autonomy of the incapacitous is every bit as important as protecting the autonomy of the capacitous.

97. I have observed before, most notably in **M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group [2015] EWCOP 9** that feelings and even strong feelings can often be expressed non-verbally. In fact, I noted in that judgment that feelings can sometimes be communicated, in contra distinction to what is actually said. DT told me in her evidence that there can be times when she considers that WA demonstrates to her both that he understands a proposed treatment and that he does not actively resist it. I took this to mean that this was absent expressed agreement. The reassuring and kindly presence and encouragement of his parents, particularly DT has, I am sure, resulted in WA receiving treatment in which there has been real and nonverbally expressed consent. It is this that the plan has tried to capture.

98. DT also recognises that WA has, in the course of the last few months, reached a tipping point in which he is entirely clear that he can no longer live without the reinstatement of what he is certain is his true date of birth. DT has told me that her son has strong beliefs, sometimes yielding to the countervailing opinions of others but also steadfast and strong when he is convinced that he is in the right. I have no doubt that whilst there is some identifiable hope of his preferred date of birth being restored, DT will be able to encourage him to take on board nutrition in some way. Equally, were hope to fade, I consider that she knows there would be nothing she could do.

99. Accommodating this within a treatment plan is, I have concluded, in the circumstances of this case, an unachievable goal. I found Dr Wild's evidence on the question of WA's best interests to be logically irresistible. The *"narrative therapy"* she recommends is not only intrinsic to achieving improved psychological health for WA, it is also constructs a pathway to capacity, the promotion of which is imposed by the MCA. Given WA's lack of enthusiasm for further therapy, the prospects of his engagement cannot be said to be encouraging. The provision of CANH in the absence of the therapeutic support was described by Dr Cahill as treating the symptoms and not the cause and thus ultimately futile. Dr C went even further, stating that feeding WA against his will, with no psychological therapy, would in fact be antitherapeutic. In other words, it would most likely be harmful. I accept both Dr C's view and Dr Cahill's graphic but, in my judgement accurate, analogy. All this highlights just how important this package of therapeutic care is. If the psychotherapy were to be offered at a time when WA was being fed against his will, I consider that the prospect of his engaging with it is vanishingly remote.

100. Two other features of Dr Wild's evidence are important. She reiterates that what she terms the *"mental defeat"* WA has experienced in the past, may cause him to interpret coercion, persuasion or imposed treatment against his will as effectively abusive. She

highlights the ever-present risk of triggering re-traumatisation. She further posits a situation where WA may not have the insight to recognise that his trauma has been triggered and that even if he did, he may not be able to raise it with the clinicians and communicate his experience.

101. One further factor must be identified. WA told me that he did not think he would physically resist if he was fed against his will because he would not want to risk hurting the nurses. I found his evidence on this point utterly compelling and moving. Despite all that he has experienced WA is the gentlest and most courteous of men.

102. Taking all these factors together I do not consider that Options 3 of the Treatment Plan is viable nor can be said, on a proper construction, to be in WA's best interests. It is fraught with unmanageable and significant risk. Ultimately, it cannot be reconciled, in my judgement, with the protection of WA's autonomy. I consider that every effort should be made, with the parents at the centre of the process, to persuade, cajole and encourage WA to accept nutrition and hydration. Attempts to deploy these techniques should be permitted with far greater persistence than would be considered appropriate in the case of a capacitous adult. I have no doubt that the attempts of persuasion will be delivered in the kindly and sensitive way that is most likely to persuade WA. I make no apologies for repeating that I consider WA has a great deal to offer the world as well as much to receive from it. No effort should be spared in encouraging him to choose life. This said, I have come to the clear view that when WA says no to CANH his refusal should be respected. No must mean no!.

103. In his childhood and adolescence WA encountered the suppression of his autonomy and the corrosion of his identity. If he will forgive me further ad hominem remarks, I would wish to point out to him that he has his very proud Palestinian name, his rich and beautiful language, a faith which sustains and supports him and a family who loves him and claim him as their own. DT told me that there were times when she was not sure whether she was looking after WA or he after her. I also noticed that Mr DT unconsciously used an Arabic expression that he later told me he had learnt from his son. They are manifestly a close and loving family. I am not in a position to reinforce WA's sense of identity in any way, only engagement in the identified psychological therapy will achieve that. I, am, however, able to protect WA's autonomy. In effect, to restore it to him. For all involved in this case the decisions have been difficult and painful. From this point on the decisions will ultimately be taken by WA with the advice and encouragement of his family and the clinicians, but no more than that.