Neutral Citation Number: [2022] EWCOP 1

IN THE COURT OF PROTECTION **Case No 13753262**

AND IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
BETWEEN

LONDON BOROUGH OF X

Applicant

-and-

(1) MR
(by his litigation friend, the Official Solicitor)
(2) PD
(3) AB

Respondents

JUDGMENT

Care home resident incapacitated by dementia — Mental Capacity Act 2005 — Whether in resident's best interests to be moved to a Jewish care home — Local authority, professionals, independent expert and Official Solicitor against a move — Move held to be in resident's best interests

BEFORE District Judge Eldergill sitting at the Court of Protection at First Avenue House, 42-49 High Holborn, London, WC1V 6NP on 1 December 2021

JUDGMENT HANDED DOWN ON 13 January 2022

Mr Lindsay Johnson appeared on behalf of the Applicant local authority and Ms Leonie Hirst (instructed by Miles & Partners LLP) on behalf of the First Respondent. The Second and Third Respondents appeared in person.

§1 — FORMAT AND HEADINGS

1. This judgment is structured under the following headings:

§2 — INTRODUCTION

2. This is formally a section 21A application made by the London Borough of X in respect of MR who has resided at a nursing home called CC since April 2020, when he was discharged from hospital to a nursing home during the first Covid emergency. He is deprived of his liberty under a standard authorisation ('DOLs Order') issued by the local authority.

3. Although this is a section 21A application, the sole issue is not whether it is in MR's best interests to return home but whether he should remain at CC Nursing Home or move to a Jewish care home, such as the T Care Home or S Nursing Home.

4. There were originally two section 21A applications, the second of which concerned MR's wife, Mrs R, who was also a resident at CC Nursing Home. Sadly, she died on 31 October 2021.

5. The Second Respondent, PD, is MR's nephew by blood (his mother is MR's sister and only sibling) and also his RPR (Relevant Person's Representative) under the standard authorisation ('DOLs') procedures. PD supported MR at home before his admission to hospital and CC Nursing Home (with shopping, medical appointments, cleaning, etc: D6), and he is also MR's executor. He believes that it is in MR's best interests to remain at CC Nursing Home.

6. The Third Respondent, AB, is the nephew of the late Mrs R, being the son of her surviving brother, and he was her RPR. He believes that it is in MR's best interests to be transferred to a Jewish care home.

7. The Applicant local authority and the Official Solicitor on MR's behalf submit that it is in his best interests to remain where he is, but the Official Solicitor thinks the decision is very finely balanced, a view with which I agree.

§3 — PROCEDURE AND HEARINGS

8. The matter first came before me on 5 October 2021 when I directed that the applications be expedited and final hearings held on 30 November and 1 December.

9. The Second and Third Respondents took Rabbinical advice and included this in their evidence to the court. Neither disagreed with the Rabbinical advice summarised by each of them and none of the parties sought to call a Rabbi to give evidence on religious matters, partly because there was no dispute.

10. Following the hearing on 1 December 2021, I was keen to explore whether it would be possible for MR to visit T Care Home, so that his awareness and appreciation of what it has to offer could be assessed and better understood. This was because of conflicting views about the extent to which his cognitive awareness enables him to be aware of, and to benefit from, his surroundings. Unfortunately, it transpired that this would take several weeks to arrange, as would a visit to his synagogue. Furthermore, there would be Covid limitations on his interaction with staff and residents. It was possible for his Rabbi, Rabbi S, to visit MR and this took place on 21 December 2021.

11. The parties had until 10 January 2022 to make any supplementary submissions they wished to make in the light of the record of Rabbi S's visit. Originally, only the Third Respondent availed himself of this option. However, at the Official Solicitor's request, on 12 January 2022, I allowed her a short time extension to file a supplementary submission, which was received the following day. In that supplementary submission, the Official Solicitor states that she is 'not strongly opposed to a move' but remains of the view that it is not in MR's best interests to move to a Jewish care home.

12. It is very unfortunate that the Covid emergency prevented any exploration of Jewish care homes prior to MR's discharge from hospital in April 2020 or shortly after his discharge, and that he had not seen a Rabbi until 21 December 2021, or been outdoors other than to hospital during his time at CC Nursing Home.

§4 — M'S HEALTH AND MENTAL CAPACITY

13. For the purposes of the Act, a person lacks capacity in relation to a matter 'if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'[1]

14. For these purposes a person is unable to make his own decision if he is unable:

- to understand the information relevant to the decision,
- to retain that information,
- to use or weigh that information as part of the process of making the decision, *or*
- to communicate his decision (whether by talking, using sign language or any other means).[2]

15. A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).[3]

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1 Mental Capacity Act 2005, s.2(1).

2 Mental Capacity Act 2005, s.3(1).

3 Mental Capacity Act 2005, s.3(2).

16. The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.[4]

17. The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.[5]

Presumption of capacity

18. Section 1 provides that a person must be assumed to have capacity unless and until it is established (on the balance of probabilities) that he lacks capacity. Furthermore, a person is not to be treated as unable to make the decision in question:

    (a) unless all practicable steps to help him to do so have been taken without success;

    (b) merely because he makes an unwise decision.

19. Whilst a person cannot be found to lack capacity *merely* because their proposed decision is unwise, fairly obviously an unwise (or irrational) decision may raise significant doubts and so trigger an assessment of their capacity.

Unjustified assumptions

20. A lack of capacity cannot be established *merely* by reference to a person's age or appearance, or to a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.[6]

Positions of the parties

21. It is common ground that MR lacks capacity to decide for himself where to reside and what care and treatment to receive. His dementia is at an advanced stage (E131), and he presents with 'marked cognitive impairment across multiple domains' (E131). He now needs assistance with all activities of daily living (including meal preparation, mobility, rehydration, personal hygiene, toileting, medication and dressing). His medical history includes a stroke, diverticulosis, musculoskeletal pain, recurrent falls, hypertension and sensory impairment. He requires a full body hoist to transfer and a special seat.

Life expectancy

22. MR is 86 years of age. Dr Prabhakaran, who is a very experienced consultant psychiatrist and Court of Protection Special Visitor, estimates his life expectancy to be between 2.3 and 4.3 years following diagnosis in early 2020. Some people outlive their prognosis and some do worse. Nevertheless, Dr Prabhakaran's expert opinion is that MR can expect to live until some time between the spring of 2022 (which is only three months away) and the spring of 2024.

23. His life is therefore very much drawing to a close and this case is about not just where and how he lives but where and how he dies, where he would wish to live and die if he still had capacity, and what he wishes for himself now. Even if he remains where he is, he may have only months left to live. This is a significant consideration because, as counsel for the Official Solicitor pointed out, at the end of life some people find comfort in returning to their roots and the familiar things and ways of their early life, and they also find comfort and support in their religion.

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4 Mental Capacity Act 2005, s.3(3).

5 Mental Capacity Act 2005, s3(4).

6 Mental Capacity Act 2005, s.2(3).

24. It is also the case that some people think that being content and fulfilled during their remaining time is more important than maximising the duration of life. I must not assume that keeping MR alive and maximising his life expectancy is the magnetic consideration in his case. In saying that, I have had regard to the Rabbinical advice which PD received about the importance of prolonging life, but also to the advice that for a terminally ill person it may be better for them 'to enjoy a quality of life rather than extended quantity of time' (D43).

§5 — THE LEGAL FRAMEWORK: BEST INTERESTS AND DOLs

25. The legal framework to be applied involves considering the European Convention on Human Rights, the Mental Capacity Act 2005, the Codes of Practice to that Act and public law issues.

26. I shall not give a lengthy recital of the law because it was not in dispute. This is a classic best interests case involving balancing many different relevant considerations.

European Convention on Human Rights

27. In reaching my decision, it is important that I have regard for MR's rights under the European Convention on Human Rights, and in particular Articles 2, 5 and 9.

28. Article 2 provides that ,'Everyone's right to life shall be protected by law'.

29. Article 5(1) imposes a positive obligation on the state to protect the liberty of its citizens.

30. The state is obliged to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge.

31. Article 5 is engaged where an incapacitated person is deprived of their liberty. A proper authorisation or court order is required, which in this case is the standard authorisation.

32. The person concerned should have access to a court and the opportunity to be heard in person or, where necessary, through some form of representation.

33. Special procedural safeguards may prove to be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves.[7]

34. Article 8 provides a qualified right that everyone has the right to respect for their private and family life, home and correspondence. Any interference with MR's family or private life must be authorised by law, proportionate ('necessary in a democratic society') and for a permitted purpose, e.g. for the protection of MR's health.

35. Article 9 states that, 'Everyone has the right to freedom of thought, conscience and religion; this right includes … freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching practice and observance.'

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[7] See *Winterwerp v Netherlands* 6301/73 (1979) ECHR 4.

36. The decision in *Re IH* [2017] EWCOP 9, which involved religious observances by incapacitated people, is relevant to the interpretation and application of Article 9.

37. Once the court has completed its analysis of MR's best interests under the MCA 2005, it must satisfy itself that any infringement of his Convention rights which arises from its (provisional) conclusion is necessary and proportionate: see *K v LBX* [2012] EWCA Civ 79 at [35].

Mental Capacity Act 2005 — Statutory principles

38. The statutory principles set out in the Mental Capacity Act 2005 are well-known to the parties.

39. Very briefly, section 1 provides that a person must be assumed to have capacity unless it is established that he lacks capacity; a person is not be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success; a person is not to be treated as unable to make a decision merely because he makes an unwise decision; 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; and 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.

Codes of Practice

40. The relevant codes of practice are the *Mental Capacity Act 2005: Code of Practice* (Department for Constitutional Affairs, London: TSO, 2007) and the *Deprivation of liberty safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice* (Ministry of Justice, London: TSO, 2008). The codes do not have statutory force but professionals and some carers must have regard to their provisions, and the courts must take them into account where relevant: see section 42.

Public law considerations

41. I accept that this court cannot direct a local authority or NHS body to provide services which they have assessed that MR does not require or which they have decided at their reasonable discretion not to provide.

Determining Best interests

42. The correct approach to determining questions about what is in MR's best interests is set out in Section 4 of the Mental Capacity Act 2005:

Section 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).

(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.'*

43. In the case of *ITW v Z* [2009] EWHC 2525 (Fam), Munby J (as he then was) gave the following guidance with regard to the different considerations listed in section 4 which the decision-maker must have in mind:[8]

i. The first is that the statute lays down no hierarchy as between the various factors ... beyond the overarching principle that what is determinative is the judicial evaluation of what is in P's 'best interests'.

[8] *ITW v Z* [2009] EWHC 2525 (Fam), per Munby J, at para. 32.

ii. The second is that the weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar, case carry much less, or even very little, weight.

iii. The third, following on from the others, is that there may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of 'magnetic importance' in influencing or even determining the outcome.

44. The fact that the individual's past and present wishes, feelings, beliefs and values must be considered tells us that this is not a sterile objective test of best interests. It is not a case of trying to determine what some hypothetical objective or rational person would decide in this situation when presented with these choices. Nor are we seeking to do nothing more sophisticated than impose on the individual an objective and rational analysis based on professional expertise of what they ought sensibly to do in that situation.

45. The law requires objective analysis of a subject not an object. The incapacitated person is the subject. Therefore, it is *their* welfare in the context of *their* wishes, feelings, beliefs and values that is important. This is the principle of beneficence which asserts an obligation to help others further their important and legitimate interests, not one's own.[9] In this important sense, the judge no less than the public authorities is MR's servant, not his master. That this is so is emphasised by Lady Hale in the *Aintree* case:[10]

45. Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that 'It was likely that Mr James would want treatment up to the point where it became hopeless'. But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.

46. It also emerges from various decisions of the previous President of the Court of Protection. Naturally, precisely how much weight to give to a person's present wishes and feelings will depend on the particular context and their circumstances. These include the degree of their incapacity; the strength and consistency of their views; the possible impact on them of knowing that their wishes and feelings are not being given effect to; the extent to which their wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation; and the extent to which their wishes and feelings, if given effect to, can properly be accommodated within the overall assessment of what is in their best interests. However, while the weight to be attached to the person's wishes and feelings will always be case-specific and fact-specific, their wishes and feelings will always be a significant factor to which the court must pay close regard.[11]

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9 *Westminster City Council v Sykes* [2014] EWHC B9 (COP) (24 February 2014), at §10.
Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant) [2013] UKSC 67 at para. 45.

11 *ITW v Z* [2009] EWHC 2525 (Fam), per Munby J, at para. 35.

Managing risk

47. Risk cannot be avoided. All decisions that involve a deprivation of liberty or compulsion involve balancing competing risks, of which the risk that the individual or others may suffer physical harm is but one. For example, detention and compulsory care or treatment may risk loss of employment, family contact, self-esteem and dignity; unnecessary or unjustified deprivation of liberty; institutionalisation; and the unwanted side-effects of treatment.

48. The court 'must adopt a pragmatic, common sense and robust approach to the identification, evaluation and management of perceived risk'. There must, as Peter Jackson J (as he then was) observed in *Hillingdon LBC v Neary*[12] [2011] EWHC 413 (COP) at para 15(3), be a proper, factual basis for such concerns.

Pessimism not necessarily determinative

49. In *Re: GC*,[13] Hedley J considered whether to allow an elderly man to be discharged from hospital to the home where he had lived for many years with his nephew KS, notwithstanding that there were serious though entirely unintentional shortcomings in the care provided by KS. Hedley J commented:

> *'GC is a man in the 83rd year of his life and my concern is to ask myself: how will he most comfortably and happily spend the last years that are available to him? Secondly I have approached this case on the basis that his primary need is for emotional warmth, emotional security and the commitment of human relationship. That has been a huge feature of his life to date and one that is not readily to be set aside. Next it seems to me that for the elderly there is often an importance in place which is not generally recognised by others; not only physical place but also the relational structure that is associated with a place ...'*

50. In connection with the issue of a trial placement, the Judge commented at paragraph 24:

> *'It seems to me that it would be wrong not to try, even with a degree of pessimism, a placement with a package of support that has been advanced, and this is another factor that has weighed with me in this case ….'*

A balance-sheet

51. The following passage about the need for a balance-sheet approach to best interests comes from the then President's judgment in the case of *Re S (Adult's lack of capacity: carer and residence)* [2003] FLR 1235:[14]

> *'… The question ... is: which outcome will best serve his interests? … [It] is clear that the court goes about deciding that question by drawing up the balance sheet identified by Thorpe LJ in Re A (Male Sterilisation) [2000] 1 FLR 549 at 560F–560H:*
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> > *Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit … Then on the other sheet the judge should write any counter-balancing disbenefits to the applicant … Then the judge*

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12 *Hillingdon LBC v Neary [2011] EWHC 413 (COP) at para 15(3).*

13 *Re: GC* [2008] EWHC 3402 (Fam), per Hedley J.

14 *Re S (Adult's lack of capacity: carer and residence)* [2003] FLR 1235, *per* Wall J, at (14).

should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant.'

52. The drawing up of a 'balance sheet' in personal welfare cases, listing the actual and potential advantages and disadvantages of each alternative,[15] should not be a dry accountant's exercise which omits what is personal but one that includes the 'personal' element of 'personal welfare'.

53. In *UR v Derby City Council and Anr* [2021] EWCOP 10, it was suggested that some factors will attract greater weight than others, and in those circumstances a balance sheet approach can be misleading. However, a balance sheet is, by definition, not just a list but a list with a value given for each item (such as £1, £5). The balance of potential gains and losses depends on the value or weight given to each listed item, so that it is difficult to discern any real difference between the two approaches if they are properly applied.

54. To summarise, in deciding what is in MR's best interests, I must have regard to his wishes, feelings, beliefs and values; the beliefs and values that would be likely to influence his decision if he had capacity; the other factors that he would be likely to consider if he were able to do so; the views of family members, professionals, non-professional carers and anyone interested in his welfare; and any and all other relevant considerations (see Mental Capacity Act 2005, section 4).

Deprivation of Liberty Provisions

55. The relevant Mental Capacity Act provisions are found in sections 4A, 21A, Schedule A1 and Schedule 1A.

56. The underlying rationale of the legislative framework is that it is a protective scheme. Anyone who is deprived of their liberty — that is, who is under another person's complete and effective control and is not free to leave — is vulnerable to abuse.

57. That risk is multiplied if they are unable to decide whether to remain or leave. Children and adults experiencing mental ill-health are particularly at risk and the law has usually afforded them special protection. This protection involves imposing legal duties on those with power, conferring legal rights on those in their power, and independent scrutiny of how these powers and duties are exercised. The effectiveness of such schemes depends on whether, and to what extent, they are observed and has to some extent been undermined by the abolition of an independent Mental Health Act/Capacity Commission led and staffed by legal practitioners.

58. In this arena, the deprivation of liberty scheme ensures that there is at least an annual assessment by two suitably qualified and independent professionals, who can ensure that the arrangement really is necessary to protect them from harm, is in their best interests, proportionate and so forth.

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15 *Re S (Adult's lack of capacity: carer and residence)* [2003] FLR 1235

Six requirements

59. Schedule A1 to the 2005 Act provides that a person may only be deprived of their liberty in a care home under a standard authorisation if they satisfy six statutory requirements: age, mental health, mental capacity, best interests, no refusals, eligibility.

60. The purpose of these requirements is the same as in the case of the 'sectioning criteria' in the Mental Health Act 1983, i.e. to prevent people who do not meet certain conditions or requirements from being deprived of their liberty. In MR's case, it is common ground that only the best interests requirement is in issue.

The best interests' requirement

61. The 'best interests requirement' is in reality four requirements masquerading as one. It is satisfied only if all of the following four conditions are satisfied:

1. *MR is being detained in the care home for the purpose of being given care or treatment in circumstances which amount to a deprivation of his liberty;* [16]

2. *This is in his best interests;*

3. *This is necessary in order to prevent harm to him; and*

4. *His detention in the care home for the purpose of being given care or treatment in circumstances which amount to a deprivation of his liberty is a proportionate response to the likelihood of him suffering harm, and the seriousness of that harm (if he were not so detained).*

62. If one or more of these conditions is not satisfied, the relevant person does not meet the best interests requirement; and, because a standard authorisation may only be given if all six requirements are satisfied, MR may not be deprived of his liberty under the MCA scheme.

§6 — ANALYSIS OF COMPETING CONSIDERATIONS

63. As already stated, the issue is very finely balanced and, as is always the case with finely balanced decisions, there are factors against a move and factors that favour a move.

In favour of CC Nursing Home

64. I agree with the Applicant that the impetus for a move to a Jewish care home came from Mrs R and her nephew and RPR, AB (D154). As the local authority submitted, if it had been in Mrs R's best interests to move to a Jewish care home then it is highly unlikely the court would have separated the couple and found it to be in her husband's best interests to remain at CC Nursing Home. The fact of Mrs R's death makes the case for a move less clear (D155).

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16 More precisely, he is a 'detained resident'. By paragraph 6 of Schedule A1 to the 2005 Act, a 'detained resident' is 'a person detained in a hospital or care home — for the purpose of being given care or treatment — in circumstances which amount to deprivation of the person's liberty.' If this is not the case, no authorisation is required because there is no deprivation that needs authorising.

65. One of the two major objections to a move is the risk to MR's life, and to his physical and mental health, if he is moved to another care home. Whilst I must have careful regard for his Article 9 religious rights, I must also have regard for his Article 2 right to respect for his life.

66. According to Dr Prabhakaran, 'It is accepted that relocation is a stressful event and can precipitate problems of mental health, physical health and can even lead to premature death particularly within the first three months of relocation' (E230).

67. Furthermore, MR has a number of the risk factors identified with adverse effects from moving, including dementia, impaired eyesight, reduced mobility, incontinence and advanced age (British Geriatrics Society, D48).

68. Dr Prabhakaran summarises the position by saying that, 'Given his multiple comorbidities, MR would be at high risk of adverse events including a higher risk of mortality, particularly within the first few months of relocation' (E231). He would be 'at serious risk of deterioration in health including in his cognitive, emotional and physical needs' (E231).

69. This is a risk to which, in my opinion, AB pays insufficient heed when, at page D/88, he states that, 'There is a small possibility that a move may disrupt [MR and his wife]'.

70. MR's nursing home General Practitioner believes that a move 'will surely affect his psychological well-being and may negatively impact on general well-being' (E59, E90). Ms P (Registered General Nurse at CC Nursing Home) similarly feels that staff have developed a rapport and that a move will be unsettling (E59).

71. On the balance of the evidence, I find that if MR is transferred to a Jewish care home there is a high risk of adverse events including a higher risk of mortality, particularly within the first few months of relocation. This risk needs to be considered in the context that his life expectancy is such that he may only have a few months left to live, so that he may well die soon whatever my decision. In his wife's case it was also asserted by professionals in these proceedings that moving her to a Jewish care home would be unsettling and was likely to have adverse consequences; she remained at CC Nursing Home and did not live long. It is also the case that a considerable number of older people with significant dementia are moved despite this risk every year, from home to hospital or a care home, or from hospital to a care home, or between care homes so as to be nearer family members. Sometimes the assessed benefits are considered to justify the assessed risks.

72. Because a move carries with it a higher risk of mortality, I must consider how important living in a Jewish care home is to MR; the beliefs and values that would be likely to influence his decision if he had capacity; and the other factors that he would be likely to consider if he were able to do so. Do the benefits of a transfer — which include giving expression to past and/or present wishes, beliefs and values — outweigh this higher risk of mortality and the serious risk of a deterioration in his health?

73. The benefits of a move are considered below. However, it is important to record here that I do not accept AB's submission that the standard of physical and mental health care which MR receives at CC Nursing Home is poor (D80), or that he is living out the rest of his years in relative misery (D87). Nor do I accept his characterisation of the issue as being that,

'23. This is not a case in which we are looking at a couple that is 'fine' where they are, set against another potentially better care home. This is a case where there are a multitude of problems causing real distress and deterioration both physically and mentally …' (D/86)

74. AB has not visited MR at CC Nursing Home for six months and he relies on his sister's accounts of MR's care and how he is faring. CC Nursing Home is rated 'good' by the CQC, and PD and the professionals involved in the case are all satisfied with the care MR receives there. In consequence, without exception they believe that a move would not be in his best interests.

75. More particularly, according to the Care and Support Plan Review, PD considers that 'the care is second to none and [the care home] have managed very well with the pandemic. [PD] said that MR [is] well fed, taken to hospital if required, if there are issues they will be dealt with right away, everybody is pleasant and there is good communication' (E91).

76. Nor is it the case that MR is unhappy where he is. When asked about his welfare and well-being, MR generally answers that he is content or happy: He told his legal representative: 'Yes, I'm quite happy here' (D130); 'Without a doubt, I am happy' (D131); 'Overall, yes, I am quite happy' (D131). Similarly, he told his IMCA: 'Overall I'm happy in the home …' (E120). Consistent with this, the DOLs assessor recorded that he is reported to be happy at the care home (E3) and that his needs were being met in the most compassionate and least restrictive way possible (E17). The MCA assessment at E58 records:

'Social worker has also considered the view of the care home which reported that MR is settled and happy; staff have developed mechanisms to meet his needs and have developed a rapport. They feel that a move will be unsettling for MR' (E58).

'MR has a routine and staff have developed relationships and mechanisms to meet his needs. His routine may be disrupted with a move to another care home where he will have to readjust with new staff' (E59).

77. It can be seen from these passages that the second major disadvantage of a move is that MR is settled at CC Nursing Home. Whilst he may benefit from the familiarity of some of the religious and cultural aspects of community life at a Jewish care home, he will lose, and is likely to be unsettled by, the loss of a sense of familiarity with his daily carers and the environment and routines of his current nursing home. For a man who is disorientated to person, time and place, any sense of familiarity with what is going on around them is important and reassuring.

78. I do accept that in general terms the quality of life and standard of care which residents at the T Care Home receive is likely to be superior to that at CC Nursing Home. That is perhaps not surprising given the respective costs. T Care Home is rated 'outstanding' by the Care Quality Commission. Had MR been discharged from hospital to the T Care Home or a similar Jewish care home in north London, I have no doubt that he would be receiving a high standard of care and in addition any religious and cultural needs he has would be well-catered for. There are disadvantages to T Care Home. It is some distance from MR's sister, family and friends in north London and MR himself seems to have been considering a move within the area near to his own home.

79. To summarise the position so far, the balance of the evidence supports findings that:

a) MR is content at CC Nursing Home, staff have developed a rapport with him and he is well cared for there with regard to his physical and mental health.

b) If he is transferred to another care home, there is a high risk of adverse events including a higher risk of mortality, particularly within the first few months of relocation. This risk needs to be considered in the context that his life expectancy is such that he may only have a few months left to live.

c) He will also lose, and is likely to be unsettled by, the loss of a sense of familiarity with his daily carers and the environment and routines of his current nursing home.

In favour of a move to a Jewish care home

80. Little or no consideration was given in April 2020 to MR's wishes or to his religious and cultural needs when he was discharged from hospital to CC Nursing Home. It was shortly after the commencement of the first lockdown, and CCGs and hospitals were under instructions to discharge hospital patients. This was extremely unfortunate because MR's and Mrs R's best interests, and their wishes and feelings concerning residence in a Jewish care home, were not properly ascertained and considered, if at all. I suspect hardly at all because some staff at CC Nursing Home were not told they were Jewish and fed them pork as a result. I am informed that this error has not been repeated (D41).

81. Since then, the care home has taken some steps to try to accommodate MR's religious and cultural needs. Food is now specially prepared for him, to cater for his dietary requirements (D133). Furthermore, it is recorded that CC Nursing Home staff play Jewish movies and music for him on a daily basis. However, at the time of the hearing it was disturbing that no Rabbi had been involved or visited MR, more than 18 months after he arrived there. It is also disappointing that his support worker said that it would not normally be for the nursing home to arrange for a Rabbi to attend, and that it would be the responsibility of the family to make such arrangements (D133). There appears to have been no attempt by anyone to try to arrange a visit to his synagogue, no one visiting from an organisation such as Jewish Visiting and, as far as I can tell, no organised attempt to celebrate or mark festival days with MR other than on one occasion (see paragraph 94 below). Article 9 surely requires more than this.

82. On the balance of the evidence, I find that before the hearing on 1 December 2021 the local authority and the care home took insufficient steps to arrange and deliver a care plan which provided sufficiently for MR's religious and cultural needs. If MR were to remain at CC Nursing Home, it would be necessary to add a condition to the standard authorisation which requires the managing authority (care home) and supervisory body (local authority) to arrange visits by a Rabbi and a weekly care plan that takes more account of his cultural and religious needs.

83. In saying that, it must be acknowledged that a secular care home such CC Nursing Home will never be able to satisfy a Jewish resident's religious and cultural needs to the same standard as a Jewish care home. That is for the simple reason that its group activities are not specifically aimed at those with a Jewish background. In contrast, T Care Home has, for example, an on-site synagogue (D88). All of that, however, raises again the fundamental question of what are MR's religious and cultural needs, and how important is Jewish religious and community life to him? Furthermore, how important were these things to him when he had capacity and what he would be likely to want now if he still had capacity?

84. To this question, PD and AB gave very different answers.

85. PD told me, and he was not contradicted, that because MR lacks capacity he is not required to undertake or observe what might otherwise be religious obligations. MR had regrettably reached the stage of his illness when Jewish law no longer applies (D41). PD gave evidence to the effect that he consulted the Office of the Chief Rabbi about this because he wanted to be certain that he received correct advice (D41): 'The Rabbi confirmed that Jewish Law imposes obligations only upon those who enjoy full mental capacity' (D42). Furthermore, once a person lacks capacity, issues such as eating bread on Passover, eating non-Kosher food and attending religious services 'do not matter any more' in the very limited sense of there being an individual

duty to observe the practices (D43). None of the parties decided to adduce evidence from a Rabbi or gave evidence to the contrary. Some similar considerations were, of course, raised in *Re IH* [2017] EWCOP9 in relation to religious observances in the context of a loss of capacity.

86. Although it is logical and compassionate not to require a person to observe, or observe strictly, religious practices which they can no longer remember or understand, that is only part of the answer. It does not warrant a conclusion that whether or not religious or cultural practices are followed is irrelevant to whether it is in a person's best interests to reside in a secular or religious care home. One must also ask, as the Mental Capacity Act 2005 does, what the person's wishes would be in this situation if they still had capacity and what their wishes, beliefs and values were when they had capacity. Unless they now express contrary wishes, or there are other overriding considerations, where possible one must seek to enable them to live their remaining days in a way consistent with those wishes, beliefs and values. The Mental Capacity Act 2005 is an enabling Act designed to help, where practicable, those without capacity to live the life they wish or would wish to live if they still had capacity.

87. PD reported in a Scott Schedule of religious values and beliefs that 'MR was not religious or orthodox and his practice of Judaism (which is a way of life and not synagogual based) was minimal' (Scott Schedule, page 1 of 15). According to PD, he was not an Orthodox Jew despite belonging to the United Synagogue (D40). He and Mrs R did not keep the Sabbath (or Festivals) on which days they would drive, cook, use electricity, watch television, make telephone calls, go to the cinema, theatre or a restaurant (including non-Rabinically supervised restaurants) and go shopping (D40).

88. In my judgement, the balance of the evidence is, however, against findings that MR was not religious and that his practice of Judaism was minimal. This is for the following reasons:

1. MR was in fact a regular attender at religious services on the Sabbath and religious festivals.

2. His Rabbi provided the court with an email dated 30 November 2021 in which he stated the following:

   'I have known MR for over seventeen years in my capacity as Rabbi of the [X] United Synagogue.

   MR and the late Mrs R have been very devoted and committed members of the X community for many years.

   Indeed, four years ago MR was honoured with the position of chatan bereishit -- The Bridegroom of the Law in our Synagogue on Simchat Torah celebrating his contribution to the community.

   I personally remember MR faithfully coming to the Synagogue every Shabbat and sitting in his fixed seat near the Holy Ark until he was no longer able.

   It must be mentioned that my understanding of MR is that he is not a person who keeps the minutiae of every aspect of Jewish law. However, he is like many Jews a devoted and committed Jew who has always sought connection with the Jewish community.

   It must also be stressed that many in our middle of the road communities are of like mind. They have a devotion to being Jewish but do not necessarily practice everything.

Indeed, if you were to look at the residents in T Care Home you will see that many there are probably not practicing everything but they still feel the necessity to connect to their Jewish roots.

For many years MR and Mrs R ran a social group that met in the Synagogue every week called Y.

I hope that through this communication it will give you a little insight into the complex relationship that many people in the Jewish community have with their Judaism.

I am happy to discuss this further if needed.'

3. MR and his late wife fairly recently considered moving to a Jewish Assisted Living project under the auspices of Jewish Care in north London (D36). Although no inquiries or decision was made, to my mind this does demonstrate that they had a Jewish housing scheme or care home in mind should they require care and support in the future.

4. MR was married in an orthodox synagogue. Although PD states that this 'does not evidence any degree of religious practice some considerable period of time later', it is further evidence of a significant past religious and/or cultural value.

5. The fact that MR's existing will expresses a wish to be buried in accordance with the Jewish faith is similarly recent evidence of a significant religious and/or cultural value.

6. MR's will leaves his estate to three Jewish charities, two of which are Jewish Care and T Care Home. This giving of tzedakah is evidence of faith or tradition and also evidence that he had a high opinion of Jewish Care and T Care Home.

89. In my opinion, the balance of the evidence supports findings that MR was a devoted and committed member of his synagogue and Jewish community over many years, and that he placed a high value on this. To use his Rabbi's phraseology, he was 'a devoted and committed Jew' who 'always sought connection with the Jewish community'. Although he did not keep the minutiae of every aspect of Jewish law, he had 'a devotion to being Jewish' and felt the necessity to connect to his Jewish roots. As AB's counsel put it when AB was legally represented:

'16. There are references in the bundle to MR and [Mrs R] being 'of Jewish background'. No circumlocution is needed: they are Jews; born in a time when their Jewish identity fundamentally shaped who they were as people. While they are not orthodox they most definitely identify as Jews; they observe the Sabbath and Festivals and their lives revolved around Judaism culturally, socially and religiously. Their Jewish identity and life as part of a Jewish community was fundamental to who they were. They attended X United Synagogue; they lived in a Jewish neighbourhood, they ate the traditional foods of Ashkenzai Jews of their generation; they lived the cultural life and communal life of twentieth century Jews.'

90. Having acknowledged the past importance to him of his Jewish faith, culture and community, it must also be acknowledged that MR now has only an imperfect grasp of what previously was important to him religiously and culturally. He is variously recorded as being unable to give an answer, or an unambiguous answer, to questions such as whether he is Jewish (D194, 'No' D196); what a Rabbi is (D195); and whether he would prefer to move to a place where there are Jewish residents (D131). He did tell Dr Prabhakaran that the options under consideration were 'interesting' and 'appropriate' without being able to develop that idea (E129). He did also say that Sabbath is a special day and that a Rabbi is something about Saturday (D195), and that

he would like to be visited by a Rabbi. When Dr Prabhakaran saw him, he did not display any verbal or non-verbal responses to convey that he understood the Jewish festivals mentioned by the doctor, leading the doctor to conclude that he had limited awareness in this regard (E230). He does not know where he is living and when asked about a move to a Jewish care home, he said 'Would be a big consideration – under the photograph … I want to go back home' (E54) and 'I can look in my purse' (E55).

91. According to nursing home staff, MR's cognitive impairment is such that he often does not actively engage in social activities or interaction to any great extent and does not realise that he is in a care home. The fact that before her death MR could no longer recognise his wife – in other words, she was not sufficiently familiar to him to make this connection – and they sat separately in the lounge suggests significant limits on his ability to understand religious and cultural activities, and to become part of a community. When AB's sister informed him of his wife's funeral he just listened; 'he did not show any emotions' (D188) and it seems that he may mistake AB's sister for his wife. He now struggles to understand even basic instructions (D133) and cannot follow the instructions for residents' games (D133). Although care home staff play Jewish movies and music for him on a daily basis, he does not show any interest (D154).

92. These observations of Dr Prabhakaran and nursing home staff are an important part of the overall picture. They indicate that there are significant limits to MR's intellectual capacity to understand religious and cultural traditions and practices, and limits to the extent to which he can assimilate and become part of a community (D82). They are, however, only part of the picture.

93. The 'Activity and Interaction Recording Form' sheets in the supplementary bundle suggest that MR has some better days in terms of communication and engagement: 'MR has been very alert, lively and very chatty today' (D10.94); 'He was singing along with the music' (D10.95); 'MR participated very well. He sang along to the majority of the musicals and recognized some actors and actresses' (D10.96); 'MR was watching the film intently. He was picking up sentences and replying to them' (D10.97); 'MR engaged very well with others in the group' (D10.98); 'MR was interactive with other residents' (D10.99); 'He enjoys watching factual programmes' (D10.107); 'He was talking about the news on the TV. He understands what is going on' (D10.110). He also enjoys his food and therefore may appreciate familiar Jewish food and delicacies (D10.97).

94. Following the hearing on 1 December 2021, I asked to see the most recent nursing home Activity and Interaction Recording Forms, which were not in the bundle. I find that they also contain significant information of a capacity to engage with some community activities and religious events:

08/08/21: *'He couldn't remember his favourite author but he did talk about Shakespeare.'*

06/09/21: *MR was 'sitting next to his wife while watching and listening to the Jewish [New Year livestream] prayers and was talking and singing out loud. M seemed to enjoy the prayers'.*

19/09/21: *MR 'did share some key life dates with me about their marriage and its memories'.*

20/09/21: *He was 'singing and talkative'.*

21/09/21: *On International Peace Day, he 'became emotional when we started to listen and sang about God'.*

05/10/21: *He was talking about his wife and his childhood.*

13/10/21: *A member of staff chatted to him about the Hindu festival of Shardiya Navrati and he said that he would like to join in the party.*

16/11/21: *He was very happy to participate in the flower arranging.*

22/11/21: *He participated in a singing session.*

13/12/21: *'He was also clapping his hands to a rhythm of the music.'*

18/12/21: *'M decorated cupcakes in the lounge with other residents.'*

95. MP's witness statement dated 6 January 2022, which records Rabbi S's visit to MR on 21 December 2021, also demonstrates a capacity to engage with, rather than intellectually understand, some long ago learnt important religious practices and communal activities. MR did not recognize Rabbi S, remember most members of the Shul or recollect being honoured. He did not respond to many questions and sometimes looked blankly into the distance. However, he seemed to understand what a Rabbi was and he was able to join in Jewish hymns:

Rabbi S: I'm going to sing. Do you remember Adon Olam?

MR started to sing Adon Olam first (in the traditional tune) before Rabbi S started to sing. Rabbi S started to sing Adon Olam. [MR sang the whole of Adon Olam unassisted.] During the Adon Olam Rabbi S stopped singing for a short while and MR continued to sing alone. Rabbi S rejoined and MR and Rabbi S finished "Adon Olam" together.

Rabbi S: Shall we do the Shema? Put your hands over your eyes. Rabbi S said the whole Shema. MR closed his eyes but did not repeat the Shema.

Rabbi S: Do you remember the Shema.

MR: I think so.

Rabbi S: [Started the Shema again] MR: Started to say the Shema but stopped after reciting a few words. Rabbi S continued the Shema alone. At the end MR said a few more words. (MR did not recite the whole of the Shema – just a few words at the beginning and a few words at the end.)

Whilst Rabbi S was reciting the Shema, MR sat and was not concentrating on Rabbi S, he occasionally looked up and stared blankly at Rabbi S.

Rabbi S: Do you remember that? MR: I do, but I don't remember the other one ….

§

Rabbi S: Started singing Ein Kelokeinu. Once Rabbi S started to sing MR followed and started to sing the first verse of Ein Kelokeinu with Rabbi S. MR did not sing the second verse but started humming the tune and yawning. When Rabbi S sang the third verse, MR sang along with Rabbi S ….

Rabbi S: When we put the Torah back in the ark, We sing "Etz Chaim Hi". Rabbi S started singing, MR joined in. He was yawning. He sung with Rabbi S very clearly. In the middle he hummed. But he sang the end of the song very clearly …. MR started singing the same song again (Etz Chaim Hi) on his own. He continued to hum the same song on his own.

Rabbi S: M, do you remember me? MR: I thought I should. I had periods of time (incoherent response)

Rabbi S: I've been Rabbi in X for Z years. Do you remember the old Rabbis? MR: I thought I would. Rabbi S: Do you remember Rabbi Z? MR: That sounds very familiar.

§

Rabbi S: M, it was lovely to see you too. MR: It was lovely to see you.

96. After his meeting with MR, Rabbi S gave his view concerning MR's residence and best interests:

'Since the last time I saw him 2 years ago in Shul, he has obviously lost a lot of memory from what I see ...

Regarding "Adon Olam", MR started to sing the traditional tune, which is usually sung at the end of the Synagogue service. He obviously knew it. In fact he was the one who started to sing it before I started. It is something deep down in the recesses of his soul.

Normally when a person goes into a Jewish care home, they don't have to be religious to go there in the first place – that's my personal viewpoint. If you go into any Jewish home, you would see residents from the 'very religious' to those that do not know anything about Judaism. It's not a good argument to say M should not go to a Jewish care home because he is not the 'most religious' person.

In the recesses of their soul a Jewish person would want to socially and religiously be connected with their Jewish roots.

I don't think MR is a very religious Jew. But he has been associated with the community for all his life. From the social, religious and communal aspect, it would be correct for him to go to a Jewish care home. You don't have to be a very religious Jew to go into the care home.

MP asked Rabbi S if he wished to share his views with the court on where MR should be placed?

Rabbi S: I think in relation to the proposal for T Care Home – they have provision for religious, social and communal life from a Jewish perspective for him. They have a lot of programmes going on in the place. I've been there myself.

Once you get him going (regarding singing the Jewish songs), it kindled something. It's deep down. If no one is going to come for 2 years he would forget. If you have that (singing) on a regular basis that would be something that would flourish or grow. It would be good because it would ignite the memories for him and would be culturally something very important to him.

From a Jewish perspective, if you left him here (CC) in his state of dementia, he will forget all the things he has been living with all his life. The past 87 years. He won't get it here (referring to his Jewish culture). That's nothing personal against CC It's just not the culture here. I think it's important to respect the cultural background of where he comes from.

M was a person who came to synagogue on Shabbat. He would pray in the synagogue. It doesn't mean he was the most religious Jew.'

97. The Activity and Interaction Recording Forms and the record of Rabbi S's visit contain important evidence. They are consistent with the well-established finding that MR is severely cognitively impaired. His intellectual limitations are such that he no longer understands the meaning or significance of many words used to convey information — such as those used by Dr Prabhakaran to try to establish his understanding of Judaism and religious festivals, or the words in the Shema — and he struggles to use language. However, he still recalls and can repeat significant information memorised long ago, before he developed dementia, such as key life dates, details of his marriage, who Shakespeare was and, importantly, religious hymns. The fact that intellectually he no longer understands their significance, or only very imperfectly, does not mean they have no significance. Indeed, the fact that they were so well memorised that he can repeat them even now implies strong significance. Furthermore, his ability to engage with familiar religious hymns and rituals including emotionally — it is recorded that singing some songs make him tearful — enables him to be with others in a group and to participate, which is a tremendous asset at this stage of his life, and likely to contribute to his emotional well-being. Enabling him to participate in activities that he still has the capacity to participate in — in particular long-learnt, familiar, religious and communal activities which do not require intellectual understanding to participate — would, I think, help him to maximise his pleasure from what time remains to him. His life now is lived emotionally and through the senses, rather than intellectually. He seems to have enjoyed some emotional connection and satisfaction from singing Jewish hymns with Rabbi S, and I accept Rabbi S's view that the singing of these hymns kindled something deep down. He engaged with the activity without understanding it. It seems to have satisfied or pleased him at an emotional and sensory level without understanding why at an intellectual level. He was also attentive to the live-streamed Jewish service.

98. Rabbi S's thoughtful representations after his visit may partly have represented his own general view ('In the recesses of their soul a Jewish person would want to socially and religiously be connected with their Jewish roots.'), rather than necessarily MR's past or present views, and they were made without having sight of some of the professional evidence that I received. His observations, and the other factors in favour of a move, have to be carefully weighed in the balance with this other information, in particular Dr Prabhakaran's opinion that there would be a high risk of adverse events if MR moves to T Care Home, including a higher risk of mortality. I have also found that MR is likely to be unsettled at first by the loss of a sense of familiarity with his daily carers and the routines of his current nursing home.

99. Having undertaken this balancing exercise as best I can, I have concluded that it is in MR's best interests to move to T Care Home as soon as practicable. Even if he were to remain at CC Nursing Home, he may have only months left to live. In my opinion, it is likely that he will benefit from the familiar religious and communal activities at T Care Home, although he would be unable to put into words why it pleases him. This gives him the best opportunity to enjoy or gain satisfaction from what life is left to him and the likely benefits outweigh the likely risks. I agree with AB and his sister that it is likely he will feel a comforting sense of familiarity and reassurance from seeing and hearing religious and cultural practices and traditions such as Friday night candles, making Kiddish, Friday night dinners, the singing of Jewish songs and a care home wide celebration of Jewish Sabbath, holy days and festivals (D82).

100. A move to a Jewish care home is also in keeping with the fact that MR was a devoted and committed Jew, and the importance of his Jewish community to him. The evidence for this finding is set out above, in particular at paragraph 88. On the balance of the evidence, I believe that this is the decision he would make for himself if he still had capacity to decide. I find that when MR had capacity he and his wife envisaged spending their last days living and dying in a Jewish care facility, and that this wish was consistent with their beliefs and values. Sadly, Mrs R's wish was not carried into effect before she died.

101. In summary, it is very unfortunate that MR was not discharged from hospital to a Jewish care home in April 2020. Before his illness advanced, he was a devoted and committed Jew who always sought connection with the Jewish community. I find that he intended to live in a Jewish care home should he no longer be able to live at home. His wishes, beliefs and values when he had capacity — who he was, how he chose to live his life, what he valued — align with a move to a Jewish care home. Because those wishes, beliefs and values were life-long, I find that it is likely that, notwithstanding the risks, he would now wish to move to a Jewish care home if he still had capacity, so as to live out what little time remains to him within such a community.

102. T Care Home has the disadvantage of being in south London but is still readily accessible, and it has a place for him. It has the considerable advantages that it has a synagogue onsite, it is rated outstanding by the Care Quality Commission and MR had a high opinion of it, as demonstrated by his will. The fact that it is rated as providing 'outstanding' care will hopefully mitigate, but cannot eliminate, the risks of a move identified by Dr Prabhakaran, nor can it eliminate the downside that MR will be giving up routines with which, and staff with whom, he has some sense of familiarity. However, he will receive his care during his final days in a care environment that he intended for himself culturally, religiously and socially; and in a manner that more fully accords with his values and the way he chose to live out his life. Although there will be clear and obvious limits to his appreciation of, and interaction with, his surroundings and care, on balance I think it likely that he will gain pleasure from some of the religious and cultural practices and traditions, although he can no longer verbalise why.