Neutral Citation Number: [2016] EWCOP 53

Case No: COP 12942115

IN THE COURT OF PROTECTION

IN THE MATTER OF S21A OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF PAUL BRIGGS

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/12/2016

Before :

MR JUSTICE CHARLES

- -

BETWEEN:

LINDSEY BRIGGS

Applicant

-and-

(1) PAUL BRIGGS
(By his litigation friend, the Official Solicitor)
(2) THE WALTON CENTRE NHS FOUNDATION TRUST
(3) WIRRAL CLINICAL COMMISSIONING GROUP

Respondents

- -
- -

Victoria Butler-Cole (instructed by Irwin Mitchell LLP) for Mrs Briggs
Vikram Sachdeva QC instructed by the Official Solicitor as Mr Briggs' litigation friend
Conrad Hallin (instructed by Hill Dickinson LLP) for the Walton Centre and the WCCG

Hearing dates 28 November to 1 December 2016

- -

Judgment Approved

Charles J :

This judgment is a public document. The hearing was held in public and no reporting restriction order has been made.

OVERVIEW

(1) This case raises issues of life and death and so vitally important principles and strongly held views. The decision I have to make is whether a part of the current treatment of Mr Paul Briggs, namely clinically assisted nutrition and hydration (CANH), should be continued. Mr Briggs is in a minimally conscious state (MCS). This is the result of the serious and permanent brain damage he suffered as the victim of a traffic accident on 3 July 2015. He is not in a permanent vegetative state (PVS)

and so the approach taken by the House of Lords in *Airedale NHS Trust v Bland* [1993] AC 789 does not apply to him. That approach was that life-prolonging treatment of a patient in PVS is properly regarded as being, in medical terms, useless or futile (see Lord Goff at 869 B/F) or that life-prolonging treatment confers no benefit on the patient (see Lord Keith at 859D) and so in reality the decision whether to continue life-prolonging treatment does not involve a weighing operation of competing factors (see Lord Goff at 869A).

(2) The life of Mr Paul Briggs does confer benefits and has value. This means that this case raises fundamental issues relating to the protection of persons who are extremely vulnerable and who have not previously made and now cannot make valid and applicable decisions for themselves.

(3) The default position for such 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 (here CANH).

(4) Subject to further clarification of the alternative care and treatment plans the consequence of my decision will be that either:

a. Mr Briggs will move to a rehabilitation unit for further assessment and treatment, which will include CANH, with the possibility that his degree of consciousness will improve, or

b. Mr Briggs will move to a hospice where he will receive palliative care, his CANH treatment will not be continued and as a result he will die.

(5) The key issues are whether on the application of the best interests test set by the Mental Capacity Act 2005 (the MCA) to all the circumstances of this case:

a. I can, and

b. if I can, whether I should

make a welfare order based on a care and treatment plan that Mr Briggs will move to a hospice on the basis that I have concluded that this is what Mr Briggs would have wanted if he now had the capacity to make the decision himself about his future treatment and care.

(6) *Conclusion.* I fully acknowledge and accept that Mr Briggs' life has value. I also recognise his natural instinct of survival.

(7) However, 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.

(8) *Discussion.* The fundamental principles that are engaged are, on the one side, the sanctity of life and so the very strong but not absolute presumption in favour of continuing Mr Briggs' life and, on the other side, the principle of self-determination.

(9) Mr Briggs is clinically stable and not presently in need of invasive treatment and so the central issue is the assessment of the weight to be given to and so of the balance to be struck between giving effect to (a) the very strong presumption in favour of the

preservation of life, and (b) the right to self-determination of a person who before he or she loses capacity has not made a valid advance decision (or a lasting power of attorney) applicable to the carrying out or continuance of the relevant treatment (here CANH).

(10) A relevant factor in the rival arguments is the effect of a valid and applicable advance decision applicable to the refusal of the relevant treatment (here CANH). It was common ground before me that if Mr Briggs had made such an advance decision it would have been decisive and so no decision would have had to have been made under the MCA best interests test. I agree.

(11) This effect of a valid and applicable advance decision is an example of a situation when the principle of self-determination has precedence over the very strong presumption of preserving life. It also shows that a decision made by a person when he or she had capacity to make it can dictate what happens to them at a later time when they lack capacity.

(12) Evidence and argument was heard over 4 days. Unusually, the proceedings were brought by Mr Briggs' wife rather than the NHS Trust and the Wirral Commissioning Group (the WCCG) who sensibly and compassionately discontinued the proceedings they had brought. A consequence of that procedural approach was that Mrs Briggs was eligible for non-means tested legal aid. This had the important result that she was able to instruct solicitors and counsel without bearing all or a part of the costs herself from savings. It is quite clear that without that representation it would have been almost impossible for Mrs Briggs to advance the arguments and evidence of Mr Briggs' family. Even if she had been emotionally able to do that the Court would not have received the assistance it has through her representation and the hearing would have been much longer. So in this case the alarming result of the situation that arose before Mr Justice Baker in *Re M (Adult Patient)(Minimally Conscious State: Withdrawal of Treatment)* [2012] 1 WLR 1653 of public funding not being provided to the family did not arise. I refer to significant public funding problems relating to proceedings that concern people who lack capacity in my judgment on the preliminary issue in this case (reported at [2016] COP 48).

(13) I mention the length of the hearing and representation because none of the earlier decisions makers had that luxury of time and the considerable assistance given by the counsel who were instructed by the parties. My focus, and that of the parties, was on the present and not the history of the decision making.

(14) It was argued by the NHS Trust and the WCCG that s. 4(5) of the MCA precluded me from making an order that had the result that the CANH treatment was not continued. I do not agree.

(15) If I rejected that argument based on s. 4(5) of the MCA, it was common and correct ground that my decision must be based on the application of the best interests test set by the MCA (see in particular ss. 1(5) and 4). That test has been considered by the Supreme Court in *Aintree University Hospitals NHS Trust v James* [2014] AC 509. The one and unanimous judgment of the Supreme Court was handed down by Baroness Hale. It addresses the relevant history and so legal background to the MCA and it gives important guidance on the approach to be taken to the application of the MCA.

(16) It is the application of the MCA, rather than the common law and inherent jurisdiction set out in the earlier cases that matters. However, the earlier cases remain relevant because they provide useful analyses of the relevant issues and form a central part of

the background to the recommendations of the Law Commission on which the MCA was based and so to the MCA.

(17) The earlier cases show, and this is confirmed in the *Aintree Hospitals* case at paragraph 22 that the question that the court must ask itself is:

> *Whether it is in Mr Briggs' best interests for it to give consent to his treatment by CANH?*

If it concludes that the answer is "yes" the court gives that consent. If it concludes that it is "no" then:

> *The court will not be able to give its consent on behalf of Mr Briggs and it will follow that it will be lawful to withhold or withdraw it.*

This definition of the question is crucially important and is derived from the earlier case law, in particular the *Bland* case, where Lord Goff explained at 868 A/D that the correct formulation of the question is crucial and that it is not whether it is in the best interests of the patient that he should die but whether it is in the best interests of the patient that his life should be prolonged by the relevant treatment and care (here CANH).

(18) That definition of the question dictates the analysis and effect of the answer, and so the legality of the continuation or withdrawal of life-sustaining treatment for persons who lack the relevant capacity to make their own decisions on whether they should or should not consent to such treatment. It reflects the doctrine of "double effect" which excludes the purpose of causing death and allows death to be knowingly caused as a side-effect and so draws a distinction between the intention underlying an action on the one hand and the consequences that are foreseen but are not intended on the other.

(19) This analysis of the issue and the effect of the answer means that this is not an assisted dying or euthanasia case.

(20) The MCA best interests test is not a substituted decision test, although it includes elements of that approach (see the *Aintree Hospitals* case at [2014] AC 501 paragraph 24) and it is one that falls to be applied now, and so in respect of Mr Briggs after his accident.

(21) The Supreme Court confirm in the *Aintree Hospitals* case that the MCA best interests test is to be applied in a holistic way (see [2014] AC 591 at paragraphs 26 and 39), and that the MCA, and a holistic application of the best interests test, are concerned with enabling the court to do for the patient what he could do for himself if he had full capacity (see the *Aintree Hospitals* case at paragraphs 1 and 18).

(22) However, as is clear from the MCA, the Supreme Court is not saying that a conclusion on what the relevant patient would have wanted and done if of full capacity is determinative of his best interests having regard to all relevant circumstances. Indeed, there are many examples of cases in which it has been concluded that this is not the case.

(23) This leads to the question whether on a holistic approach the court can conclude that it is in the best interests of a person who lacks capacity that life-sustaining treatment should not be carried out or continued on them on the basis of **the weight** it gives to a conclusion that this is what he or she would have wanted and decided if they had not specifically considered the position they are now in following their loss of capacity or factors relating to it.

(24) In my view the answer is that the court can do this. And so the issue is whether I should do so having weighed all the relevant and competing circumstances.

(25) As shown by earlier cases before and after the MCA came into effect, I stress that important and weighty factors in the consideration of whether the court can conclude what treatment the relevant person would have wanted and, if it can, the weight to be given to that conclusion in all the circumstances of the case including in particular the very strong presumption in favour of preserving a life that has value, include

(A) Points that the relevant patient has not considered or been able to consider:

a. the question whether he or she would wish such treatment to be withdrawn if they were in MCS, or

b. what medical opinion considered to be his or her best case scenario following their emergence from MCS, and the prospects of that happening, or

c. the impact of a serious brain injury on his or her likely feelings about a life with very severe physical handicaps, or

d. the possibility or likelihood of the suffering pain if CANH is withdrawn

(B) The clinical stability of the patient and so for example the absence of undue pain or discomfort and an acute illness and the existence of a settled or happy presentation.

(26) *The oral evidence.* I heard oral evidence from members of Mr Briggs' family and a colleague, two members of his treating team (a consultant in neurological rehabilitation who had been responsible for the care of Mr Briggs since 26 January 2016 (Dr. Mahendran), and a specialist speech and language therapist (rehabilitation) (Ms Ankers) who is a SMART assessor and carried out a SMART assessment on Mr Briggs between 23 February and 17 March 2016, and a consultant in neurorehabilitation since 1998 (Dr Walton) who was one of the Royal College of Physicians working party whose report in 2013 is titled "Prolonged disorders of the consciousness – National Clinical Guidelines" (the "2013 National Clinical Guidelines"). Dr Walton had given a second opinion and then was also instructed to give expert evidence in these proceedings. I take this opportunity to pay tribute to all the witnesses. They all gave that evidence honestly and helpfully. It was clear that the rival views held by the family and the treating team were strongly held and flowed from their respective involvements in the life of, and so their personal and professional relationships with, Mr Briggs.

(27) The involvement of the treating team has been with Mr Briggs after the accident and so a Mr Briggs who has serious and permanent brain injuries and who is and will be totally dependent on others for his day to day physical care. And so with the severely disabled Mr Briggs who lacks capacity. The involvement of his family and friends has been with Mr Briggs as a wife, mother, brother, sister in law and friend before and after his accident and so with the loving husband, father, son and brother, popular colleague and very physically active outdoors Mr Briggs as well as with the seriously disabled Mr Briggs who now lacks capacity.

(28) These different involvements have clear links to the central clash of principles that arises in this case, namely:

a. The sanctity of life and so the preservation and prolongation of Mr Briggs' life. Understandably this lies at the heart of the strongly held and consistent view of Mr Briggs' treating consultant that it would be unethical to withdraw his treatment by CANH and so deprive him of the opportunity of leading a life of value.

b. Autonomy and so self-determination which enables a person with capacity to do so to refuse life-sustaining treatment and so as a consequence to choose the side-effect of death. That decision can be made for any reason including that in existing or defined future circumstances that person considers that his or her life is or would be intolerable or has or would have no value and so not worth living. Understandably, the family want to achieve the result that they are convinced Mr Briggs would have wanted and decided on.

(29) *The medical evidence and my findings.* There was a significant amount of common ground recorded in a statement provided to me by counsel for the parties after the hearing. What follows reflects that common ground and sets out my findings and conclusions on the disputed matters.

(30) *The diagnosis.* As a result of his accident Mr Briggs sustained multiple injuries including traumatic brain injury. CT scans in June and September 2016 reflect the evolution of consequences of diffuse axonal injury (disruption to the neurological pathways within the brain that can be associated with poor neurological recovery) with development of cerebral atrophy (loss of brain volume). His current clinical presentation is in keeping with the changes seen on the CT brain scans. So there is clear physical evidence of extensive brain damage. And it is common ground that the average life expectancy for patients with such severe brain injury is of 9 to 10 years if appropriate medical treatment is given.

(31) It is common ground that Mr Briggs is in a MCS. The main utility of a SMART test is to distinguish between whether a person is in a MCS or a PVS. Mr Briggs' was the subject of a SMART assessment over the period 23 February to 17 March 2016 which diagnosed that he was in MCS minus. Clinical observation of Mr Briggs since then supports the view that he has demonstrated some progress and so it is common ground that he has improved since the SMART assessment but remains in MCS. There are degrees of MCS and he is categorised as being between MCS minus (the closest to VS) and MCS plus (the nearest to emergence from MCS). It was accepted in oral evidence that some of the observations relied on to show his improvement need to be treated with caution. For example, because the appropriate process was not fully observed and because use of a switch reliant on motor function (a process being used to assess the giving of "yes" and "no" answers) is unlikely to be reliable because of unpredictability of dystonia and increased tone and Mr Briggs may find it difficult to press a switch twice consecutively to indicate a "no" response. Also, if the helpful graph produced by Ms Ankers from the medical notes is continued to the date of the hearing (as she helpfully did during her evidence) earlier higher performance is not repeated.

(32) However, it remained common ground and I accept that (a) there has been some improvement since the SMART assessment, (b) the assessment of Mr Briggs' level of awareness has been carried out under sub-optimal conditions on his acute ward as regards environment (and so, for example, noise and other distractions), positioning and some medication, and (c) a specialist rehabilitation ward will provide the right setting for managing these matters effectively.

(33) He has Paroxysmal Sympathetic Hyperactivity (PSH) which occurs in patients with severe brain injury and has had episodes that are typical of PSH with generalised dystonia (PAID syndrome). These episodes include groaning, back arching, sweating, rapid heart rate and mildly raised temperature. Episodes reported by staff as "severe extensor spasms and back arching" and observed by Dr Walton are dystonic in nature, have a different pattern of movement to spasticity and do not always respond to anti-spasticity medication. His dystonic episodes are likely to be painful and can have various triggers including problems with his bowels. Some of them include vocalisation which could either signal distress or be due to involvement of laryngeal muscles with laryngeal dystonia. Clearly, these episodes are or would be distressing for family and friends who observe them.

(34) His PAID syndrome is being treated by medication and an important aspect of his further assessment and treatment is the control and reduction of these episodes. Not only are they likely to be painful so long as they continue they are exhausting and so have a significant impact on his ability to show awareness.

(35) *The recommendation, prognosis and the best case scenario.* I base this on the written joint statement of Dr Mahendran and Dr Walton and their other written and oral evidence.

(36) They both recommend that Mr Briggs should be moved to a specialist rehabilitation unit because after 6 months there it will be possible to give a clearer neurological diagnosis and prognosis. The range of that diagnosis and prognosis and so Mr Briggs' "best case scenario" is important and I return to it.

(37) In her statements and oral evidence Dr Mahendran was at times more optimistic than Dr Walton but very properly she accepted that parts of her statements were in language that gave a misleading impression of the degree of improvement demonstrated by Mr Briggs since his SMART assessment. In her second statement she referred to "medical best interests" and orally she confirmed that her view throughout has been and that it would not be ethical to withdraw CANH from a patient in MCS because of the possibility of improvement or continued improvement. When asked her position in respect of someone who is diagnosed as being in a permanent MCS because it has lasted 5 years she replied that it would not be her decision and she would seek advice.

(38) As the treating consultant on an acute ward this ethical and/or medical best interests approach by Dr Mahendran to the preservation of life is understandable and commendable. I accept the submission made on behalf of the NHS Trust and the WCCG that it is difficult to see how the treating team could have adopted a different approach to that which they have taken since Mr Briggs' accident. I do so because of the difficulty they face in assessing and giving weight to the evidence about what Mr Briggs would have wanted. Hindsight is a wonderful thing and with it I suspect that improvements could have been made by both sides in the communications between the treating team and the family but this would not have altered their rival positions.

(39) The two neuro-rehabilitation consultants agree that any improvement in Mr Briggs' level of consciousness will not be accompanied by a significant increase in his physical abilities. Accordingly, it was common ground that his best case scenario is one in which he will remain severely physically impaired and so dependent on others for all of his physical care. It was not asserted that a possibility that this would not be the case should be recognised and taken into account.

(40) They agree that in assessing improvement in Mr Briggs' awareness the relevant period starts when his intensive care ended in October 2015. They also agree, as is indicated

by the 2013 National Clinical Guidelines, that for some patients in MCS a longer period than the six months of rehabilitation they recommend are beneficial to optimise functional abilities. But both gave evidence of what they considered to be Mr Briggs' "best case scenario".

(41) Dr Walton was asked questions with a view to her accepting that it was too early to form and so give a view on Mr Briggs' best case scenario. She did not accept this. Dr Mahendran was not asked questions about this to the same extent but confirmed her agreement with the joint statement describing the best case scenario and said that unless Mr Briggs has the recommended assessment for six months he would not have been given the chance for his maximum potential to be explored. Dr Walton echoed this by saying in her view it was too early to make the decision on whether Mr Briggs' treatment by CANH should be continued.

(42) It was not put to them that their view on the best case scenario was inconsistent with the 2013 National Clinical Guidelines, which are sometimes relied on to support the possibility of emergence from a MCS within 5 years of its onset. It was pointed out to me in submission that the 2013 National Guidelines make it clear that whilst duration is clearly important a number of other factors may also influence the point at which emergence from MCS may be regarded as "highly improbable" which include the patient's general condition and any other comorbidities, the nature and severity of the injury, the level of responsiveness and the observed trajectory of improving responsiveness over a period of months (or, in some cases, years) and that the combination of these factors is likely to have stronger predictive value than a simple time-limit.

(43) The recommendation is based on the proposition that I accept that after 6 months in an improved and appropriate setting a better informed neurological diagnosis and prognosis could be given.

(44) It is however also based on a possibility that at the end of that six months that it will be clearer that Mr Briggs has improved to, or is likely or more likely to improve, to MCS plus or to emerge from MCS. I find that this use of the description was that it was not possible to say one way or the other whether such an improvement would occur. Dr Walton would not put percentages on it.

(45) The best case scenario was formulated and described as a best case scenario, and so it was put forward on the premise that after 6 months on a rehabilitation unit the better informed diagnosis would be that Mr Briggs had emerged from MCS or it was likely that he would do so and the better informed prognosis would be based on the conclusion

(46) Dr Walton was asked questions with a view to her accepting that there was a real possibility that the best case scenario underestimated Mr Briggs' ability to recover and improve and that after rehabilitation the best case scenario may be better. She did not accept this and in my view was clear that it was based on the premise referred to in the last paragraph and on that premise it was realistic.

(47) Unsurprisingly, Dr Walton said that she could not totally exclude the possibility that the best case scenario was an underestimate or an underestimate in some respects. But she gave this evidence in the sense that a better overall scenario was sufficiently unlikely to make it unrealistic and that in respect of some aspects of it (e.g. that Mr Briggs might regain capacity to make complex decisions) not impossible only in the sense that one should never say never.

(48) In the joint statement the best case scenario was stated to be that Mr Briggs may be able in the future to display emotion and answer simple questions about his feelings. This description was clarified in oral evidence. That clarification was to the effect that Mr Briggs may be able in the future to make a choice between whether he wore a red or a blue T-shirt but would not be able to make a choice as to what he wore by reference to, for example, the fact that it would be cold outside and he should wear a jumper.

(49) As to the display of emotion Dr Walton explained that people with brain injuries such as those suffered by Mr Briggs demonstrate pleasure from things such as watching football on the television or listening to music or on social occasions or on seeing people and that, as the result of their brain injury is that they no longer appreciate the impact of their physical and other disabilities and so how they were before their injuries occurred, they do not demonstrate distress or depression and appear content and happy.

(50) It was put to her that there was a possibility of Mr Briggs improving to a state of awareness that enabled him to make his own decisions about his treatment or to take an active part in the decisions made concerning the bringing up of his daughter and family life. These were not accepted save in the sense that one can never say never. Some of this questioning was put in general terms about people with brain damage with the result that the answers did not found a different conclusion on the degree of possibility advanced and accepted by Dr Walton.

(51) I adopt the statement agreed between counsel which describes the best case scenario as follows:

> The most realistic best case scenario for Paul Briggs is that he will:
>
> a. Not regain mental capacity to make complex decisions
> b. Be happy
> c. Be able to make simple choices such as what colour t-shirt to wear
> d. Have some pleasurable experiences
> e. Have some painful experiences
> f. Be unlikely to be depressed given his lack of insight, including lack of insight as to his pre-injury life, and pre-injury expressed wishes and feelings
> g. Not have any improvement in his physical abilities
> h. Be severely physically impaired
> i. Need 24 hour care and be dependent on others for all activities of daily living
> j. Have some improvement in his medical symptoms with the optimal treatment that would be available, including PSH, dystonia, groaning and contractures.

(52) Dr Walton also gave evidence, which I accept, that if the CANH treatment is not continued Mr Briggs' PSH and dystonia will need careful and expert management if his pain and distress is to be minimised through sedation and other palliative care.

(53) *The evidence of the family, friends and colleagues.* I discuss this in more detail later.

(54) I put to counsel for the Respondents, and it was accepted by them, that this oral evidence was given with dignity, courage and conspicuous honesty. Mr Briggs' wife and mother were recalled after the medical evidence to answer questions based on Dr Walton's evidence that as a result of his brain damage Mr Briggs was now a different person and in line with other patients Dr Walton has experience of would, on the best case scenario, probably demonstrate pleasure and so happiness and would not be depressed. Neither of them tried to embellish their views and again gave evidence from the heart as to what they thought their husband and son would have wanted. It was clear that although the brain damage he has suffered means that Mr Briggs is now

a changed person who will not have insight into his previous wishes, beliefs and values and the impact on him of his brain and other injuries they still regard him as the husband, father and son they loved and love.

(55) I confirmed with counsel that in my view they were right not to cross examine on the basis that any family member, colleague or friend had any motivation (e.g. financial) other than what they thought Mr Briggs would want. It was clear that they did not.

(56) Understandably, they had all reached their common view by routes that differed and so, for example, placed different emphasis on aspects of Mr Briggs' condition and prospects after his accident and had reached their conclusions over different timescales.

(57) The written and in particular the oral evidence of the family, colleagues and friends, the manner in which it was given and their closeness to Mr Briggs convinced me in the sense that I am sure (and so have no reasonable doubt) that if Mr Briggs could make the decision himself having regard to the evidence and argument I have heard about his best case scenario and the rival contentions as to what is now in his best interests he would conclude that he would not give consent to his treatment by CANH.

(58) Many individuals and families would reach different conclusions about what they want themselves and about what their family member would want. At the heart of any application of the MCA is the relevant patient, here Mr Briggs. His family and those who know him best gave evidence with courage, dignity and at considerable emotional cost to themselves that has convinced me of what Mr Briggs would have wanted and would have decided was in his best interests if he had been sitting in my chair during the hearing.

REASONING

Introduction

1. On 3 July 2015 Mr Briggs was the victim of a road traffic accident when he was travelling to work on his motorcycle. As a result of that accident he suffered serious brain and other multiple injuries and was rendered unconscious. He is now in a minimally conscious state (MCS) and does not have the capacity to make decisions relating to his care and treatment or to communicate his wishes and feelings to others. His survival has been and is dependent on the package of the care and treatment he has received and is receiving in hospital. That care and treatment includes clinically assisted nutrition and hydration (CANH). If that treatment is no longer given he would die.

2. His present placement is at a hospital within the Walton Centre NHS Foundation Trust (the Walton Centre) and he has been there since 22 January 2016.

3. On the day of his accident he was admitted to one of the Liverpool Major Trauma Centres (Aintree University Hospital and The Walton Centre, which are on the same hospital site) where he was treated in the intensive care unit. He was later transferred to Arrowe Park Hospital on the Wirral for ongoing treatment. He required intensive care until October 2015 (and so for 4 to 5 months).

4. It is now just over 10 months since Mr Briggs was transferred to his present placement and just under 17 months since he suffered his accident. His treating team are of the opinion that Mr Briggs should be transferred to a rehabilitation unit where his progress can be monitored and promoted. His wife and family are of the opinion

that Mr Briggs should be transferred to a hospice where he will no longer be treated by the receipt of CANH and will receive care directed to enabling him to die as painlessly and as peacefully as possible.

5. The consequence of my decision will be whether Mr Briggs continues to live or die. It is therefore inevitable that the issues engage strongly held views on the relevant moral, ethical and philosophical issues. My focus is on the approach to be taken applying the law of England and Wales and so the Mental Capacity Act 2005 (the MCA).

6. The test I must apply is not whether Mr Briggs should live or die. Rather it is whether it is in his best interests for him to continue to receive life-sustaining medical treatment that he could have refused consent to if he had the capacity to make that decision.

7. That does not mean that the consequences of the best interests test that I have to apply are not relevant. Obviously they are.

Background law and principles

8. The law makes a clear and important distinction between:

   i) the continued lawfulness of life-sustaining treatment, and

   ii) the taking of a positive step (by act or omission) to cause the death of another person.

9. It also makes a clear and important distinction between:

   i) the ability of an individual to refuse life-sustaining treatment, and

   ii) the ability of an individual to order a doctor to treat him in a particular way.

10. These distinctions found conclusions reached in cases before the enactment of the MCA and are reflected in its terms. Applying them to treatment of the kind in issue in this case, the law provides that patients who have capacity to make decisions about their medical treatment, and so who are in a position to exercise their autonomy or right of self-determination in respect of their treatment:

    i) can choose to have or not to have the medical treatment that is on offer to them,

    ii) that choice determines the lawfulness of the treatment, and so

    iii) if those patients agree to have it the treatment is lawful, but

    iv) if they refuse to have it the treatment is unlawful and cannot be given lawfully however strongly the treating doctors or others may disagree with that patient's choice.

    Their determinative choice represents their conclusion on what promotes their own best interests.

11. So no doctor or court can imposes a course of treatment on such a patient who can take into account what he or she wants to in making the relevant choice and so make decisions that others may feel are bad, unethical, or not in their best interests that will

mean that an existing medical problem will cause their death or result in their unborn child not being born alive.

12. However, such patients cannot compel or obtain an order from a court that compels a doctor to treat them in a particular way.

13. So, if Mr Briggs had the capacity to make the choice on whether his treatment by way of CANH should continue, the law provides that he can make it and so, in this case, if he had capacity he could have chosen whether he is treated at a rehabilitation centre or a hospice.

14. How does the law deal with patients, like Mr Briggs, who lack the capacity to make that choice?

15. Parliament has provided for this in the MCA. In doing so it clearly had regard to the pre-existing law relating to:

    i) patients who have capacity, and

    ii) the giving or refusal of consent to treatment (including life-sustaining treatment) to patients who do not have the relevant capacity to make the choice themselves.

16. The MCA sets out the principles that apply for its purposes as follows:

> **1 The principles**
> (1) The following principles apply for the purposes of this Act.
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
> (3) -----
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

17. Section 62 of the MCA provides that:

> **62 Scope of the Act**
> For the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961 (assisting suicide).

18. The most relevant provisions of the MCA relating to what persons with capacity can do to determine what should happen to or in respect of them if and after they no longer have the capacity to make the relevant decisions themselves, are:

> **9 Lasting powers of attorney**
> (1) A lasting power of attorney is a power of attorney under which the donor ('P') confers on the donee (or donees) authority to make decisions about all or any of the following –
> (a) P's personal welfare or specified matters concerning P's personal welfare, and
> (b) P's property and affairs or specified matters concerning P's property and

affairs,
and which includes authority to make such decisions in circumstances where P no longer has capacity.
(2) A lasting power of attorney is not created unless –
(a) section 10 is complied with,
(b) an instrument conferring authority of the kind mentioned in subsection (1) is made and registered in accordance with Schedule 1, and
(c) at the time when P executes the instrument, P has reached 18 and has capacity to execute it.
(3) An instrument which –
(a) purports to create a lasting power of attorney, but
(b) does not comply with this section, section 10 or Schedule 1,
confers no authority.
(4) The authority conferred by a lasting power of attorney is subject to –
(a) the provisions of this Act and, in particular, sections 1 (the principles) and 4 (best interests), and
(b) any conditions or restrictions specified in the instrument.

11 Lasting powers of attorney: restrictions
(1) A lasting power of attorney does not authorise the donee (or, if more than one, any of them) to do an act that is intended to restrain P, unless three conditions are satisfied.
(2) The first condition is that P lacks, or the donee reasonably believes that P lacks, capacity in relation to the matter in question.
(3) The second is that the donee reasonably believes that it is necessary to do the act in order to prevent harm to P.
(4) The third is that the act is a proportionate response to –
(a) the likelihood of P's suffering harm, and
(b) the seriousness of that harm.
(5) For the purposes of this section, the donee restrains P if he –
(a) uses, or threatens to use, force to secure the doing of an act which P resists, or
(b) restricts P's liberty of movement, whether or not P resists,
or if he authorises another person to do any of those things.
(6) …
(7) Where a lasting power of attorney authorises the donee (or, if more than one, any of them) to make decisions about P's personal welfare, the authority –
(a) does not extend to making such decisions in circumstances other than those where P lacks, or the donee reasonably believes that P lacks, capacity,
(b) is subject to sections 24 to 26 (advance decisions to refuse treatment), and
(c) extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care for P.
(8) But subsection (7)(c) –
(a) does not authorise the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the instrument contains express provision to that effect, and
(b) is subject to any conditions or restrictions in the instrument.

Advance decisions to refuse treatment
24 Advance decisions to refuse treatment: general
(1) 'Advance decision' means a decision made by a person ('P'), after he has reached 18 and when he has capacity to do so, that if –
(a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and
(b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment,
the specified treatment is not to be carried out or continued.
(2) For the purposes of subsection (1)(a), a decision may be regarded as specifying a treatment or circumstances even though expressed in layman's terms.

(3) P may withdraw or alter an advance decision at any time when he has capacity to do so.
(4) A withdrawal (including a partial withdrawal) need not be in writing.
(5) An alteration of an advance decision need not be in writing (unless section 25(5) applies in relation to the decision resulting from the alteration).

25 Validity and applicability of advance decisions
(1) An advance decision does not affect the liability which a person may incur for carrying out or continuing a treatment in relation to P unless the decision is at the material time –
(a) valid, and
(b) applicable to the treatment.
(2) An advance decision is not valid if P –
(a) has withdrawn the decision at a time when he had capacity to do so,
(b) has, under a lasting power of attorney created after the advance decision was made, conferred authority on the donee (or, if more than one, any of them) to give or refuse consent to the treatment to which the advance decision relates, or
(c) has done anything else clearly inconsistent with the advance decision remaining his fixed decision.
(3) An advance decision is not applicable to the treatment in question if at the material time P has capacity to give or refuse consent to it.
(4) An advance decision is not applicable to the treatment in question if –
(a) that treatment is not the treatment specified in the advance decision,
(b) any circumstances specified in the advance decision are absent, or
(c) there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.
(5) An advance decision is not applicable to life-sustaining treatment unless –
(a) the decision is verified by a statement by P to the effect that it is to apply to that treatment even if life is at risk, and
(b) the decision and statement comply with subsection (6).
(6) A decision or statement complies with this subsection only if –
(a) it is in writing,
(b) it is signed by P or by another person in P's presence and by P's direction,
(c) the signature is made or acknowledged by P in the presence of a witness, and
(d) the witness signs it, or acknowledges his signature, in P's presence.
(7) The existence of any lasting power of attorney other than one of a description mentioned in subsection (2)(b) does not prevent the advance decision from being regarded as valid and applicable.

26 Effect of advance decisions
(1) If P has made an advance decision which is –
(a) valid, and
(b) applicable to a treatment,
the decision has effect as if he had made it, and had had capacity to make it, at the time when the question arises whether the treatment should be carried out or continued.
(2) A person does not incur liability for carrying out or continuing the treatment unless, at the time, he is satisfied that an advance decision exists which is valid and applicable to the treatment.
(3) A person does not incur liability for the consequences of withholding or withdrawing a treatment from P if, at the time, he reasonably believes that an advance decision exists which is valid and applicable to the treatment.
(4) The court may make a declaration as to whether an advance decision –
(a) exists;
(b) is valid;
(c) is applicable to a treatment.
(5) Nothing in an apparent advance decision stops a person –

(a) providing life-sustaining treatment, or
(b) doing any act he reasonably believes to be necessary to prevent a serious deterioration in P's condition,
while a decision as respects any relevant issue is sought from the court.

19. As appears from those sections:

i) the fact that a patient is making what others think is an unwise decision does not of itself mean that he or she lacks the capacity to make that decision, although the reasons for and against the decision may have an impact on the issue of capacity (see s.1(4) of the MCA),

ii) persons who have capacity can make advance decisions refusing consent to the carrying out or continuation of identified treatment on them in identified circumstances (including life-sustaining treatment) at a time when they lack capacity. A valid advance decision has effect as if the person making it had capacity and made the same decision refusing consent when the question arises whether the treatment should be carried out or continued (see ss. 24 to 26 of the MCA). This is a clear recognition of the right of self-determination and the point that the sanctity of life is not an absolute principle, and

iii) persons who have capacity may make lasting powers of attorney that empower the donee(s) of the power to make a decision on their behalf (see ss. 9 to 12 of the MCA), including decisions to refuse life-sustaining treatment. If they do so, the authority conferred on the donee(s) is subject to the principles of the MCA (in particular its principles and the best interests test) and any conditions or restrictions specified in the instrument (see ss. 9(4) and 11(8)).

20. *Advance decisions.* It has been said (see *Re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2012] 1 WLR 1653 at paragraph 226) that the MCA provides stringent conditions that have to be complied with in respect of an advance decision relating to life-sustaining treatment. In my view this is overstating what is provided. The decision has to be accompanied by a statement that it is to apply even if life is at risk and has to be made in writing and witnessed. What is not provided is that the person making it has have any particular knowledge or have had any particular advice. In that context what is provided is less stringent than what the common law requires for the signing of a bank guarantee.

21. Importantly, the advance decision also has to identify with clarity the treatment to which, and the circumstances in which, it is to apply which go a long way to identifying what the person who has made it has considered and taken into account.

22. A safety net is provided by both s. 25(2)(c) and s. 25(3). Section 25(2)(c) does not specify whether to qualify the inconsistent act must take place when the person has capacity. Section 25(3) provides a test in fairly general terms. But it seems to me that an interpretation of these safety nets based on the sanctity of life or anything else (e.g. the detail of prognosis and alternatives at the time when the question about the treatment arises) that sets a low threshold to rendering an advance decision invalid or inapplicable would run counter to the enabling intention of ss. 24 to 26 of the MCA. In any event, if those provisions did found the view that an advance decision was invalid or inapplicable, and so a best interests test became determinative, I consider that the court would have to take into account the impact of that removal of that person's right of self- determination that he or she has sought to exercise by making an advance decision.

23. *Lasting powers of attorney.* By making a lasting power of attorney the person is choosing to give a person they trust the power and authority to make the relevant decision. In many ways the formalities and requirements for a valid and effective lasting power of attorney are more stringent than those for an advance decision (see Schedule 1 and the Regulations (SI 2007 No 1253).

24. This is not the place to discuss either:

    i) the weight to be given to "conditions or restrictions specified in the instrument" and the application of the principles of the MCA and the bests interests test, or

    ii) what is required to found a "reasonable belief" for the purposes of s. 4(9), or

    iii) the extent of the restriction relating to restraining P (as defined) having regard to the approach taken in *Cheshire West* to what constitutes a deprivation of liberty (which, save in defined circumstances is not authorised by the MCA – see s. 4A).

25. However, in this context and that of the application of ss. 5 and 6 of the MCA, the generally accepted approach is that the "reasonable belief" test is objective and that any deprivation of liberty is rendered lawful separately from the relevant treatment which can be lawful as a consequence of an advance decision, a decision by a donee of a lasting power or attorney, s. 5 of the MCA or a welfare order of the COP (see my approach on the preliminary issue in this case reported at [2016] EWCOP 48).

26. The relevance for present purposes of the provisions relating to lasting powers of attorney is that they provide strong support for the view that Parliament was intending to enable decisions, including those on life-sustaining treatment, to be made by persons (donees) who an individual with capacity (P) authorised to make them. Those donees can include persons who are chosen because of their close knowledge of P's wishes, feelings, beliefs and values and the trust P has in them to do in future circumstances for P what he or she would have done but cannot do for themselves.

27. This enabling approach to lasting powers of attorney is supported by the point made by Nugee J in *Miles and Beattie v the Public Guardian* [2015] EWHC 2960 (CH); [2015] COPLR 676 at paragraph 19 where he said:

> --- it does seem to me that it is right that the Act should be construed in a way which gives as much flexibility to donors to set out how they wish their affairs to be dealt with as possible, the Act being intended to give autonomy to those who are in a position where they can foresee that they may in the future lack capacity to specify who it is that they wish to act for their affairs

28. *Comment on these enabling provisions.* The sections relating to advance decisions and lasting powers of attorney are directed to enabling people with the relevant capacity to make choices refusing a wide range of future treatment (including life-sustaining treatment), or to giving donee(s) of a lasting power of attorney power to give or refuse consent to refuse any such treatment, at a time when the donors lack capacity and when, because of brain or other injuries, they may be very different and have very different perspectives on a whole range of issues including the quality of their life.

29. In the case of an advance decision the individual is enabled to assess and decide what he or she wants when they are and those close to them are, or can be, in very different

circumstances. In the case of a lasting power of attorney the individual can include conditions or restrictions relating to the authority of the donee(s).

30. This ability to dictate (or impose conditions or restrictions in respect of) decisions about life-sustaining treatment recognises that the right to self-determination can dictate future decisions or steps to be taken in the future.

31. In determining what is to happen to, or in respect of, them in the future individuals need to predict what they would want in future circumstances. In making that decision individuals will not know what they will actually feel or want and so have to predict it. To make that prediction they will take into account a range of factors relating to their beliefs, values, lifestyle, wishes and feelings. That is not an easy task for them and their personal history, character, wishes, feelings, belief and values will be central to their performance of it.

32. They may decide not to make the future decision themselves but give someone else the authority to make it on their behalf. The donee(s) will be making a decision for the donor in light of the circumstances that exist at the time and with their knowledge of what the donor would have wanted them to do.

33. The most relevant provisions of the MCA when a person lacks capacity are:

> **4 Best interests**
> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of –
> (a) the person's age or appearance, or
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
> (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 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,
> (c) any donee of a lasting power of attorney granted by the person, and
> (d) any deputy appointed for the person by the court,
> as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
> (8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which –

(a) are exercisable under a lasting power of attorney, or
(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.
(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.

5 Acts in connection with care or treatment
(1) If a person ('D') does an act in connection with the care or treatment of another person ('P'), the act is one to which this section applies if –
(a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and
(b) when doing the act, D reasonably believes –
(i) that P lacks capacity in relation to the matter, and
(ii) that it will be in P's best interests for the act to be done.
(2) D does not incur any liability in relation to the act that he would not have incurred if P –
(a) had had capacity to consent in relation to the matter, and
(b) had consented to D's doing the act.
(3) Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.
(4) Nothing in this section affects the operation of sections 24 to 26 (advance decisions to refuse treatment).

6 Section 5 acts: limitations
(1) If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied.
(2) The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.
(3) The second is that the act is a proportionate response to –
(a) the likelihood of P's suffering harm, and
(b) the seriousness of that harm.
(4) For the purposes of this section D restrains P if he –
(a) uses, or threatens to use, force to secure the doing of an act which P resists, or
(b) restricts P's liberty of movement, whether or not P resists.
(5) …
(6) Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by –
(a) a donee of a lasting power of attorney granted by P, or
(b) a deputy appointed for P by the court.
(7) But nothing in subsection (6) stops a person –
(a) providing life-sustaining treatment, or
(b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition,
while a decision as respects any relevant issue is sought from the court.

General powers of the court and appointment of deputies
15 Power to make declarations
(1) The court may make declarations as to –
(a) whether a person has or lacks capacity to make a decision specified in the declaration;
(b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;

(c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.
(2) 'Act' includes an omission and a course of conduct.

16 Powers to make decisions and appoint deputies: general
(1) This section applies if a person ('P') lacks capacity in relation to a matter or matters concerning –
(a) P's personal welfare, or
(b) P's property and affairs.
(2) The court may –
(a) by making an order, make the decision or decisions on P's behalf in relation to the matter or matters, or
(b) appoint a person (a 'deputy') to make decisions on P's behalf in relation to the matter or matters.
(3) The powers of the court under this section are subject to the provisions of this Act and, in particular, to sections 1 (the principles) and 4 (best interests).
(4) ---
(5) ---
(6) Without prejudice to section 4, the court may make the order, give the directions or make the appointment on such terms as it considers are in P's best interests, even though no application is before the court for an order, directions or an appointment on those terms.
(7) ---
(8) ---

34. As appears from those sections, if in the exercise of their right of self-determination a person has made a valid and effective advance decision or lasting power of attorney about whether or not to refuse consent to the carrying out or continuation of identified treatment in identified circumstances, the MCA provides that:

i) a person (D) can make decisions as to the giving and the withdrawal of treatment to a person who lacks capacity (P) if D reasonably believes that it will be in P's best interests for the act (namely the carrying out or continuation of treatment) to be done, and

ii) D is protected from any liability for that act that he would not have incurred if P had had capacity and had consented to the act (and so the giving or continuation of treatment - see s. 5 of the MCA).

35. That protection from liability is founded on and limited by the lawful authority that P could have given in accordance with the criminal and civil law by the exercise of his or her right of self-determination.

36. Life-sustaining treatment is not excluded from the acts that s. 5 of the MCA provides that D can do in respect of the care or treatment of P without incurring liability. So, s. 5 can be relied on in respect of the carrying out, continuation, commencement or termination of acts relating to life-sustaining treatment. (In the case of Mr Briggs this would be the case for his treating team if no order of the court was sought before the present "do not resuscitate" and "do not return to intensive care" instructions decided on by his treating team are carried out).

37. Life-sustaining treatment is mentioned in respect of exceptions to both the limitations imposed by s. 6 on the protection given by s. 5 and the prohibition imposed by s. 4A on depriving a person of his liberty.

38. Section 5 also provides that it does not affect the operation of advance decisions to refuse treatment.

39. Sections 5 and 6 are a key part of the MCA. They are directed to enabling decisions makers on the ground to make a wide range of decisions relating to acts in connection with P's care or treatment. This is why the permission of the court is generally required to bring proceedings about an issue covered by s. 5.

40. If those on the ground obtain the permission of the court to bring proceedings relating to the care or treatment of P the court can make declarations, appoint a health and welfare deputy or make welfare orders (see ss. 15 and 16 of the MCA).

41. However, the court cannot empower a deputy to refuse consent to the carrying out or continuation of life sustaining-treatment (see s. 20(5) of the MCA). The court must make any such decision itself and does so by making a welfare order under s. 16(2)(a) of the MCA that provides that by making such an order the court makes the decision on behalf of P. The court can also make a declaration based on the effect of that order and has sometimes made declarations based on its best interests decision although in my view that is not the appropriate approach under the MCA (see *Re MN* [2015] EWCA Civ 411 at paragraphs 87 to 91).

42. The effect of a welfare order is that the best interests decision on which it is founded has the effect that a decision in exercise of the right of self-determination would have had so, and in line with s. 5 of the MCA, the protection it provides from liability reflects the lawful authority that P could have given in accordance with the criminal and civil law by the exercise of his or her right of self-determination.

The making of a best interests decision by a decision maker (including the court) under the MCA in respect of life-sustaining treatment

43. In contrast to an individual when he or she is making an advance decision or a lasting power of attorney and so predicting and deciding what they will want to happen in the future, the court is making its decision on someone's behalf (see s. 16(2)(a) of the MCA) when that person (P) lacks capacity and is, or may be, in very different circumstances to those he or she enjoyed earlier in their lives and so, for example, before they were the victims of an accident that has caused significant and continuing brain and other injuries.

44. The test is now a statutory test and the factors in s. 4 of the MCA are not given any priority. Of key importance in this case is s. 4(6) and so the weight to be given (with my emphasis on parts of the language) so far *as is reasonably ascertainable* to:

    iv) Mr Briggs' *past and present* wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

    v) Mr Briggs' beliefs and values that would be likely to influence his decision *if he had capacity*, and

    vi) the other factors that Mr Briggs would be likely to consider *if he were able to do so.*

45. Before any of these matters can be taken into account they must be "*reasonably ascertainable"* and the influence of Mr Briggs' beliefs and values is to be assessed on the premise that he *had capacity* now and, in my view, the influence of the other factors he would be likely to consider is assessed *if he were able to do so* now, and so on the same basis.

46. The sub-section clearly introduces a number of "what if" issues and assessments. An obvious problem set by s. 4(6) is how the decision maker is to determine the existence

of, and then the weight to be given to, the past and present matters it refers to at a time when P cannot (or cannot clearly) communicate and explain either:

vii) what he or she used to wish and feel and how they would have applied their beliefs, values and other factors they thought were relevant,

viii) what he or she now wishes and feels or how they would now take their past beliefs and values and other relevant factors into account if they were able to do so.

47. As to the past a decision maker can gather and consider evidence of what the relevant person has said and done when he or she had capacity and was able to make their own decisions.

48. A court can if necessary make binding findings of fact and it carries out the weighing exercise required by the MCA with the benefit of hearing evidence that is tested and argument. As a consequence, it is likely to be in a better position to determine the existence of, and the weight to be given to, the matters set out in s. 4(6) of the MCA that are based on the past when P had capacity than, for example, treating doctors are. So, if P's family are asserting that they favour a different conclusion to that reached by the medical team, it is likely that in many cases to be reasonable if not inevitable for doctors to give great and probably determinative weight to medical and ethical issues in their exercise of the MCA best interests test pending the resolution of the existence of the matters in s. 4(6) and the weight to be given to them by a court.

49. As to the present what the relevant person says, does, demonstrates and communicates about the matters referred to in s. 4(6) has to be assessed against the background that he or she does not have the capacity to make the relevant decision and so to weigh those matters with other relevant factors.

50. The sanctity of life is a factor within s. 4(6) and a relevant circumstance within s. 4(2). As is the basic instinct to survive. However, in my view care must be taken not to assume that a particular P would, if able to, give them particular weight or regard them as determinative now that he or she is in different circumstances. To do so would run counter to the "past and present" approach required by the sub-section and the clear recognition by the MCA that some people would predict and provide that life-sustaining treatment should not be given or continued in the circumstances that now exist for them.

51. In the case of someone in the position of Mr Briggs a central problem is that the points that on his best case scenario:

ix) found or are likely to found the result that his demeanour, behaviour and limited communication demonstrate pleasure, happiness or contentment and do not demonstrate distress or depression, namely his brain damage and its impact on what he appreciates and processes, also means

x) that he may not be able to formulate wishes and

xi) have the result that he cannot identify and weigh beliefs, values and factors he would take into account now if he had capacity and so determine and communicate what his wishes are now having regard to them.

52. So, for example, it is not correct to assume that because a P, and others in an equivalent position, demonstrate contentment and happiness that their present wishes or feelings are that they wish to, and so if they had capacity to do so they would now

consent to life-sustaining treatment. Although the demonstration of these matters is a pointer to what they now wish and in particular to what they now feel it seems to me that they also have, and generally will have greater, relevance to the establishment of the point that their lives have real value, and so the weight to be given to the preservation of those lives.

53. In this context it must be remembered that:

xii) issues relating to life-sustaining treatment are intensely personal,

xiii) a fundamental principle is that a person with capacity can make decisions that determine what is to happen to them in the future and so "an earlier self can bind a future and different self" with the result that the principle of self-determination outweighs the sanctity of life, and so

xiv) if persons who do not have the relevant capacity (Ps) are treated as individuals, just as in the case of individuals who consider whether or not to make an advance decision concerning the giving of life-sustaining treatment based on their own predictions and assessments, in the circumstances that exist for them some Ps would, if they were able to, consent to life-sustaining treatment and others would not.

54. It is confirmed by the Supreme Court in the *Aintree Hospitals* case, which concerned life-sustaining treatment that the correct approach to the application of the MCA and its best interests test is to see P as an individual and consider what P would have done if he or she had capacity. Paragraphs 1, 18, 24 and 26 of the judgment of the Supreme Court state:

> 1. --- [The MCA] provides for decisions to be made on behalf of people who are unable to make decisions for themselves. Everyone who makes a decision under the Act must do so in the best interests of the person concerned.
>
> 18. --- [The MCA] is concerned with enabling the court to do for the patient what he could do for himself if of full capacity ---
>
> 24. --- This is, as the Explanatory Notes to the Bill made clear, still a "best interests" rather than a "substituted judgement" test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie. To take a simple example, cannot be in the best interest to give the patient food which he does not like when other equally nutritious food is available.
>
> 26. Beyond this emphasis on the need to see the patient as an individual, with his own values, likes and dislikes, and consider his interests in a holistic way, the Act gives no further guidance. ---

55. The Supreme Court in the *Aintree Hospitals* case also make it clear that a holistic approach is to be taken to the application of the MCA and its best interests test, see paragraph 26 cited above, and paragraph 39 which draws together other points made in the judgment in the following terms (with my emphasis):

> 39. The most that can be said, therefore, is that in considering the best interests of *this particular patient at this particular time*, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and

> its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; *they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be*; and they must consult others who are looking after him or interested in his welfare, *in particular for their view on what his attitude would be.*

56. In my view, the factors that will give indications as to what the individual P wants include the interests of other people who P would have been likely to take into account and so, for example, many if not most Ps when they had capacity would have taken into account their relationships with others (e.g. spouse and children), how they think they their children should be parented and the impact on those closest to them of what they decide to do.

57. Pausing there, it is clear and important to stress that a conclusion on what P would have done is not determinative of the MCA best interests test and so, by stating that the MCA enables the court to do for the patient what he could do for himself if of full capacity, the Supreme Court is not saying that a conclusion on what the patient would have done is decisive. The test is not a "what P would have done test", it is a best interests test and so a test that requires the decision maker to perform a weighing or balancing exercise between a range of divergent and competing factors.

58. In that exercise the force, clarity or certainty of conclusions that found competing factors will affect the weight to be given to them and that weighing exercise is not a linear or binary exercise.

59. The approach of the Supreme Court shows that the paragraphs in the judgment of HH Judge Hazel Marshall QC in *Re S and Another (Protected Persons)* [2010] 1 WLR 1082 cited by Hayden J at paragraph 27 of his judgment in *Re N* [2016] COPLR 88) are correct and so support the view that P is at the very centre of the decision-making process. I gratefully adopt this citation which was directed to a very different type of case but in my view it applies to all applications of the best interests test. It is:

> 55. In my judgment it is the inescapable conclusion from the stress laid on these matters in the 2005 Act that the views and wishes of P in regard to decisions made on his behalf are to carry great weight. What, after all, is the point of taking great trouble to ascertain or deduce P's views, and to encourage P to be involved in the decision-making process, unless the objective is to try to achieve the outcome which P wants or prefers, even if he does not have the capacity to achieve it for himself?
>
> 56. The 2005 Act does not, of course, say that P's wishes are to be paramount, nor does it lay down any express presumption in favour of implementing them if they can be ascertained. Indeed the paramount objective is that of P's "best interests". However, by giving such prominence to the above matters, the Act does, in my judgment, recognise that having his views and wishes taken into account and respected is a very significant aspect of P's best interests. Due regard should therefore be paid to this recognition when doing the weighing exercise of determining what is in P's best interest in all the relevant circumstances, including those wishes.

60. The weight to be given to a conclusion on what P would have done for himself or herself in the past or in the present if P was able to make the decision will be very fact sensitive. For example:

xv) P's history may show that he or she has made a series of damaging investment or lifestyle decisions and so although if they had capacity they would be likely to do so again the court (or other decision maker) can conclude that it would not be in their best interests for such a decision to be made on their behalf,

xvi) it is not uncommon that what P would have wanted and would now want is not an available option,

xvii) it is not uncommon that very understandable expressions of present wishes and feelings "I want to go home" would not be made if P was able to weigh the existing competing factors by reference to P's beliefs and values, and in any event are not in P's best interests, although current expressions of wish can inform which of available alternatives has the best chance of being successfully implemented,

xviii) the point that an individual and a court cannot compel a doctor to give certain types of treatment is a factor in cases relating to life-sustaining and other treatment (as an individual can only exercise his or her right of self-determination between available choices), and

xix) the existence of clinical conditions, physical illness and the types of life-sustaining treatment (e.g. resuscitation or treatment in intensive care) and the pain or loss of dignity they cause can be highly relevant factors in reaching a conclusion contrary to the evidence of P's family that P would have wished treatment to continue (see for example *NHS Trust v VT* [2014] COPLR 44, a decision of Hayden J).

61. In such cases it can be said that the court is not enabling P to do want he could and would do for himself or herself if of full capacity.

62. But, in my view when the magnetic factors engage the fundamental and intensely personal competing principles of the sanctity of life and of self-determination which an individual with capacity can lawfully resolve and determine by giving or refusing consent to available treatment regimes:

xx) the decision maker and so a judge must be wary of giving weight to what he thinks is prudent or what he would want for himself or his family, or what he thinks most people would or should want, and

xxi) if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life.

63. In paragraph 35 of the judgment in the *Aintree Hospitals* case the Supreme Court sate:

> 35. The authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive. As Sir Thomas Bingham MR said in the Court of Appeal in *Bland's* case [1993] AC 789, 808, "A profound respect for the sanctity of human life is embedded in our law and our moral philosophy". Nevertheless, they are also all agreed that this is not an absolute. There are cases where it will not be in a patient's best interest to receive life-sustaining treatment.

64. So, that strong presumption sets the default position and a starting point to the required process of reasoning but, as I have already said, it does not dictate what the relevant person's attitude (wishes and feelings) are now or were in the past.

65. Also, in my view care must be taken not to take that presumption into account cumulatively in the reasoning process and so in the ascertainment of what P would have wanted now and decided now if of full capacity and the weight to be given to that conclusion as a free standing issue (e.g. because there is no evidence that P considered certain issues), and then again in the ultimate balancing act.

66. The test or issue is not whether the relevant person would have made a valid advance decision that the proposed life-sustaining treatment should not be carried out or continued in the existing circumstances if he or she had addressed that issue when they had capacity. However, if the court was of the view that he or she would not have done so I have not thought of a basis on which it could be concluded that the strong presumption in favour of preserving life could be outweighed by a view based on what P would have done.

67. Also, if the court was to find that the relevant person would have made such an advance decision that would be relevant to, but not determinative of, what his or her attitude (wishes and feelings) would now be and so the decision they would make now, if they were able to do so. This is because that decision could not have been made in light of the evidence and argument put before the court. And unless there was evidence that the relevant person had considered and decided to make an advance decision in terms that were known (so, as mentioned in argument if Mr Briggs had had his accident travelling to sign an applicable advance decision) it is unlikely that there would be evidence about a detailed consideration of the factors that the relevant person would have had regard to in making that choice.

68. It was submitted by counsel for the NHS Trust and WCCG that the fact that a person had not made an applicable advance decision was an indication that he or she would not have done so if they had thought about it and that such inaction indicated a decision or wish that life-sustaining should be carried out. This was in effect a submission that it is only when a person has made a decision that, if it had been signed, would have been valid and applicable under ss. 24 to 26 of the MCA that the court can conclude that the giving or continuation of life-sustaining treatment is not in P's best interests simply on the basis that this is what P would have chosen for himself or herself. I say "simply" to make clear that as is apparent from the "do not resuscitate" and "do not return to intensive care decisions" that have been made by the treating team in respect of Mr Briggs that the submission was not directed to those and similar circumstances. I do not agree.

69. My disagreement is founded on the point that the MCA requires a holistic and enabling approach and in my view this means that the court can and should take a realistic approach to the way in which people conduct their lives and make their decisions and so:

xxii) firstly make findings on the evidence relating to the matters set out in s. 4(6) on the attitude and approach of the relevant individual when he or she had capacity to the fundamental and deeply personal principles now at stake relating to the giving or continuance of life-sustaining treatment, and then

xxiii) apply those findings to the relevant circumstances in which the best interests decision now has to be made on whether life-sustaining treatment should be given or continue to be given to that person, to determine what decision he or

she would have made if they now had capacity and so, in exercise of their right of self-determination was able to make the decision.

70. At step (ii), the court will address points that the evidence shows that the relevant person (P) did not specifically consider aspects of the present situation (e.g. being in MCS, the detail of his or her present position and best case scenario, difficulties and consequences of withdrawing CANH) and take them into account in a holistic way with all other factors, including the strong presumption in favour of preserving life and so the powerful instinct for survival, in determining how they would affect the attitude and choice of that particular P.

71. I acknowledge and urge that the evidence and reasoning relied on to reach a conclusion that P would not have given consent to the relevant life-sustaining treatment, and then to rely on it as a weighty or determinative factor to depart from the default position that P's best interests are promoted by preserving his or her life, require close and detailed analysis which founds a compelling and cogent case that this is what the particular P would have wanted and decided and so considered to be in his or her best interests.

72. It is also obvious that the existence of a relevant written statement (referred to in s. 4(6)(a)) would be helpful and so of particular relevance in the way that an advance directive or living will was before the MCA was enacted. But it is also obvious that in real life many if not most relevant expressions of wishes and feelings will not be in writing.

73. This approach promotes the protection and preservation of life of severely disabled people who lack capacity and whose survival is dependent on life-sustaining treatment because it requires that the factors assessed on a past and present basis are sufficiently compelling to outweigh the very strong presumption that underlies the default position (see for example and by analogy the citation from and the decision in *In re AK (Medical Treatment: Consent)* [2001] 1 FLR 129 at paragraph 83 of Baker J's judgment in *Re M*). As I have said, that intense analysis will address points that the evidence shows that P did not specifically consider aspects of the present situation.

74. I have deliberately not tried to set out how convinced the court has to be about what P would have decided if he or she was able to do so because, in my view, the weighing exercise is so case and issue sensitive and is not a linear or binary exercise, and because here I am sure (in the sense that I have no reasonable doubt) on the decision that Mr Briggs would have made if he was able to do so.

75. I have not expressly mentioned the Mental Capacity Code of Practice which addresses decisions about life-sustaining treatment at paragraphs 5.31 to 5.33. This is because they are addressed in the *Aintree Hospitals* case that lies at the heart of my analysis and conclusion.

Earlier Cases

76. The *Aintree Hospitals* case is obviously important as is *Airedale NHS Trust v Bland* [1993] AC 789. The *Aintree Hospitals* case cites and discusses a number of the earlier cases and in *Re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2012] 1 WLR 1653 Baker J sets out a helpful account of earlier cases.

77. I pick out in date order *W Healthcare NHS Trust v H and others* [2005] 1 WLR 834 which addresses the law before the MCA on advance directives and, like other cases, discusses *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 which came down in

favour of the best interests test, *United Lincolnshire Hospitals NHS Trust v N* [2014] COPLR 60 a decision of Pauffley J, and *Re N* [2016] COPLR 88, another decision of Hayden J.

78. Unsurprisingly it was submitted to me by Mr Sachdeva QC that I need to address what Baker J said at paragraphs 228 to 230 of his decision in *Re M,* namely:

> 228. --- it does not follow from the fact that she indicated that she would not wish to continue living in a vegetative state that she would have wished to have ANH withdrawn when she was conscious, albeit minimally. In addition, I have to take into account the fact that M has lived in her current minimally conscious state for many years. We have no way of knowing how she now feels about her current life. In those circumstances, the court must be particularly cautious about attaching significant weight to statements she made before her collapse.
>
> 229. --- But the crucial distinction between an advance decision that meets the criteria required by sections 24 to 26 of the 2005 Act and other expressions of wishes and feelings is that an advance decision must address specifically the circumstances in which it will be binding and is made in the knowledge that it will be decisive if those circumstances arise. In other words, an adult who makes an advance decision knows that it will be decisive in the event that he or she becomes incapacitated and is unable to communicate their current wishes and feelings.
>
> 230. I accept without qualification that B and S are accurately relying the various statements made by M in the past. I accept, therefore, that when her grandmother and father were in declining health and moved to live in nursing homes, M said on more than one occasion words to the effect that she would not wish to live like that, that she would not wish to be dependent on others, and that she "wanted to go quickly close quote. I also accept the evidence that, when reports about Tony Bland appeared on the television, M express views to the effect that it will be better to allow him to die. But, as conceded on behalf of the applicant, there is no evidence that M ever specifically considered the question of withdrawal of ANH, or ever considered the question whether she would wish such treatment to be withdrawn if in a minimally conscious state. Furthermore, even if M did specifically consider those questions, there is no way of knowing her current views, having lived in that state for over eight years. Given the importance of the sanctity of life, and the fatal consequences of withdrawing treatment, and the absence of an advance decision that complied with the requirements previously specified by the common law and now under statute, it would be in my judgement be wrong to attach significant weight to those statements made prior to her collapse.

79. The reference to the lack of specific consideration of certain points in paragraph 230 mirrors the approach taken by the Court of Appeal to the existence of an advance directive in *W Healthcare NHS Trust v H and others* and, as appears earlier, I accept that these are matters that need to be taken into account in assessing the cogency and so the weight to be attached to the past wishes and feelings of P and P's past beliefs and values.

80. The first and important point to be made on the approach taken by Baker J in *Re M* to the evidence of the family concerning P's past wishes and feelings beliefs and values is that his decision predates the *Aintree Hospitals* case. In my view the last sentence

of paragraph 228 and his approach in paragraphs 229 and 230 (which is echoed in paragraphs 244(f) and 247(5) under the heading "balance sheet") runs counter to the holistic approach that the Supreme Court confirms is to be taken to enabling P to do what he would have wanted if of full capacity, and so to addressing the matters set out in s. 4(6), in all the relevant circumstances of the case, to try to ascertain what P would have wanted and decided. This is because he overplays the requirements for an applicable advance decision and its absence (which by definition is a starting point for the exercise under s. 4 of the MCA). Also, he does not address what M would have done, and so her attitude to the application of the competing fundamental principles, by reference to his findings on what she had said and done when she had capacity on the basis that "there is no way of knowing her present views" (which is always going to be the case when P cannot communicate any such views).

81. As appears above I prefer the approach taken by both Pauffley J and Hayden J to the assessment of P's past wishes and feelings, beliefs and values in the application of s. 4(6) of the MCA. Their decisions are after and apply the *Aintree Hospitals* case.

82. Naturally I accept that the facts of the cases decided by Pauffley J and Hayden J differ from this case and that an approach directed to each individual P is essential. A significant difference is the additional factors in them that favoured a best interests decision that consent to the treatment should not be given by the court. In Pauffley J's case *N* (P) had been physically resistant to all efforts to provide her with nutrition and had pulled out a nasogastric tube and several cannula (she was receiving adequate hydration and dextrose solution through an intravenous line that had been placed into a foot which she could not reach). And in *Re N,* Mrs N (P) suffered from very advanced multiple sclerosis. After hearing the family evidence the Official Solicitor changed his position and no longer opposed the withdrawal of CANH and it was common ground that if this was done with palliative care Mrs N would not feel pain. Also, Mrs N's position was very different to Mr Briggs' best case scenario (see paragraph 75 of the judgment) and in light of that it is unsurprising that an issue arose as to whether or not Mrs N was in a PVS or MCS.

Does section 4(5) of the MCA prevent me making a welfare order and declarations based on a care and treatment plan that Mr Briggs' CANH is not to be continued.

83. In *Re M (Adult Patient) (Minimally Conscious State: Withdrawal of Treatment)* [2012] 1 WLR 1653 it was argued by the Official Solicitor that where a person in MCS is in an otherwise clinically stable state it can never be in his or her interests to withdraw or withhold life-sustaining treatment and as for a person in PVS, but with a different consequence, a weighing exercise should not be carried out. It was argued that to intentionally withdraw life-sustaining treatment from such a person would amount to unlawful killing or murder. This argument was rejected for the reasons given by Baker J in paragraphs 98 to 103 of his judgment and it has not been advanced before me.

84. In rejecting that argument Baker J does not refer to s. 4(5) or s. 62 of the MCA.

85. The NHS Trust and the WCCG advanced a similar argument in reliance on those two sections. In doing so counsel submitted, that a proper application of s. 4(5), and so one that as a matter of construction recognises that it should be construed to give effect to Convention Rights, means that there is no separate argument based on Convention Rights. I agree. Counsel pointed out that Article 2 of the ECHR, save as qualified therein, provides that no-one shall be deprived of his life intentionally.

86. It was submitted that s. 4(5) adds to s. 62 and that the reference in to "*a desire to bring about death*" in s. 4(5) refers to such a desire of anyone and not only that of the relevant decision maker and so includes a desire or wish of Mr Briggs to die.

87. Understandably, given the existence of the "do not resuscitate" and "do not return to intensive care" decisions that have been made in respect of Mr Briggs it was argued by the NHS Trust and the WCCG that the withholding of that life-sustaining treatment would not be motivated by a desire of anyone to bring about Mr Briggs' death. This argument accords with the argument advanced by the Official Solicitor in *Re M* because it relies on (a) the clinical conditions that give rise to the need for such invasive treatment to found a conclusion that it would be useless, pointless or over burdensome to give such treatment, and (b) that conclusion to trigger the application of the question identified by the House of Lords in the *Bland* case and so the effect of the answer to it.

88. As Lord Goff explained in the *Bland* case at 868 A/D that question is crucial and it is <u>not</u> whether it is in the best interests of the patient that he should die but whether it is in the best interests of the patient that his life should be prolonged by the relevant treatment and care (here CANH). The question dictates the analysis and effect of the answer, and so the legality of the continuation or withdrawal of life-sustaining treatment for persons who lack the relevant capacity to make their own decisions on whether they should or should not consent to such treatment. It reflects the doctrine of "double effect" which excludes the purpose of causing death and allows death to be knowingly caused as a side-effect and so draws a distinction between the intention underlying an action on the one hand and the consequences that are foreseen but are not intended on the other. As appears from *Lambert & others v France* (Application no 46043/14) (5 June 2015) a similar approach is taken in French law.

89. It is well established that CANH is medical treatment and the contrary was not argued. Rather, it was argued that in this case the side-effect of death becomes the, or a, motivation because Mrs Briggs' position is that all life-sustaining treatment, including antibiotics, should not be given and her case is based on what Mr Briggs would have wanted, and that wish has been expressed in terms that he would have wanted to die.

90. It seems to me that in the cases in which the clinical condition of P has founded the conclusion that life-sustaining treatment was considered to be useless, pointless or over burdensome, the wishes and feeling of P, if examined and taken into account, could be expressed in terms that P would or would not want to die. Indeed this can be said of any case in which the known consequence of the decision taken on treatment is that the patient will die.

91. It is clear that no-one involved in this case wants Mr Briggs to die.

92. In my view, the ordinary meaning of the language of s. 4(5) is that it is referring to the person making the best interests decision. It was accepted that in reaching its decision on a proper application of the best interests test the court would not be motivated by a desire to bring about Mr Briggs' death and the argument was that s. 4(5) has the result that a proper application of that test precludes the court from relying on the central argument advanced by Mrs Briggs based on Mr Briggs' wishes and feelings and what he would have wanted and would have decided.

93. I reject this argument because in my view:

xxiv) the question for the court is: *Whether it is in Mr Briggs' best interests for it to give consent to his treatment by CANH?*, and

xxv) in assessing the views, wishes, feelings and motivation of any relevant person in the application of the best interests test (and so in determining what Mr Briggs' would have wanted and decided for himself if he was able to do so) the court should do so by reference to that question and the analysis and consequences of the answer to it that has been explained in the *Bland, Aintree Hospitals* and other cases.

That question and the analysis and consequences of the answer to it address all types of life-sustaining treatment and so, for example, they are not limited to treatment that can be said to be useless, pointless or over burdensome because of the patient's clinical position or otherwise.

94. On that approach and analysis the court would not be taking into account a desire to bring about Mr Briggs' death albeit that if he had capacity so could determine what treatment he had, as a matter of law, he could be motivated by a desire to die or express himself in that way, and he may well not have analysed the issue by reference to that question and the doctrine of double effect.

The medical evidence

95. I have dealt with this in the Overview.

The evidence of the family, colleagues and friends

96. It is not easy to convey to those who did not hear it the force of the oral evidence given by Mr Briggs' wife, mother, two brothers, his sister in law and a police colleague. They all confirmed and added meaning and force to their statements. There were further statements to the same effect from other colleagues.

97. The Official Solicitor, or his lawyers, rejected the warning given by Hayden J in *Sheffield Teaching Hospitals NHS Foundation Trust v TH* [2014] EWCOP 4 where the judge said that his lawyers had not absorbed the force of the emphasis placed on a holistic evaluation by the Supreme Court. Worryingly, as in the case before Hayden J, the Official Solicitor, through his lawyers, sought to rely on the ways in which Mr Briggs' mother and one of his brothers had expressed themselves as a basis for weakening the force of their evidence. It would be surprising if loving family members did not express themselves in terms that differed in some respects and arrived at their conclusions for reasons that differed in some respects and over different periods of time. Complete consistency of approach and expression would give rise to more concern. I express the hope that the Official Solicitor will in future not seek to test family evidence in such a pedantic and so unsympathetic and unhelpful a way.

98. The core of the evidence was that of Mr Briggs' wife and his mother, which was supported by his two brothers. This loving family effectively spoke with one voice in supporting the views of Mr Briggs' wife. They agreed that she knew him best and agreed with her on what Mr Briggs would now want in his existing circumstances, including the most recent written medical evidence, and added their own reasons for reaching the same conclusion. After the oral medical evidence Mr Briggs' wife and mother were recalled to address the point that had been made that the extent of Mr Briggs' brain damage meant that he was now a different person who would not appreciate how he had been before his accident. Both of them had heard all of the oral medical evidence that had also highlighted the possibility of Mr Briggs suffering pain and distress if his CANH treatment was not continued which was linked to the medication of his PSH and dystonia.

99. They confirmed that they had not altered their views and in doing so they did not try to embellish their evidence. It is clear that they know that as a result of his brain damage Mr Briggs is now a different person who will not have insight into his previous wishes, feelings, beliefs, values, approach to life and the impact on him of his brain injury but that to them he still also remains the husband, father and son they loved and love.

100. Mr Briggs' wife is sure that her husband and the father of their young child would not consent to his CANH treatment being continued and made it clear that she is pursuing this painful litigation to try to achieve the result for her husband that she is sure he would have wanted and chosen if he was able to do so. All his close family support that position.

101. The totality of the family evidence has convinced me in the sense that I am sure (and so have no reasonable doubt) that if Mr Briggs had heard the evidence and argument that I have, including the evidence about his best case scenario and the possible distress, pain and difficulties he and his family may face if his CANH treatment is not continued he would have would have decided not to give consent to the continuation of his CANH treatment. I add that he would have been supported in this decision by his family and they would have faced the tragic consequences of his accident together.

102. This conclusion and the views of Mr Briggs' family and friends is not based simply on general assertions although I acknowledge that the examples of the conversations relied on do not specifically address the withdrawal of CANH treatment and the position of someone in MCS or Mr Briggs' best case scenario. But it is based on a clear description of Mr Briggs as a man, his beliefs and values and a number of relevant conversations.

103. Mr Briggs was always an active and outdoor person who, as a boy did not enjoy school. At an early age he wanted to join the army and this is what he did. He served in the Gulf War and after leaving the Army he was keen to and sometime later did join the police where he worked in the traffic department. As confirmed by a work colleague and his family as a policeman he witnessed traffic accidents which resulted in serious injury to motorists and visited some of them in hospital. The details of those cases is not in the evidence.

104. Also in the army he experienced action and he kept badges in his bedside drawer to remember colleagues who were killed in action. Details of the action he experienced and the resultant deaths of and injuries to colleagues he witnessed was not in the evidence.

105. He was also a risk taker. For example, he continued scuba-diving in an area after a shark attack had taken place and many tourists had left or cancelled their holiday. Both before and after an earlier motorcycle accident (in which he broke his leg) he was clear that he was prepared to take the risks involved in riding a motorcycle which he enjoyed.

106. Accordingly the comments made by Mr Briggs were made by a man who had witnessed action in the army, death and serious accidents.

107. It is also clear that he was an outgoing and popular man who enjoyed company and food. His family and friends speak with a common voice that he was extremely close to his wife and daughter and was a committed and loving family man. He had met his wife in 1995 shortly after he left the army and they have been married for about 16 years. His daughter is now five and sadly is frightened of visiting her father at the

hospital. In this context, his wife describes how Mr Briggs did not think that visiting family members in a care home was appropriate for children.

108. Mr Briggs' experience of witnessing death and the consequences of serious accidents informs and probably explains the number of conversations, views and discussions reported in the evidence before me about death and injury. The one closest to home relates to his mother-in-law and her refusal of PEG feeding and nutrition when she was terminally ill with cancer. His wife reports that he fully supported her and her mother in this decision and told her that he would never want a feeding tube. This provides a clear indication that Mr Briggs did not consider it was sensible to prolong life at all costs and thought it was right that the suffering of his mother-in-law was not prolonged. Indeed his wife reports that he used to ask why there was not something legal that could be done to end her mother's suffering. His wife has now made an advance decision herself that she does not want a feeding tube. And she told me that as she knows that as she and her husband have a very similar stance on matters she feels with absolute confidence that he would be doing exactly for her as she is now doing for him by asking for life-sustaining treatment to be withdrawn if their roles were reversed.

109. Mr Briggs had conversations related to Tony Bland, Michael Schumacher, Tony Nicklinson and Jules Bianchi. I accept that he did not know the detail of the circumstances of any of them and that, in making the remarks he did, he was not specifically directing his attention to someone in his present circumstances. However, all of his comments about these people are consistent and are to the effect that he would not wish to live like that and for example in the case of Tony Nicklinson that he understood why he wanted to die. He made similar remarks about victims of traffic accidents some of whom he had visited in hospital and news reports on the television.

110. Mr Briggs' sister-in-law reports a conversation she had with him about a television programme. It took place a few months before his accident in July 2015. She thinks the programme was called "24 hours in A&E" and it was a reality TV programme rather than a drama. It was showing a man on life support with various machines keeping him alive. Mr Briggs told her that he would want the life support machine to be turned off as he would not want to be kept alive like that as it was not "living". She recalls him saying that in that scenario we should turn off the machine and let him go. She replied that if it was her she would like the chance to see what the medical profession could do but he was adamant that in that sort of situation he would want to be allowed to pass away. The conversation was only a short one but she remembers it very clearly.

111. Members of the family told me that in their view Mr Briggs would regard his present situation as horrible and one that he would not wish to continue. Included within the reasons given are that a life in which he did not have the ability to communicate with his wife and child is not one that he would be willing to have. In her second statement his wife says in her view even if Mr Briggs was peaceful, if he was experiencing anything at all, she can imagine Mr Briggs asking "why are you torturing me?"

112. Mr Briggs' wife and family are convinced that if he was able to express it his view would be "enough is enough" because his view on his best case scenario would be that for him this was not a life that was worth living. So they are convinced that he would refuse consent to the continuation of his treatment by CANH. In line with that his police colleague said she just knows that Mr Briggs would not have wanted to be kept alive like this.

Why am I convinced that Mr Briggs' family are right?

113. I have tried to stand back from the emotion and obvious depth of love and emotion for and about Mr Briggs demonstrated in the court room and to ask whether the man described to me, and so a man with his beliefs and values and approach to life would consent to his CANH treatment if he had heard the evidence and argument before me.

114. My views are set out below.

115. It is clear that he would have taken a realistic approach to the medical views and advice. I have set out what I consider that to be in the "Overview". It is also clear that he would have acknowledged that there is uncertainty and so a possibility in the senses I have set out in paragraphs (47) and (50) but, in my view, like his family this would not have diverted him from making his decision on a realistic assessment of what lay in store for him during his life expectancy.

116. Like counsel for Mr Briggs' wife I have proceeded on the basis that the result of 6 months of further treatment and rehabilitation will be that the best case scenario is achieved or is likely (in the sense of more likely than not). However, I acknowledge the difficulty that the family have with that approach because I think they are right in thinking that Mr Briggs would factor in the point that the hoped for improvement to the best case scenario is only a possibility.

117. I have also proceeded on the basis that in the best case scenario Mr Briggs will, as a result of the impairment of his functioning caused by his brain injury, be happy, content and experience pleasure and so he will not be distressed or depressed or have wishes and feelings that his life is not worth living. An aspect of this is that his PSH and dystonia will be better controlled.

118. I have done this because:

xxvi) if on that premise I conclude that Mr Briggs would not have consented to the continuation of his CANH treatment I do not have to examine his attitude to a less good best case scenario, and

xxvii) that premise identifies a life that has value to which the strong presumption that it should be preserved plainly applies.

119. I acknowledge that there is no evidence that Mr Briggs ever specifically addressed that best case scenario but, in my view, if he was able to do so, he would be horrified by that prospect for himself and his family. This is because he would consider that that he and they would have to lead lives in which because of his very limited cognitive and physical abilities he could not take an active and meaningful part in anything that they had previously enjoyed and valued as individuals and had hoped and expected to enjoy together during and after the childhood of his daughter. In my opinion his views, values and beliefs about how life should be lived would cause him to conclude that for him such a life was intolerable.

120. As a risk taker and a man of courage I consider that he would not take a different view based on the possibilities that as a result of the ending of his CANH alone, or together with the treatment of his PSH and dystonia, would cause him pain and him and others distress. In my view, he would consider that his family would take comfort from knowing that this arose from what he wanted.

Standing back - Has the default or starting position that the strong presumption that a person's best interests are best served by preserving their life been rebutted?

121. As I have pointed out earlier P's wishes and feelings and so what P would have done if he or she was able to do so is not determinative of the best interests test. The same applies to the very strong presumption in favour of preserving life and this is shown by the earlier MCS cases in which, unlike in a PVS case, there is a balancing or weighing act to be performed and conclusions that because of a person's clinical condition or illness that continued treatment would be futile, overly burdensome or offer no hope of improvement or recovery have been important factors underlying the decisions that it is in the best interests of a person to withdraw life-sustaining treatment.

122. I acknowledge that Mr Briggs' PSH and dystonia and the prospects of controlling them do not found such conclusions about the treatment for them but recognise that if Mr Briggs' needed to be resuscitated or returned to intensive care that they could apply to that treatment.

123. Many of the cases set out a balance sheet listing the relevant factors and circumstances for and against the rival alternative decisions. This is an aide-memoire or a tool (see *Re F (A Child) (International Relocation Cases)* [2015] EWCA Civ 882 at paragraph 52, and the comments of McFarlane LJ about a holistic approach are also useful). The balance sheets produced in this case also suffered from the difficulty that it was difficult to capture the degree of potential improvement in Mr Briggs' condition and the description of his best case scenario. For example, all agreed that these descriptions in the joint statement of Dr Mahendran and Dr Walton suffered from this problem and needed clarification. Also it was accepted by Dr Mahendran that some of the language she had used on the possible extent of improvement gave a misleading impression. This linguistic problem is inherent in the description of matters of degree and so in the crucial exercise of giving weight to competing factors that is at the heart of the application of the best interests test.

124. To take an example, the general descriptions used in the written evidence were relied on for cross examination directed to establishing that there was a realistic possibility (rather than a likelihood) that Mr Briggs would regain capacity and be able to make and communicate his own decisions about his treatment, and the oral evidence established that this was only a possibility in the sense that one can never say never. Indeed Dr Walton's point that because of his brain damage Mr Briggs would be a different person and so would not appreciate or process the extent and impact of his injuries and so in his realistic best case scenario it was likely that he would be happy, show pleasure and not show distress or depression was based on him not having such capacity as that would or could lead to very different feelings and depression.

125. In making and reasoning their recommendation the two doctors, in broad terms, took a wait and see approach based on a possibility of further improvement in Mr Briggs' level of awareness. Also, they did not address in any detail in their written and oral evidence the weight they had given to the wishes, feelings, values and beliefs of Mr Briggs although, as I understood her, Dr Walton stated orally that if Mr Briggs had made an applicable advance decision it would have been in his best interests for the CANH treatment to be withdrawn. And I add that Mr Briggs' wife felt that Dr Walton had listened carefully and sympathetically to the views of the family and was giving realistic advice on her husband's prospects.

126. This is not a criticism of the two doctors. However, it was disappointing that counsel for the Official Solicitor, as Mr Briggs' litigation friend, did not address the issue on the premise that the realistic best case scenario identified by Dr Walton (and agreed to by Dr Mahendran) as a possibility was in fact achieved. Rather, his argument was that as Dr Walton had concluded it was too early to reach a decision that the case

should be adjourned for reconsideration after the 6 months of treatment and rehabilitation recommended by the two doctors.

127. In my view, there was considerable force in the submission made on behalf of Mrs Briggs that if that best case scenario was achieved, and if it was not, on any adjourned hearing the Respondents would be arguing that it was in Mr Briggs' best interests for his CANH treatment to be continued. This certainly accords with the view of Dr Mahendran and the way that counsel for the NHS Trust and the WCCG advanced their arguments (although depending on identity of the rehabilitation unit they may not be involved in 6 months and, in any event, there will be a different a treating team).

128. In my view, on an in all the relevant circumstances approach to the very difficult issue in this case the weighing exercise comes down to whether Mr Briggs' best interests are best promoted by giving more weight to:

xxviii) the very strong presumption in favour of preserving life, or

xxix) the great weight to be attached to what Mr Briggs as an individual would have decided himself if he had the capacity and so was able to do so.

129. I have concluded that as I am sure that if Mr Briggs had been sitting in my chair and heard all the evidence and argument he would, in exercise of his right of self-determination, not have consented to further CANH treatment that his best interests are best promoted by the court not giving that consent on his behalf.

130. This means that the court is doing on behalf of Mr Briggs what he would have wanted and done for himself in what he thought was his own best interests if he was able to do so.