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Case No: 12398359

Neutral Citation Number: [2014] EWCOP 16
COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/07/2014

Before :

MRS JUSTICE PAUFFLEY

Between :

United Lincolnshire Hospitals NHS Trust	<u>Applicant</u>
- and -	
N (by her litigation friend the Official Solicitor)	<u>Respondent</u>

Debra Powell for the Applicant
Nageena Khalique for the Respondent

Hearing dates: 15 July 2014

Judgment Mrs Justice Pauffley :

Introduction and issue

1. On 15 July 2014, I read documents, heard submissions, oral representations from N's former husband and evidence from the jointly instructed independent expert. At the end of the process, there was complete agreement between the parties as to what, in N's best interests, the treating clinicians should and should not be permitted to do. I expressed my complete satisfaction with the course outlined, commenting that Dr Barry Jones, consultant gastroenterologist, had given immensely impressive and utterly compelling evidence. Subsequently, an order was submitted and approval given.
2. This is my judgment, delayed for a few days as the result of commitments to other cases.
3. The central issue is whether it would be lawful and in N's best interests for the Applicant Trust to make further efforts to establish and maintain a method of providing her with artificial nutrition.
4. The application is urgent because N has not been receiving nutrition since 14 June 2014 and is at risk of suffering serious deterioration in her condition.
5. This matter came before Mr Justice Wood in the urgent applications list on Tuesday 8 July 2014, when directions were made providing for, *inter alia*, independent expert gastroenterology evidence and a final hearing on Tuesday 15 July 2014.
6. N is a woman in her early fifties. In June 2013, she suffered a sub-arachnoid haemorrhage. She is in a minimally conscious state (MCS) and lacks capacity to make decisions as to her medical treatment.
7. In mid June 2014, N was admitted to hospital from the care home where she had been living because the PEG tube through which she was fed was no longer in place. Since then, N has been physically resistant to all efforts to re-establish a method of providing her with nutrition. She has pulled out a naso-gastric tube and several cannulae.

Background summary

8. This analysis of the clinical background owes much to the excellent summary comprised within Miss Powell's Position Statement.
9. In June 2013, N suffered a sub-arachnoid haemorrhage (a bleed into the brain as a

result of a burst artery) and developed early hydrocephalus (increased pressure within the brain). As a result, she suffered significant brain damage.

10. A feeding tube known as a RIG (radiologically inserted gastrostomy) was inserted through the anterior abdominal wall directly into the stomach. N repeatedly attempted to pull out the feeding tube and was successful on a number of occasions necessitating its replacement, which was done through the existing track.
11. On 6 November 2013, N was transferred to a specialist Hospital for Neuro-disability, but did not make any neurological recovery. In the discharge letter dated 26 February 2014 it is said that she:
 - i) has severe cognitive communication impairment;
 - ii) has not been able to follow any commands or engage in interaction;
 - iii) is unable to indicate a yes/no or a choice from objects or pictures;
 - iv) has been unable, due to her level of cognitive functioning, to engage in detailed communication assessment and it has not been possible to develop a reliable system of communication;
 - v) has a severe and global cognitive impairment;
 - vi) has been unable to engage with choice making or communicate preferences.
12. N was discharged to a care home where she lived until mid June 2014 when it was noticed that the feeding tube was no longer in place. She was admitted to a local Hospital, managed by the Applicant Trust.
13. On admission, N was frequently resistant to physical interventions including routine observations and personal care – pushing staff away with her left hand, removing blood pressure cuffs, moving her head away and so on. N has little or no sensation or function on her right side as a result of her stroke, but her left arm is fully functional. Although at times she is compliant, in general she continues to resist physical interventions. She does not communicate or respond meaningfully to commands or interactions; she does not indicate choices.
14. N shows no inclination or ability to eat or drink. On 16 June 2014 an unsuccessful attempt was made to re-insert the PEG (percutaneous endoscopic gastrostomy) but the track had healed. It was impossible simply to re-pass the tube through the original track.

15. On 20 June 2014 Dr A, consultant gastroenterologist, attempted to place a PEG tube but, despite heavy sedation, the extent of N's physical resistance meant that it was unsafe to continue and the procedure was abandoned. A further attempt to site a RIG was made on 26 June 2014 with the same outcome. An endeavour was made on the same day to site an intravenous line into one of the large veins of her arm, for the purpose of delivering total parenteral nutrition (TPN), but N pulled it out immediately.
16. Subsequently, on 26 June 2014, a naso-gastric tube was passed under sedation, with a "bridle" attached to the tube to make it more difficult for N to remove it. Nevertheless, she succeeded in removing the NG tube within around 40 minutes by hooking her finger around the tube adjacent to her nose (above the attachment point of the bridle, thereby circumventing its anchoring effect) and removing it from her stomach.
17. On 27 June 2014 an unsuccessful attempt was made to insert a feeding tube under radiological guidance, despite the use of sedation.
18. N has been without nutrition since 14 June 2014. An intravenous line has been placed into her foot, which she cannot reach with her hand, enabling intravenous fluids to be given. N is therefore receiving adequate hydration and, in addition, dextrose solution.
19. She is considered to be unsuitable for the administration of TPN (intravenous nutrition), because this must be done through a large vessel in either the neck or the arm. It is considered very likely or almost certain that she would pull out the line, as occurred on 26 June 2014; this would be potentially hazardous because of a significant bleeding risk. It is not possible for TPN to be administered through the smaller vessels in the foot.
20. On 27 June 2014 N was reviewed by a consultant neurologist, Dr H, who concluded it was very unlikely that there would be significant neurological recovery, the sub-arachnoid haemorrhage having occurred 12 months previously. In his opinion, N's physical resistance to intervention is more likely to be the consequence of an aversion to sensory stimulus than meaningful action because she responds in a similar way to any physical contact on her left side, even light touch.
21. Dr H suggested that if a feeding jejunostomy (a tube inserted into a fistula through the abdominal wall into the jejunum, part of the small intestine) were to be placed on the right side of N's abdomen, she might not be aware of it because of her right sided sensory impairment; and she might be less likely to pull it out.
22. Dr A considered this to be a possible option, but that the chances of N "encountering" the tube with her left hand and pulling it out would be significant – she tends to move her left arm around over her front. If she were to pull it out this could result in small bowel perforation and leakage of feed and intestinal contents into the abdominal cavity, which would be life threatening and very painful.

23. Mr K, consultant surgeon, considers that N's physical resistance practically prohibits the replacement and maintenance of the usual options for artificial feeding, unless N were to be physically restrained or so heavily sedated as to require a lifelong High Dependency Unit bed, which he does not consider to be in her best interests. He is concerned that if N were to pull out the tube inserted by way of jejunostomy there would be a high risk of leakage of bowel content, with consequent peritonitis and life-threatening sepsis. N already has intra-abdominal adhesions, which would increase the risks of surgery somewhat, and has a ventriculoperitoneal (VP) shunt in place (for hydrocephalus) which creates a risk of encephalitis – a severe neurological complication – if there is abdominal infection.
24. Mr K considers the risks entailed by the creation of a surgical jejunostomy “are overwhelming the hoped chance of managing on long term with her parenteral nutrition.” He sought a second opinion from Mr R, consultant general and colorectal surgeon employed by the Trust, who shares Mr K's concerns. On balance, Mr K does not consider it appropriate to attempt jejunostomy.
25. On 2 July 2014 a second gastroenterology opinion was sought from Dr R, consultant gastroenterologist at the Trust. She considered that N is unsuitable for total parenteral nutrition (TPN - intravenous feeding), because she is likely to pull out the line; and that further attempts at a NG tube are unlikely to be successful. If she were to pull out the tube whilst a feed is running there is a risk of aspiration. Dr R considered that a jejunostomy placed on the right side was an option, but that there was still a high risk that N would pull it out, which could have significant consequences. A PEG was also considered possible, but there were similar risks if it was pulled out.
26. A Speech and Language Therapy assessment was conducted on the same day, and it was concluded that N should remain “nil by mouth”.
27. On 7 July 2014 an anaesthetic assessment was conducted by Dr J, consultant anaesthetist, who concluded that N did not present an increased anaesthetic risk above the general population, although he had not been able to assess her airway. He stated that if a PEG insertion was in her best interests then an anaesthetic, preferably inhalational, with spontaneous breathing to assess the airway would be the safest option.
28. On 6 July 2014, it was recorded by a member of nursing staff that N “Appeared distressed as she was wet, now dry. IV paracetamol given as appeared in pain using Abbey pain score.”

Views of N and her family

29. N lived alone. She had a long marriage but was divorced some time ago. She has an adult daughter, D. N's former husband, H, and daughter have been contacted by the Trust and spoken to about N's situation. H attended the hospital on 17 June 2014. He

stated the view of the family is that “this is not a dignified life.” D, who has been abroad, said that she and her family felt that her mother had “always been a private person and would like to be respected for that”, and that the family did not want to put her through unnecessary distress.

30. D has made a statement in which she expresses the view that N would not be comfortable living as she does now and postulates that this may be why she is refusing to have a PEG inserted “if she has any remaining capacity.” She gives evidence of a conversation that she was told her mother had prior to her brain injury with a friend as to their wishes if they had been incapacitated in a road accident. Apparently, both said that they would not like to continue life in a reduced capacity. D states that although this is different, she believes it summarises what her mother’s views would have been.
31. D goes on to say that other members of N’s family agree that N would prefer the dignity of not having the PEG “forced on her”. D believes that her mother has no quality of life and cannot interact with her environment or other people.
32. One of N’s cousins, C, who has been close to and known N all her life provided a short written statement. C says that one of the most distressing things about the current situation is that even when young, N did not enjoy being touched; and so the necessity of having everything done for her, as now, must be intolerable for N. C maintains that to know all the things N used to enjoy are lost to her is very distressing for her family. They would wish that N could find peace, rest and could know she is loved.
33. At the hearing, H addressed me from the well of the court. He re-emphasised that N is a “very private person, that she would not want the PEG forced upon her and that their daughter, D – for whom all of this is so very difficult – had summed things up very well.”

Evidence of the jointly instructed expert

34. Dr Barry Jones is a consultant physician and gastroenterologist. His observations in relation to N are similar to those of Dr H but there are some differences. Dr Jones referred to the GCS score recorded in the notes as 11 (Eye 4; Verbal 1; Motor 6) but questions how this fits with a diagnosis of MCS. He also states that a score of 6 (obeys commands) for the motor responses is “perhaps a little ambitious”.
35. Within his written report, Dr Jones noted that N’s left arm and hand “moved with apparent purpose” when he tried to examine her face and mouth. He describes how she repeatedly pulled the bedclothes over her face and pushed him away.
36. By contrast with Dr H, Dr Jones noted that N’s eyes followed him to the left “but also

surprisingly to the right, given her previous conjugate gaze to the left described in the (specialist neurodisability hospital) notes”. However, like Dr H, he found that N did not smile or register any facial expressions and he was unable to elicit positive or negative responses from her, except for her pushing him away and covering her face with the bedclothes.

37. Whilst Dr Jones acknowledges Dr H’s diagnosis of MCS he formed the opinion that N’s awareness of his presence was recognisable and that she did not want him to examine her. Dr Jones concluded that N appears to be sentient and was able to remove a nasogastric tube and bridle which required a degree of dexterity, effort and determination. He states that “it is possible that despite her severe cognitive impairment as part of her [MCS], she is able to express her refusal of these treatments”. In oral evidence, Dr Jones confirmed his agreement with Dr H’s opinion of N as being in a minimally conscious state.
38. Dr Jones has reviewed the medical records and disagrees with Dr A’s assertion that “gastrostomy tube was pulled out by patient” because he could not find evidence to support this. He notes that the nurses at N’s nursing home replaced the tube successfully following balloon failure on only one occasion and could find no evidence of N pulling out her tube whilst in her nursing home.
39. Furthermore, Dr Jones does not agree with Dr A’s suggestion that N would need perpetual sedation to maintain or allow artificial feeding. He states that this assertion is not supported by the nursing home’s experience of N as the nurses managed for a considerable period of time using distraction techniques.
40. Dr Jones also disagrees with the proposition that N could be comfortable during the final phase of her life with the administration of IV fluids which, he opines will only serve to prolong N’s distress, if any.
41. Finally, Dr Jones agrees with Dr A that if the next procedure (to facilitate artificial feeding) fails, then no further attempts should be made but disagrees with the use of IV fluids if nutritional treatment is not possible.
42. By the time that Dr Jones came to give his oral evidence, shortly before 3pm on 15 July, he had had the opportunity of discussing matters not only with the legal teams and clinicians but also with N’s former husband, H, representing the views of her family including those of her daughter.
43. Dr Jones explained that the overriding question was not just whether a PEG tube with flange positioned on the right hand side of N’s abdomen would work it is whether that would be in her best interests. He referred to “N’s quality of life, to the limitations placed upon her by aphasia (inability to understand and produce speech)” describing that it “would appear to be zero.” Dr Jones said there was “very little evidence she gains pleasure from interaction with others including family members.” There is “just

a possibility she can recognise human contact, but (he) had specifically tested for the primitive grasp reflex and N does not do that.” She had not wanted to hold his hand at all. It is possible, said Dr Jones, that there is “some very minimal level of cognitive function. But if she is able to perceive her present situation, that would make it even more painful. If she cannot, then the result is the same.” Dr Jones’ belief is that to impose a possible feeding treatment regime upon N would not be in her best interests.

44. He also described the perils of re-feeding syndrome at this stage, after N has been without food for 31 days. He described the sudden reintroduction of food to a starving patient as potentially “catastrophic because of enormous metabolic stress. The patient would become extremely agitated and confused.... Control of the condition is indicated by daily blood tests. To obtain blood from N would require restraint by 4 or 5 people.” Dr Jones said he would “not wish to be associated with monitoring which required such a degree of restraint.”
45. He explained that he did not believe feeding “should be reintroduced if monitoring could not be satisfactorily carried out. It would be possible to place a PEG tube under general anaesthetic but monitoring could not occur without severe restraint.” He regarded “continued attempts to feed as futile, as well as burdensome and it would be unkind to impose that upon N.” He added that his understanding from the evidence is that she would not have wanted such a procedure to be tried. “All the information we have, suggests she would not have wished to be kept in this condition.”
46. Dr Jones concluded his evidence by saying that he had “asked himself, what would be achieved by continuing the efforts to reintroduce feeding?” He had concluded that it would be “a perpetuation of a state in which none of us would wish to find ourselves and one which N would not have wished to experience.”
47. On the subject of maintaining the infusion of intra venous fluids through the cannula into N’s foot, Dr Jones said that in his opinion it would be better to withdraw fluids altogether so as to allow N a peaceful and dignified death. If fluid replacement were to continue, survival time would be a lot longer. Sedation would be used in some cases of palliative care. Dr Jones did not believe N would require opiates but would suggest that the palliative care team should “help guide the staff as well as the family.”

The legal framework

48. The legal framework within which this decision is to be made is elaborated with the Position Statements of Miss Powell on behalf of the Trust and Ms Khalique for the Official Solicitor. Again, this part of my judgment relies extensively upon their optimal analyses.
49. Section 1(5) Mental Capacity Act 2005 provides that:

“An act, or decision made, under this Act for or on behalf of the person who lacks capacity must be done, or made, in his best interests.”

50. Section 4 provides guidance as to how decisions are to be made:

“4(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.

(4) He must, so far as is reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(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-

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- (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 ss (6).

...

(10) “Life-sustaining treatment” means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) “Relevant circumstances” are those-

- (a) of which the person making the determination is aware, and
- (b) which it would be reasonable to regard as relevant.”

51. The Mental Capacity Act Code of Practice, issued by the Lord Chancellor under s42(1)(b), to be taken into account by the court under s42(5) as relevant to the questions arising in these proceedings, provides relevant guidance at paragraph 5.31 – 5.33:

“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 a 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.

5.32 As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision maker must consider the range of treatment options available to work out what would be in the person’s best interests. All the factors in the best interests’ checklist should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.

5.33 Importantly, section 4(5) cannot be interpreted to mean that doctors are under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person’s death is foreseen. 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.”

52. There is a strong presumption in favour of the preservation of life, see e.g. In re M (Adult patient) (Minimally conscious state: withdrawal of treatment) [2012] 1 WLR 1653, paras 7, 220, 222. This does not displace the patient’s best interests as the paramount consideration for the court.
53. The court will not order medical treatment to be provided if the clinicians are not willing to offer that treatment on the basis of their clinical judgment (see AVS and a NHS Foundation Trust [2011] EWCA Civ 7, per Lord Justice Ward at para. 35, and Aintree University Hospitals NHS Foundation Trust v David James and others [2013] 3 WLR 1299 para. 18) but the power under s15(1)(c) of the Act to make declarations as to “the lawfulness or otherwise of any act done, or yet to be done, in relation to [the] person” enables the court to rule on the lawfulness of the proposed withholding of life-sustaining treatment, in this case further attempts at provision of a method of

providing artificial nutrition.

54. Lady Hale, giving the judgment of the Court in Aintree, said [para19-22]:

“However, any treatment which the doctors do decide to give must be lawful. As Lord Browne-Wilkinson put it in Airedale NHS Trust v Bland [1993] AC 789, which concerned the withdrawal of artificial hydration and nutrition from a man in a persistent vegetative state, “... the correct answer to the present case depends upon the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If in the circumstances they have no right to continue artificial feeding, they cannot be in breach of any duty by ceasing to provide such feeding” (p883). Generally, it is the patient’s consent which makes invasive treatment lawful. ...

20. ... the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it.

21. In Bland, Lord Goff (with whose judgment Lord Keith and Lord Lowry expressly agreed) pointed out that “the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of treatment” (p868). To the same effect was Lord Browne-Wilkinson, at p884:

“... the critical decision to be made is whether it is in the best interests of Anthony Bland to continue the invasive medical care involved in artificial feeding. The question is not the same as, ‘Is it in Anthony Bland’s best interests that he should die?’ The latter question assumes that it is lawful to perpetuate life: but such perpetuation of life can only be achieved if it is lawful to continue to invade the bodily integrity of the patient by invasive medical care.”

22. Hence the focus is on whether it is in the patient’s best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it.”

55. The test to be applied by the court is whether the treatment would be in the patient’s best interests. Whilst –

“the starting point is a strong presumption that it is in a person’s best interests to stay alive ... this is not absolute. There are cases where it will not be in a patient’s best interests to receive life-sustaining treatment”. [para 35]

“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 to put themselves in the place of the individual patient and ask what his attitude is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be.”
[para39]

56. In so doing the Court must consider whether the treatment in issue would be futile in the sense of being ineffective or being of no benefit to the patient. The treatment does not have to be likely to cure or palliate the underlying condition or return the patient to full or reasonable health, rather it should be capable of allowing the resumption of a quality of life which the patient would regard as worthwhile. The Court must weigh the burdens of the treatment against the benefits of continued existence and give appropriate weight to N’s family life [para 40].

The balance sheet exercise

57. It is, of course, incumbent upon me to apply a balance sheet approach, as in Re M (*supra*) at para.s 246-248.
58. The advantages of attempting to re-insert a PEG would be that –
- i) if successful, N would be kept alive for many more years and may be able to return to a relatively comfortable state at her care home where she was excellently cared for;
 - ii) she would be spared the effect of non-provision of artificial nutrition and hydration as well as the associated risk of developing bed sores, tissue breakdown, iron and vitamin deficiencies;
 - iii) she would continue to experience life as a sensate being with a degree of awareness of herself and her environment;
 - iv) other medications, anti epileptics and anti depressants could be reinstated and would be likely to be beneficial;
 - v) she may gain pleasure from things which one of her care home carers (albeit that her close family members believe differently) consider she has derived pleasure – company, some television programmes, some physical touch;

59. The advantages of not attempting to re-insert a PEG are that –
- i) although her life will be cut short, perhaps by many years, she would be freed from the further pain and distress she may be suffering;
 - ii) she would be spared further invasive surgical procedures as well as needle insertion for general anaesthetic, under severe restraint, with attendant trauma;
 - iii) she would not be subjected to the associated risks of insertion of a PEG or re-feeding syndrome;
 - iv) she would not be subject to a need for repeated restraint to achieve the required monitoring or repeated or prolonged sedation;
 - v) she would be freed from the indignities of her current situation;
 - vi) being allowed to die would accord with N’s reported comment made prior to her brain injury as to her wishes and feelings should she be incapacitated in the context of a road traffic accident;
 - vii) by authorising the non-replacement of the PEG tube or other methods of providing artificial nutrition and thereby allowing N to “die with dignity”, the court would be acting in accordance with what family members believe she would have wanted.
60. There is no evidence that N has made any advance refusal of treatment directly applicable to the circumstances in which she now finds herself, namely in a minimally conscious state facing the prospect of no further provision of nutrition. However, what the views of the patient might be, and what the views of the family are, are highly material factors when considering best interests, although not determinative: An NHS Trust v (1) A and (2) SA [2006] LS Law Medical 29, per Waller LJ at para 59.

Discussion and conclusion

61. As I said at the end of the hearing, I was left in no doubt as to where N’s best interests lie as the result of my overall survey of the evidence coupled, importantly, by the oral testimony of Dr Jones.
62. I considered him to be an exceptionally impressive witness upon whose evidence and opinion it is entirely appropriate to rely. He is not only a gastroenterologist of very great experience and expertise he is also an individual of enormous compassion and

great insight into the human condition. His evidence touched upon a wide range of issues including, as it was bound to do, the consequences for N of withdrawing fluids. When he left the witness box to resume his seat at the back of court, Dr Jones spoke briefly to H who had sat listening intently throughout.

63. Though I was unable to hear exactly what Dr Jones had said, not least because it was a whispered conversation, the sense conveyed was clear. Dr Jones was empathising with H, expressing compassion and the hope that his evidence had not added to H's understandable distress.
64. Ultimately, the outcome of these proceedings is clear. There could be no issue as to capacity. Upon the basis of a united medical opinion, it is sufficient for me to say that as the result of N's disabilities consequent upon her brain injury, she lacks capacity within the meaning of s.2 of the Mental Capacity Act to litigate and also to make decisions about her medical treatment, particularly the administration of artificial nutrition. Moreover, there is no likelihood of her regaining capacity in the future.
65. I also find that it is not in N's best interests that a further attempt be made to insert a PEG or to secure other means of providing her with artificial nutrition. I am entirely satisfied that the entire range of treatment options has been carefully and diligently considered by the team of clinicians at the local hospital as well as by Dr Jones. I have considered and weighed all factors in the best interests' checklist as well as the available information about N's views in relation to life sustaining treatment. Similarly, I have taken account of the wishes and feelings of N's close family members.
66. The critical decision is whether it is in N's best interests to continue invasive, risk laden, medical care as would be involved in a further attempt at artificial feeding. I am utterly convinced that it would not. Accordingly, I declare that it is lawful and in her best interests for the clinicians (a) not to make any further attempt to secure a means of providing artificial nutrition; (b) to withdraw the provision of intravenous fluids and dextrose; and (c) to provide such palliative care and related treatment (including pain relief) as considered appropriate to ensure she suffers the least distress and retains the greatest dignity until such time as her life comes to an end.