



Neutral Citation Number: [2019] EWCOP 45

Case No: 1348552

**COURT OF PROTECTION**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 21/10/2019

**Before:**

**THE HONOURABLE MR JUSTICE MACDONALD**

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**Between:**

**An NHS Foundation Trust**  
**-and-**

**Applicant**

**AB**  
**(By Her Litigation Friend, the Official Solicitor)**

**First**  
**Respondent**

**-and-**

**Second**  
**Respondent**

**CD**  
**-and-**

**Third**  
**Respondent**

**A Local Authority**

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**Ms Fiona Paterson** (instructed by **the Trust Solicitor**) for the **Applicant**  
**Ms Susanna Rickard** (instructed by **the Official Solicitor**) for the **First Respondent**  
**The Second Respondent did not appear and was not represented**  
**Mr Jack Anderson** (instructed by the **Local Authority Solicitor**) for the **Third Respondent**

Hearing date: 9 October 2019  
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**Approved Judgment**

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

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THE HONOURABLE MR JUSTICE MACDONALD

This matter is subject to a reporting restriction order. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the terms of the reporting restriction order are complied with. All persons, including representatives of the media, must ensure that the reporting restriction order is strictly complied with. Failure to do so will be a contempt of court.

**Mr Justice MacDonald:**

**INTRODUCTION**

1. In this matter I am concerned with the question of whether it is in the interests of AB to have fitted an intrauterine contraceptive device (hereafter IUD) at the same time as she undergoes a caesarean section with the benefit of a spinal anaesthetic pursuant to the order of Mostyn J made on 24 September 2019. The application is brought by the Trust, represented by Ms Fiona Paterson of counsel. At the outset of this hearing that application was opposed by the local authority who are responsible for safeguarding AB, represented by Mr Jack Anderson of counsel. At the conclusion of the evidence, the local authority indicated that it no longer actively opposed the application but did not consent to it. At the outset of the hearing the application of the Trust was also opposed by the Official Solicitor, represented by Ms Susanna Rickard of counsel. However, again, at the conclusion of the evidence the Official Solicitor moved to a position of not consenting but not actively opposing the application. AB's mother, CD, has in the past agreed that an IUD should be inserted, but not immediately after birth, so as to reduce what she considers to be the risk of post-partum infection. CD did not attend this hearing nor was she represented. However, an email to the court from her previous solicitors indicates that CD opposes the application of the Trust.

**BACKGROUND AND EVIDENCE**

2. AB is a 25 year old woman who has been diagnosed with moderate learning disabilities and who is 38 weeks pregnant. She is the adopted daughter of CD, a midwife and native of Nigeria. AB came to the United Kingdom when she was 13 years old, having previously been raised by relatives in Nigeria. AB's late grandmother was heavily involved in her upbringing up until her death in May 2017. AB speaks both English and Igbo.
3. The local authority has previously been engaged in supporting AB. Contained in the papers is a support plan dated 10 October 2013 which describes AB being supported 24 hours a day, 7 days a week, although it is unclear by whom and to what level of intensity. Elsewhere it is said that the previous level of supervisory support provided to AB by the local authority comprised 4 nights per week overnight social work support, forty-two hours per week daily support and one day's attendance at a Day Centre. It would appear that this level of support ceased in September 2018 due to an overpayment. It is unclear when this, or a different level of support recommenced, albeit the local authority contends that AB has remained supported at all times by an informal network.
4. In April 2019 it was discovered that AB had become pregnant. The gestational dates would suggest that AB conceived whilst on a trip to Nigeria to stay with relatives from 28 October 2018. The primary purpose of AB's trip was to visit her grandmother's grave. It would appear that AB remains very attached to her late grandmother and frequently asks of her whereabouts. Whilst in Nigeria, AB stayed with, and was cared for by her two maternal aunts. AB's mother, CD, was with her in Nigeria between 15 December 2018 and January 2019.
5. The local authority has not been able to ascertain from AB's family, or otherwise, the circumstances under which AB became pregnant in Nigeria and, at least on the basis

of the oral evidence given by the local authority Learning Disabilities Team Manager at this hearing, it is unclear whether the local authority has taken any effective investigative steps in this regard. The Police investigation into the circumstances of AB's pregnancy is ongoing with a number of investigatory steps still outstanding. The local authority's own safeguarding investigation is likewise yet to be completed, with no clear timescales for its conclusion.

6. As a result of her pregnancy, AB has been the subject of previous hearings before Lieven J (see *Re An NHS Trust v AB* [2019] EWCOP 26), the Court of Appeal (see *Re AB (Termination of Pregnancy)* [2019] EWCA Civ 1215) and Mostyn J. On 21 June 2019, Lieven J declared that it was in AB's best interests for her pregnancy to be terminated. On 11 July 2019 the Court of Appeal allowed an appeal against that decision and set aside the declarations made by Lieven J. As I have noted, on 24 September 2019 Mostyn J determined that it is in AB's best interests to deliver her baby by means of a caesarean section. AB's expected date of delivery is 20 October 2019. Her pregnancy is progressing normally and, with support, AB has been compliant with all obstetric investigations and pre-natal care. AB appears to be excited and happy about the prospect of having a baby, although the Trust considers that there is uncertainty over the extent to which AB understands her pregnancy and the fact of her impending delivery and care of a child. In particular, during a "dry run" of the authorised caesarean section, AB has appeared distressed and tearful.
7. AB has been assessed as lacking capacity to consent to sexual intercourse. On 25 September 2019, an assessment of her capacity to consent to / use contraception was undertaken by Professor X (Psychiatrist specialising in intellectual disability), Dr N (Consultant Perinatal Psychiatrist) and Ms T (treating consultant obstetrician). The outcome of that capacity assessment indicates that AB lacks capacity to consent to / use contraception. AB has been the subject of repeated capacity assessments by her treating team with respect to a variety of aspects of her pregnancy, including mode of delivery and contraception, all of which have indicated that AB lacks capacity to take the decisions that have been the subject of those assessments. No party sought to dispute that AB *presently* lacks capacity in respect of decisions concerning contraception.
8. At issue during this hearing has also been the extent to which further educative work and support would assist AB either to better participate in the decision making process regarding the insertion of an IUD or, even, to *gain* capacity in respect of that decision. Prior to the conclusion of the evidence, both the local authority and the Official Solicitor sought to argue that, with further educative work, AB could *gain* capacity in respect of decisions concerning contraception. Prior to the conclusion of the evidence the Official Solicitor further argued that, in any event, even if AB did not gain capacity a period of further educative work and support prior to any contraception being employed for AB would permit AB to better participate in the decision making process regarding such contraception, consistent with the demands of s 4(4) of the Mental Capacity Act 2005.
9. These arguments advanced by the local authority and the Official Solicitor relied on the opinion of a Senior Clinical Nurse Specialist in learning disabilities, Ms Q, who had indicated that she was optimistic that AB would *gain* capacity with respect to decisions concerning contraception with further educative work and support. During the course of the evidence, this contention continued to be advanced by the local

authority and the Official Solicitor notwithstanding (a) the evidence of Ms T that it is “extremely, extremely, extremely unlikely”, and the evidence of Dr N that it was “extremely unlikely”, that AB will gain capacity in respect of decisions concerning contraception and (b) the evidence of Professor X, unchallenged in cross-examination by either the local authority or the Official Solicitor, that Ms Q had expressed a similar level of optimism in AB’s ability to gain capacity in respect of decisions concerning modes of delivery but that AB plainly continued to lack capacity in respect of such decisions notwithstanding at least fifteen sessions with AB undertaken by Ms Q on the issue of mode of delivery. Indeed, the fact that AB has made no gains in this regard was acknowledged by Ms Q herself in a professionals meeting held on 10 September 2019.

10. With respect to the level of risk of further unplanned pregnancy in the near future, both the local authority and the Official Solicitor argued during the course of the hearing that on the evidence before the court the risk of an unplanned pregnancy for AB was at present, and in effect, *nil*. Before turning the reasons advanced for that assertion, it is important to note that the conclusion on the part of the local authority and the Official Solicitor that the risk of a further unplanned pregnancy for AB in the near future is in effect *nil* was one drawn by the local authority and the Official Solicitor in the following forensic context:
  - i) There have been previous safeguarding concerns when AB was aged 16 years old and living at home, following a report that AB had been pulling down her brother’s trousers and attempting to touch his penis.
  - ii) In her statement, CD says that in approximately May 2018, AB informed her that she wanted to have sex. CD was informed by AB’s teacher that no lessons on relationships or sex had been undertaken with AB and CD states in her statement that she had heard nothing further in this regard.
  - iii) AB’s family has offered no explanation for how AB became pregnant in Nigeria, including as to the precise timing, location and circumstances of her becoming pregnant in that country, CD stating that “Nobody in the family understands how it could have happened” (although CD has also speculated that the father could be a family friend who knew AB in England, was described by AB as her “boyfriend” in October 2018 and went to Nigeria at the same time as AB). On 4 October 2019, when asked how she got pregnant, AB replied that “The people pregnant me” when she was in Nigeria.
  - iv) When AB became pregnant in Nigeria, she was in the care of her maternal aunts. Her mother, CD, was with her in Nigeria between 15 December 2018 and January 2019. These three adults are now proposed by the local authority as the primary supervisors who will safeguard AB from risk of further unplanned pregnancy. One of the aunts has yet to arrive from Nigeria and, accordingly, has yet to be the subject of detailed assessment by the local authority.
  - v) The Police investigation into the circumstances by which AB came to fall pregnant is ongoing and has as yet drawn no conclusions in this regard that are capable of informing an accurate assessment of future risk of unplanned pregnancy.

- vi) The local authority's own safeguarding investigation into the circumstances by which AB became pregnant is also ongoing and has yet drawn no conclusions in this regard that are capable of informing an accurate assessment of future risk of unplanned pregnancy.
- vii) In his statement dated 25 May 2019, Professor X notes the following the exchange with AB during a capacity assessment on 21 May 2019:

“Using a picture reference of a man and women in bed, we asked if [AB] knew what ‘sex’ means or what it means to have ‘sex’, [AB] replied ‘no’. She said she was not allowed to kiss and said her mum says she is not allowed to kiss. She pointed to the picture of a condom which she called a ‘fee-dom’ or a ‘pom-pom’. We asked what these were for and she was unable to answer. She said these were ‘bad’ and that ‘I [AB] don’t like it. I [AB] don’t want my boyfriend. I don’t want him to sleep in my bed’. We asked if her boyfriend had slept in her bed and she replied that he came into her room, when we asked where, she said ‘in [home address]’. When we asked when this had happened, she was unable to answer. We asked if he slept in her bed and she replied ‘no’. She said her auntie was home at the time. They had watched TV. Her auntie made her food. She then described washing dishes. She then said ‘I don’t want my boyfriend in my room’. She later denied that he had been in her room.”

As I have noted, CD has confirmed that AB knew a man she described as her “boyfriend” in October 2018. CD confirms in her statement that this person visited the family home on five occasions. CD is also clear that this boy was in Nigeria at the same time as AB. It is apparent from the statement of the social worker however, that CD asserts that she is unable to provide contact details to the Police for this “boyfriend” and, as I have noted, none of the family have been able to offer any information on how AB came to be pregnant in Nigeria.

- viii) Later during the capacity assessment on 21 May 2019, and during exploration of her understanding of sex, AB stated to Professor X that she did not want sex, does not like it and that “I don’t want kisses”. When shown a picture of an ejaculate stain on the bed, AB stated that this was ‘mess’ from a ‘pom-pom’. When asked if there had ever been ‘mess’ from a ‘pom-pom’ in her bed, AB did not answer. AB was noted to be markedly more subdued during these exchanges.
- ix) Whilst a further assessment is now being undertaken of CD following a complaint by CD regarding the first, and negative, viability assessment, that first viability assessment of CD dated 26 July 2019 nonetheless noted as follows:

“There are significant concerns in regards to how AB conceived the baby given she has no capacity to consent to sexual intercourse, and CD appears not to be interested to know who sexually assaulted her daughter, not agreeing with the assessment that AB does not have the

capacity to consent to sex and therefore not agreeing that she was raped. The Metropolitan Police have concluded their investigation because the incident took place in Nigeria, which is not in their jurisdiction.

I am concerned that a family member who is travelling to Nigeria to support CD was caring for AB when she was sexually abused in Nigeria. This therefore, raises significant concerns as to how this vulnerable woman became pregnant in the care of her trusted family members.

CD has expressed to myself and colleagues that her daughter has no learning difficulties, and does not agree with health professional's assessments of her daughter including the Capacity Assessments. This therefore raises serious concerns in regards the level of responsibilities that will be given to AB in respect of the care of the baby when no professionals are present. This could put a vulnerable child at risk of Significant harm of Death, due to AB's high level of needs which could supersede the needs of her child."

- x) During a capacity assessment on 25 September 2019 AB stated, in an apparently shocked manner, that she had seen a condom and that the man puts the condom on "If excited" and that a man had done that with her in Nigeria. When asked how often she had seen a condom AB replied "In the bum". During the capacity assessment on 4 October 2019 AB again appeared to describe the act of a man putting on a condom and stated that "The people is sleeping, put it inside it. In the bum" (Ms T was clear that AB knows the difference between the anus and the vagina and points to her bottom when she says bum, although I note during the exchange on 17 July 2019 AB placed her hand over her groin immediately after stating the baby would come out of her "bum").
- xi) On 4 October 2019, AB talked about a woman making a video of her on the bed with a man at AB's family home in the following exchange (which exchange I acknowledge is not without difficulties forensically):

"LD: Someone made a video?

AB: Yes.

LD: When?

AB: The lady.

LD: The lady made a video?

AB: Yes.

LD: When did the lady make a video?

AB: They got it. They got this one [indicating LD's phone].

LD: They got that one?

AB: Yes.

LD: When did the lady make a video?

AB: Video people. Sleeping on the bed.

LD: Sleeping on the bed?

AB: Yes.

LD: Who made the video?

AB: A lady.

LD: A lady?

AB: Yes.

LD: Okay. Who did the lady make the video of?

AB: The man.

LD: The man?

AB: No. Mn-mm. The lady video the man, sleep with them.

LD: The lady makes a video of the man, sleeping with them?

AB: Yes.

LD: With you?

AB: No. Not me.

LD: Not you?

AB: No. A lady.

LD: A lady?

AB: Yes.

LD: Did she make a video of you?

AB: Yes.

LD: When you were sleeping with a man?

AB: Yes.

LD: Where.



AB: The man in the room?

LD: The man in the room?

AB: Yes. She put me on the bed. Video me.

LD: Where did that happen?

AB: On the bed.

LD: But was it in England?

AB: Yes, England.

LD: Was it in Nigeria?

AB: No. England.

LD: In England?

AB: Yes.

LD: Okay. When?

AB: Today.”

- xii) Ms T gave evidence (which was not challenged in cross-examination) that AB has on other occasions made statements to suggest that she could have been coerced into sex, saying sex had taken place at the family home and describing “mess” (AB’s word for ejaculate) as having got on her mother’s bed sheets.
- xiii) At times AB can behave inappropriately towards others, being overly friendly and familiar with people, including strangers, by touching them and kissing their hands. Professor X relates that AB has a history of stripping naked and then leaving the family home. AB has demonstrated herself to be familiar with sexualised language even though planned sex education does not appear to have taken place.
11. The high level of confidence expressed to the court by the local authority and the Official Solicitor that, notwithstanding the matters set out at paragraph 10 above, the risk of a further unplanned pregnancy in the near future for AB is, in effect, *nil* was based on the contention, advanced by the local authority and supported by the Official Solicitor, that the local authority now has in place a complete, comprehensive and effective support plan to safeguard AB from the risk of unplanned pregnancy, which plan *negates* the need for contraception at this point in time and allows for a further period of work with AB to increase her ability to participate in decisions concerning contraception. In summary, the plan advanced by the local authority and, during this hearing, endorsed by the Official Solicitor is:
- i) AB will not be left at home alone;
- ii) AB will not be left unsupervised with a male;

- iii) AB will be accompanied in the community;
  - iv) AB will be with CD, a trusted family member or support worker at all times (the plan being that, if CD is caring for the new-born child, a rota will be arranged whereby AB's maternal aunts (one of whom will arrive shortly from Nigeria) will take turns on a rota to live in with the family);
  - v) There will be weekly visits to family home by a social worker to "check to ensure the risk management plan is complied with".
12. Within the context of the foregoing plan, in addition to submitting, through Ms Rickard, that the risk of AB being exposed to further sexual activity (and therefore pregnancy risk) is at present, and for the foreseeable future, close to nil, on behalf of the Official Solicitor Ms Rickard further invited the court to conclude that AB's pregnancy would not have occurred had AB been in CD's care as "that pregnancy was not something CD wanted for AB, nor something she anticipated occurring, and it is not something she is likely to risk being repeated". The Official Solicitor argued that this inference can safely be drawn from (a) the fact that CD has been extremely distressed by AB's pregnancy (as noted by Lieven J in her judgment at [14]) and (b) from CD's level of cooperation following the discovery of the pregnancy. In summary, and again in the context of the matters summarised in paragraph 10 above, the Official Solicitor submitted that:
- "Simply put, given CD's care of AB, her co-operation and agreement with the local authority, and the additional support and attention AB is receiving arranged by the local authority, there is no reason to believe AB will encounter a further situation in the foreseeable future in which sexual activity is allowed to take place".
- Within this context, the Official Solicitor submitted that there is no justification at this point in time for the interference with AB's bodily autonomy that the fitting of an IUD would result in and nor is there any pressing need at this time for such a step. The Official Solicitor accordingly submitted that the application of the Trust was premature and should be dismissed.
13. The local authority likewise contended during the hearing, in the context of the purported safeguarding plan summarised above, that following "a number of conversations with" CD, it has no reason to consider that the plan to protect AB from further unplanned pregnancy will be ineffective and, accordingly, the use of contraception is "unnecessary and overly invasive". I pause to note that in what purports to be its final safeguarding plan dated 8 October 2019, under the heading "Vulnerability to abuse", the local authority fails to mention all but one of the matters listed at paragraph 10 above as a risk factor for continued vulnerability to sexual abuse.
14. The local authority continued to advance, and the Official Solicitor continued to give her support to the purported safeguarding plan outlined above (in the context of a proposal whereby CD will care for the new-born child whilst AB also lives at home) during the hearing notwithstanding the following matters:

- i) In the absence of the completion of the Police investigation into the manner in which AB became pregnant and the local authority's safeguarding investigation, there is as yet no clear and concluded picture of the nature and extent of the risk that any safeguarding plan based on family and professional supervision is required to protect against.
- ii) Within this context, as I have noted, when AB became pregnant in Nigeria, she was in the care of her maternal aunts. These adults are now proposed by the local authority as being integral to the safeguarding plan based on family supervision, notwithstanding that neither of them, on the local authority's own evidence, is able to explain how AB came to be pregnant whilst in their care nor have steps been taken by the local authority to further investigate that matter with them.
- iii) The final draft of the local authority's safeguarding plan had only been completed on the morning of this hearing. From the oral evidence given by the local authority Team Manager it was not clear if that plan had been shared in detail with, or even based on proper consultation with AB's treating obstetric team, Professor X, Dr N, Children's Services and the Mental Health Team. It was further unclear the extent to which the details had been discussed with the family, and in particular the maternal aunt who is due to arrive from Nigeria to be an integral part of the safeguarding plan.
- iv) As I have noted, the purported safeguarding plan fails to identify all but one of the risk factors for vulnerability to abuse that are clear from the documentary evidence before the court and which are summarised at paragraph 10 above.
- v) Whilst the purported safeguarding plan relies on a high level of co-operation by the family, which the Official Solicitor and the local authority consider has been evidenced by the family, the records show that prior to AB becoming pregnant she had not been seen in the Mental Health Learning Disability Clinic (hereafter MHLDC) since July 2018. The MHLDC had not been informed of AB's absence from the country, during which extended absence she missed several appointments (and became pregnant). CD has not attended this hearing.
- vi) The evidence before the court indicates that AB's behaviour at home can be extremely challenging, including grabbing a knife during an incident of disturbed behaviour, destroying two televisions in response to CD's refusal to agree to AB going to Nigeria. Professor X considers that these behavioural outbursts present a considerable risk to AB and to others. As recently as July 2019 the following report was made by the care home in which AB was placed:

“On 5 July 2019, [AB] came up to staff in the kitchen, saying she was not happy because she wanted to have the iPad to look at something. When they were not immediately able to meet her demands, she attempted to grab a kettle, saying she was going to “burn the baby”. She also attempted to grab the microwave and to throw that to the floor, but staff were able to stop her from doing this. She then slapped a staff member on the back, but became calm again in response to staff's interventions. On 7 July 2019, [AB] refused

medication, refused to eat, did not engage with staff, and said she was not happy. She reportedly picked up a pencil and tried to dig it into her ear. She also reportedly threw a computer onto the floor, threatened to “kill” staff with a knife, and to beat up her co-resident (an elderly disabled women). She also said she wanted to “kill the baby” and slapped herself in the stomach. Police had to be called as the staff were not able to calm her down. However, when they arrived she quickly settled.”

- vii) In this context, in her judgment of 21 June 2019 Mrs Justice Lieven noted as follows at [14] regarding the impact of AB’s behaviour in the family home as set out in an email from CD in February 2018 that read as follows:

“AB likes going out but unfortunately there is a limit to the episodes of outing that her care package and my circumstance can contain. As a result, the exit house key has to be hidden. At the least opportunity, AB would leave the home. At one instance, in X Road, AB left home on her own and I had to search for AB for one hour and found her in R market area. The reason being that I came back from night duty, and she let herself out when I was asleep.”

- viii) Again within this context, I also note in this context the observations of King LJ in the Court of Appeal at [12]:

“On 16 May 2019, by which time AB was about 16 weeks pregnant, CD arrived at the hospital with AB, together with all of AB’s possessions packed into three suitcases and two rucksacks. CD told the hospital that she was ‘handing over’ the care of AB. Since that time, AB has lived in a residential unit. In her statement, CD says that she did not do this for fear of being ostracised by her community if AB had a termination, but because she felt she could not support AB in having a termination. CD’s position at trial was that, contrary to her feelings in May, she would now wish to have AB back to live with her even if she had a termination. The rights and wrong of all of this were not matters with which the judge needed to concern herself and, for my part, the relevance is only in that it highlights that AB’s home circumstances are complicated and that it would be naive to presume that an easy solution to the conundrum presented to the court would be for AB to have her baby and move back home where she and her baby would live with, and be cared for, by CD.”

- ix) Finally within this context, in her statement dated 19 June 2019, Dr N recorded as follows in respect of a situation that now amounts to the current plan of the local authority for AB and her child to be discharged to live with CD, with CD both caring for the child and being at times responsible for the supervision of AB with a view to protecting her from the risk of further unplanned pregnancy:

“I have been asked about the possibility of [AB] and the baby returning to live with her mother after the delivery. [AB] struggles to tolerate frustration as a result of her learning disorder and mood

disorder, and, from the description in her clinical notes and by other's account, when frustrated she can have significant outbursts of anger. Consequently, I not consider that [AB] could cope with living in the same household as a baby or a young child. Her outbursts would probably increase. She find the baby crying or her mother's (or whomever was caring for her) attention being diverted away from her difficult to tolerate. I believe that [AB] would have to live separately from her mother and the baby and visit them, in the eventuality that the baby's care was allocated to her mother. It would be detrimental to her mental health and too risk for the baby's wellbeing for them to live in the same place".

- x) Dr N is clear, in evidence that remained unchallenged in cross-examination, that AB is at greater risk than the general population of a deterioration in her mental state following the birth of the baby on the basis that she demonstrates features of a mood disorder, women with such disorders being at an increased risk of puerperal psychosis and at a higher risk of post-natal depression.
  - xi) Whilst the local authority sought to give assurances as to its level of commitment to the safeguarding plan, I note that the previous safeguarding plan, which commenced on 10 October 2013, was suspended in September 2018 for financial reasons (due to an overpayment) and stood suspended for such reasons at the time AB fell pregnant.
15. During the hearing itself, the Team Manager was questioned extensively on the local authority's plan to safeguard AB from a risk of a further unplanned pregnancy, and more generally. The evidence of the Team Manager was, I regret to observe, wholly unconvincing, characterised as it was by a lack of clear understanding of the current situation for AB, equivocality in respect of the anticipated role of other key agencies and an unwillingness to confirm cardinal aspects of the safeguarding plan beyond stating a *hope* that these aspects would be implemented. Within this context, it was clear from the evidence of the Team Manager that:
- i) There is as yet no clear and settled plan regarding the care of AB's child following her birth. The Team Manager was unable to relate to the court what stage Children's Services has reached regarding its view on post-natal care of the child, nor when it would complete that assessment. Accordingly, the purported safeguarding plan has been formulated in a situation of continuing uncertainty as to the care plan for the new born child. The most that could be said by the Team Manager is that the learning disability team are *hoping* that CD will be the carer for AB's daughter and AB following the birth.
  - ii) Within the context of the negative viability assessment detailed above, the Team Manager appeared to indicate that it is the intention of the local authority that a further detailed assessment of CD will be undertaken over a period of 12 weeks *whilst* CD cares for AB's child and AB. Within this context, it appeared to be the case that the local authority intended to implement its supervision plan *before* having assessed the extent to which CD could both care for a new born child and perform the central role in the safeguarding plan for AB that the local authority envisages for CD.

- iii) In advancing the safeguarding plan the Team Manager appeared to be unaware of the information summarised in Lieven J's judgment at [14], was unable to provide any definitive timescales for the Police investigation, the local authority's safeguarding investigation or a decision by Children's Services as to the care of AB's child and was unable to detail what the involvement of the Mental Health Team would be in supporting AB at home beyond stating a "hope" that it would provide the necessary support for the plan in accordance with its statutory duties.
  - iv) The Team Manager did not appear to have considered or reflected on the fact that at least one of the relatives who is seemingly central to the safeguarding plan of the local authority was in Nigeria and caring for AB at the time AB fell pregnant, nor made any effective enquiries consequent upon this fact to assess the impact of this fact on the efficacy of the proposed safeguarding plan. The supervision plan of the local authority contains no information at all regarding how the risk of unplanned pregnancy will be managed for AB if and when she returns to visit Nigeria.
  - v) The Team Manager had no clear conception of how the local authority would be alerted as to problems or risks developing in the placement within the context of the plan providing for only weekly visits by social workers.
16. As I have noted, whilst Ms Rickard had indicated to the court following the evidence of Ms T that the Official Solicitor was giving careful consideration to her position in light of Ms T's evidence regarding the level of *pain* a later insertion of the IUD would cause AB, in the context set out above, and until the Court expressly invited them to give further thought to their respective positions at the conclusion of the evidence, the local authority continued to advance, and the Official Solicitor continued to contend that the purported safeguarding plan rendered as *nil* the risk of unplanned pregnancy in the near future and *negated* the need for contraception at this point in time and pending further work with AB, the Official Solicitor expressing apparently untrammelled "confidence" in the effectiveness of the proposed safeguarding plan.

#### THE MEDICAL EVIDENCE

17. With respect to the medical position, as I have noted, the court has reports from, and heard oral evidence from Professor X, Dr N and Ms T.
18. Ms T was an extremely impressive witness, who gave measured, well informed and well-reasoned evidence within her field of expertise in obstetrics. Ms T is clear that AB does not have capacity to make a decision as to contraception. Ms T carried out an educative session with AB using items to demonstrate various methods of contraception and had tested AB's retention of knowledge at an ante-natal appointment a week later. Ms T found that AB had not retained the majority of the information from the earlier session and that, whilst she did retain some information, she was unable to use and weigh information to come to a decision. Ms T was also clear in her view that further work with AB was *not* likely to improve her understanding and ability to participate in the decision making process regarding contraception. In this context, Ms T pointed out that she has undertaken some seven sessions with AB on the question of delivery methods but that AB's understanding of this topic had not moved. As with the question of contraception, Ms T considered

that whilst AB retained some information on delivery methods she could use or weigh information to make a decision.

19. Within this context, pressed by the local authority on the possibility of AB gaining capacity to make decisions as to contraception, Ms T was incredulous at the suggestion, stating, in the context of her extensive contact with and assessment of AB's capacity in respect of delivery methods and contraception, that it is "extremely, extremely, extremely" unlikely that AB will gain capacity on the question of contraception. Ms T was clear that AB had not passed *any* of the capacity assessments undertaken with her, retaining some information but being unable to use it to understand the decision in question and to weigh risks versus benefits.
20. As to methods of contraception, Ms T was clear that, for AB, the IUD method of contraception is by far the most preferable. Ms T stated that, first, it is very effective at preventing pregnancy and much more effective than oral contraception. Second, Ms T pointed to the fact that barrier contraceptive methods such as condoms rely on others for their effectiveness. Third, hormonal contraceptives, particularly those containing only progesterone can have an adverse impact on those patients with mood disorders, features of which AB demonstrates. Ms T stated that use of hormonal contraceptives is further complicated by the fact that AB is currently on sertraline and risperidone for her mood and behavioural issues. Further, Ms T gave evidence that a combined oral contraceptive of oestrogen and progesterone could not be administered for the first six weeks following birth and, given the fact AB will have had a caesarean, up to eight weeks following birth administration would carry with it the risk of venous thrombosis. Further, Ms T considered that this form of oral contraception has a much higher failure rate than an IUD and that oral contraception is not an ideal long term contraceptive option. Within this context, Ms T was clear that an IUD is the best contraceptive solution for AB.
21. Ms T stated that, if authorised by the court, the IUD will be inserted when the caesarean incision is open, which allows the IUD to be carefully situated and checked in situ. As AB will have the benefit of a spinal anaesthetic, Ms T was clear that the implanting of the IUD in this manner will not result in any pain and that this method carries with it minimum risk of infection and minimum risk of perforation of the uterus. Given that AB will not have had a vaginal delivery, Ms T stated that there is also a minimum risk of the IUD being expelled. By contrast Ms T was clear that the insertion of an IUD at a later date would be extremely painful for AB. Ms T said this would be consequent on the fact that (a) AB would have a tight cervical opening having not given birth vaginally, (b) the insertion would require a prolonged speculum examination, (c) AB has demonstrated herself to have a relatively low tolerance of pain and (d) many women have described the discomfort of having an IUD fitted as "worse than giving birth". Ms T stated that the insertion vaginally could take between five and ten minutes although it was impossible to be certain given that no imaging of cervix has been undertaken and it is not yet possible to state which position AB would have to be in for the insertion of the IUD. As to later insertion of IUD at same time as AB underwent a smear test, Ms T was concerned that this would prolong the speculum examination and that AB would thereafter equate the extreme pain of the IUD insertion with the smear test that she would have to undergo every three years.

22. Dr T was clear that a second pregnancy would be extremely detrimental for AB, who has looked distressed and upset through the process of “dry run” for the planned caesarean section, fighting back tears. As her treating obstetrician, Ms T considers that AB has found the process of pregnancy difficult and overwhelming. Ms T considered that a second pregnancy for AB would be “disastrous” for her.
23. Dr N likewise gave evidence with clarity and insight. As to capacity, Dr N stated that AB lacks capacity in respect of the question of contraception and that it is “extremely” unlikely that she will gain capacity in this regard. Whilst clear that AB does not fulfil all the criteria for a mood disorder, Dr N was equally clear that AB does exhibit some of the features of a mood disorder and that, consequently, she is at a higher risk of post-partum psychosis than the general population for this reason (Dr N also making the point that as AB is adopted it is not possible to say how that elevated risk is further affected by genetic loading). Within this context, Dr N considers that AB will require close monitoring for the first six weeks, that hormonal contraception would have the potential to have an adverse impact on her mood and that insertion of the IUD at the point of the caesarean section would be much less distressing for AB in the context of the mental health vulnerabilities and leave AB with fewer distressing memories than a later, separate procedure. As to impact of a further pregnancy, Dr N was clear that she would be “dismayed” if AB became pregnant again, given the associated psychological risks to AB.
24. Finally Professor X, a professor of psychiatry specialising in learning disabilities at the Z Hospital was clear that AB lacks capacity with respect to decisions concerning contraception. Further, and as I have noted, Professor X simply could not accept Ms Q’s view that with further educative work AB could gain capacity on the question of contraception. Nor did Professor X believe that further work would result in AB being better able than she is now to participate in decisions concerning contraception within the context of her lack of capacity in this regard. Within this context, Professor X noted that extensive work done with AB on the question of delivery method had not resulted in any such improvement in AB’s ability to participate and that in work on the question of contraception AB had shown no ability to better retain information over time or a greater capacity to use and weigh information over time. This evidence strongly correlated with that given by Ms T. In so far as this evidence is said by the local authority to be contradicted by Ms Q’s view that AB will gain capacity in respect of contraception, the local authority chose not to call Ms Q and, as set out above, Professor X pointed out in evidence that was unchallenged in cross-examination by either the local authority or the Official Solicitor that Ms Q had expressed a similar level of optimism in AB’s ability to gain capacity in respect of decisions concerning modes of delivery but that AB plainly continued to lack capacity in respect of such decisions notwithstanding at least fifteen sessions with AB undertaken by Ms Q on the issue, as acknowledged by Ms Q herself in a professionals meeting held on 10 September 2019.

## THE LAW

25. First, the following provisions of the Mental Capacity Act 2005 are relevant to the question of capacity:



## **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) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

.../

## **2 People who lack capacity**

- (1) For the purposes of this 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.
- (2) It does not matter whether the impairment or disturbance is permanent or temporary.
- (3) A lack of capacity cannot be established merely by reference to—
  - (a) a 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 his capacity.
- (4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

.../

## **3 Inability to make decisions**

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

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of—

- (a) deciding one way or another, or
- (b) failing to make the decision.

26. Within this statutory context, a number of cardinal principles can be identified to which the court must have regard when deciding, on the balance of probabilities, whether a person lacks capacity in respect of the relevant decision or decisions, in this case capacity to make decisions in respect of contraception, for the purposes of the 2005 Act (see *PH v A Local Authority* [2011] EWHC 1704 (COP) at [16]):

- i) A person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s 1(2)). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s 2(4) and see *KK v STC and Others* [2012] EWHC 2136 (COP) at [18]).
- ii) Determination of capacity under Part I of the Mental Capacity Act 2005 is always ‘decision specific’ having regard to the clear structure provided by sections 1 to 3 of the Act (see *PC v City of York Council* [2014] 2 WLR 1 at [35]). Thus capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person’s capacity to make decisions generally. The requirement is to consider the question of capacity in relation to the particular transaction (its nature and complexity) in respect of which the decisions as to capacity fall to be made (see *Masterman-Lister v Brutton & Co* [2003] 1 WLR 1511 at [27]).
- iii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s 1(3)).
- iv) A person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise (Mental Capacity Act 2005 s 1(4) and see *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP) at [7]).
- v) The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see *R v Cooper* [2009] 1 WLR 1786 at [13] and *York City Council v C* [2014] 2 WLR 1 at [53] and [54]).
- vi) 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 (the so called ‘diagnostic test’). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s 2(2)). The question for the court is not whether the person’s ability to take the decision is *impaired* by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered *unable* to make the decision by reason thereof (see *Re SB (A*

*Patient: Capacity to Consent to Termination*) [2013] EWHC 1417 (COP) at [38]).

- vii) A person is “unable to make a decision for himself” if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means (the so called ‘functional test’). In *PCT v P, AH and The Local Authority* [2009] COPLR Con Vol 956 at [35] Hedley J described the ability to use and weigh information as “the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another”. An inability to undertake any one of these four aspects of the decision-making process will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see *RT and LT v A Local Authority* [2010] EWHC 1920 (Fam) at [40]). The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s 3(4)(a)).
  - viii) For a person to be found to lack capacity there must be a causal connection between the ‘functional test’, being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act, and the ‘diagnostic test’, ‘impairment of, or a disturbance in the functioning of, the mind or brain’ required by s 2(1) of the Act (see *York City Council v C* [2014] 2 WLR 1 at [58] and [59]).
  - ix) Whilst the evidence of psychiatrists is likely to be determinative of the issue of whether there is an impairment of the mind for the purposes of s 2(1), the decision as to capacity is a judgment for the court to make (see *Re SB* [2013] EWHC 1417 (COP)).
27. With respect to best interests, once again, the statutory provisions with which the court is concerned are as follows:

#### **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.

28. Within this statutory context, the following propositions can be drawn from the authorities regarding the nature and scope of the best interests assessment with respect to contraception for those lacking capacity:
- i) The test for whether P has capacity to consent to contraception was stated by Bodey J in *In re A (Capacity: Refusal of Contraception)* [2011] Fam 61 at [64] as being whether P is able to understand and weigh up the immediate medical issues surrounding contraceptive treatment, including:
    - a) The reason for contraception and what it does (including the likelihood of pregnancy if it is not used during sexual intercourse);
    - b) The types of contraception available and how they are used;
    - c) The advantages and disadvantages of each type of contraception;
    - d) The possible side effects of each type of contraception and how they can be dealt with;
    - e) How easily each type of contraception can be changed;
    - f) The generally accepted effectiveness of each type of contraception.
  - ii) In the assessment of best interests, the question of risk must be weighed, including the risk of future pregnancy and the risks to mental and physical health associated with pregnancy, childbirth and/or the removal of the child. The appraisal of risk should be sensible and not aim at the elimination of all risk. Where a person is not sexually active, does not show an interest in sexual relations and is well supervised at home and in the community, those factors should also be taken into account in the best interests evaluation.
  - iii) In considering best interests, the court should strive for a balance between protection and autonomy (see *A Local Authority v K (by the Official Solicitor)* [2013] EWHC 242 (COP)). The court should endeavour to achieve the least restrictive option.
  - iv) In circumstances where the insertion of an IUD will prevent AB from having children and making a significant choice regarding her own body, AB's Art 8 rights are engaged. Proper consideration of P's Art 8 rights is achieved through the best interests appraisal under s 4 of the Mental Capacity Act 2005 (see *K v LBX* [2012] 1 FCR 441).
  - v) In undertaking the best interests evaluation, there may in a particular case be one or more factors that are of 'magnetic importance' in the outcome of that evaluation and which may even be determinative of it (see *An NHS Trust v DE* at [84]).
  - vi) Even a small risk that P will elude the supervision put in place is a factor to be taken into account when considering whether to authorise contraception (see *Re P* [2018] EWCOP 10 at [50]).

29. In this case, the Court has also been required to consider in some detail the terms of s 4(4) of the Mental Capacity Act 2005, which requires the court to ensure that P must, so far as reasonably practicable, be permitted and encouraged to participate, or to improve her ability to participate, as fully as possible in any act done for her and any decision affecting her (see *Wye Valley NHS Trust v Mr B* [2015] COPLR 843 at [18]). In the context of s 1(3), the term 'practicable' is interpreted in the Code of Practice as meaning "practical and appropriate" depending on "personal circumstances, the kind of decision that has to be made and the time available to make the decision".
30. Section 4(4) is plainly a vital provision of the act, ensuring as it does that all reasonably practicable steps are taken to ensure that a person who lacks capacity retains the fullest possible level of autonomy in the decision making process appropriate to their particular circumstances, even if she lacks the capacity to take the decision herself. As King LJ noted in the Court of Appeal at [71]:

"Part of the underlying ethos of the Mental Capacity Act 2005 is that those making decisions for people who may be lacking capacity must respect and maximise that person's individuality and autonomy to the greatest possible extent."

However, the use of the words "so far as reasonably practicable", and the interpretation placed on them in the Code of Practice, also make clear that efforts to permit and encourage P to participate in the decision have their limits. In particular, the search for increased autonomy for P in respect of the decision to be taken cannot be allowed to result in actions antithetic to P's best interests. Within this context, there must be a balance struck between autonomy and protection.

## DISCUSSION

31. As I have noted, the local authority and the Official Solicitor do not consent to, but no longer actively oppose the application of the Trust. The court understands that CD continues to oppose the application of the Trust. Having considered the evidence and submissions in this matter, I am satisfied that there remains an appreciable risk of future unplanned pregnancy in respect of AB. I am further satisfied that AB at present lacks capacity in respect of decisions concerning contraception and that it is highly unlikely that further work with AB will result in her gaining capacity in that regard and unlikely that further work will increase her ability to participate in such decision making. Further, I am entirely unconvinced that the purported safeguarding plan that has been advanced by the local authority and endorsed by the Official Solicitor during this hearing is sufficient to meet the appreciable continuing risk of future unplanned pregnancy in this case. Finally, I am satisfied that it is in AB's best interests to be fitted with an IUD at the time of her caesarean section. My reasons for reaching these conclusions are as follows.

### *Risk of Future Unplanned Pregnancy*

32. It is important to note that this court is not concerned at this point with making findings of fact, but rather with the assessment of risk. Whilst the evidence set out at paragraph 10 above might be insufficient by itself to ground specific findings of fact on the balance of probabilities regarding, for example, the manner in which AB became pregnant or the full extent to which she may have been exposed to sexual

exploitation or sexual abuse in the past, that evidence is in my judgment plainly relevant to the assessment of the extent to which AB is at future risk of a further unplanned pregnancy.

33. Having regard to the matters set out above, I am satisfied that AB remains at an appreciable risk of unplanned pregnancy. That risk is grounded in the fact that AB has already become pregnant despite lacking capacity to consent to sexual intercourse, that it remains entirely unclear how AB became pregnant, that those adults who had care of AB at the time she became pregnant are not able to provide any information regarding how this came to pass (and accordingly the local authority is unable say whether, and if so how, the family were involved in the circumstances by which AB became pregnant and, therefore, the extent they can provide effective protection for AB in this context), that there is evidence from a number of sources (including records with respect to the family and a number statements by AB herself as set out in detail above) that suggest that AB has been involved in other sexual activity and may have been the victim of sexual abuse or sexual exploitation and that AB is a plainly vulnerable and trusting individual who can behave inappropriately towards others. Further, and in the context of neither the Police nor local authority having concluded their criminal and safeguarding investigations respectively, I am satisfied that the local authority is unable at present to state definitively the precise nature and extent of the risk to AB of further unplanned pregnancies. The significance of this forensic lacuna appeared to be entirely lost on the Team Manager. However, I am satisfied that the level of risk of further unplanned pregnancy in respect of AB is further increased by the fact that that risk is at this point incompletely assessed and thus difficult to quantify definitively.
34. Within the foregoing context, in my judgment it is plain that in the short term there is an appreciable risk that AB will be sexually active or exposed to sexual activity whilst she remains in the United Kingdom, or indeed if and when she visits her family in Nigeria. Further, as a young women, the chances of AB conceiving are high and, accordingly, the risk of AB being sexually active or exposed to sexual activity translates to a concomitant appreciable continuing risk of unplanned pregnancy. In the medium to longer term, given AB's age this appreciable level of risk will continue for at least a further ten years, during which time I am satisfied that it is likely that AB will return to Nigeria to visit her family.
35. Whilst I accept that in the difficult area of risk assessment, different risk assessors may come to different conclusions regarding on the level of risk presented by a given situation, I am concerned that within the forensic context set out in this judgment, both the local authority and the Official Solicitor arrived at a risk assessment of unplanned pregnancy for AB in the near future of *nil*. In light of the matters I have recounted, I struggle to see how such a conclusion could have been properly drawn from the evidence available, including that evidence concerning the purported safeguarding plan advanced by the local authority. In respect of the latter, that the local authority's purported safeguarding plan drove the local authority and the Official Solicitor to return a *nil* result in respect of risk of unplanned pregnancy in the near future seems to me to indicate an entirely unjustified level of confidence on the part of the local authority and the Official Solicitor in what amounts to an incompletely formulated plan founded on a home situation that remains uncertain, fluid, opaque and incompletely assessed in terms of risk.

### *Capacity*

36. As I noted, there no dispute as between the Trust, the local authority and the Official solicitor that AB lacks capacity to decide whether to receive contraception in the form of a IUD. I am likewise satisfied that based on the evidence before the court that AB at present lacks capacity to take decisions concerning the insertion of an IUD for the purposes of contraception.
37. Having heard the evidence of Ms T, Dr N and Professor X, and the evidence of the Team Manager, I am entirely satisfied that it is at present highly unlikely that AB will *gain* capacity in respect of these matters. In this regard I prefer the evidence of Ms T, Dr N and Professor X to the evidence of the Team Manager and the views of Ms Q to which my attention has been drawn. Having considered the capacity assessments and the exchanges that have taken place with AB, it is plain that whilst AB is able to retain some information, she has little if any understanding of the medical issues surrounding contraceptive treatment. Those capacity assessments undertaken over a number of months do not in my judgment show any evolution in this regard. As I have observed at a number of points, this reflects the position with the work undertaken by Ms Q in respect of delivery methods. Whilst I note the position taken by Ms Q, and whilst I listened carefully to the evidence of the Team Manager, viewed in the context of the medical evidence before the court their respective positions appeared to me to arise more from adherence to a conceptual or ideological viewpoint regarding the importance of ensuring autonomy for those lacking capacity than from a careful, dispassionate and considered assessment of AB's own abilities.

### *Best Interests*

38. AB's past and present wishes and feelings in respect of contraception are difficult to ascertain having regard to her limitations. From the transcripts of exchanges with AB during various capacity interviews, it is apparent that AB is able to retain some limited information on the types of contraception and sometimes can recall in simplistic terms the purpose of contraception. Within this context, there is one exchange with AB in which she *might* be taken to be expressing a view in favour of contraception, although ultimately this exchange on 4 October 2019 remains equivocal in its meaning:

“LD: Okay, so this is called a coil.

AB: Coil.

LD: And I think the doctors talking about maybe putting it in your tummy.

AB: Yes.

LD: To stop any more babies growing in your tummy>

AB: Yes.

LD: What do you think about that?

[AB gave a thumbs up].



LD: Why do you say thumbs up.

AB: Good.

LD: Good?

AB: Yes, I like it, I am excited.

LD: You like it?

AB: Yes. Tummy, inside it.

LD: Why do you like it?

AB: It's good."

39. Within the foregoing context, I am not satisfied that it is possible with any degree of certainty to establish AB's wishes regarding the use of contraception or in respect of the different methods of contraception available. I do note however that, whilst AB appears happy now to be pregnant, prior to becoming pregnant she at times stated that she did not want to get pregnant.

40. With respect to AB's beliefs and values, as King LJ noted in the Court of Appeal at [58], it is difficult in this case to establish AB's beliefs and values and import them into the best interests analysis in circumstances where:

"AB, however, has never had capacity and there can therefore be no direct evidence as to her actual beliefs and values; who can say if she might not have lost her faith or rebelled against the tenets of her community by the time she reached her twenties. It may be that, had she capacity, she would have been heavily influenced by the beliefs governing her community, but there is no evidential basis for concluding that to be the case, and to import those views into the best interests analysis would be mere speculation."

Within this context (and whilst for my part I consider that there will be some cases where it is possible to establish direct evidence of the actual beliefs and values of P notwithstanding P having always lacked capacity) there is in this case no cogent direct evidence of AB's beliefs and values regarding the use of contraception and, within this context, it would be likewise artificial to extrapolate the same from the environment in which AB lives, not least because the court has heard no evidence of what the community in which AB was raised thinks about the use of contraception.

41. I have also taken carefully into account the views of CD regarding the use of contraception for AB, insofar as those views can be ascertained. As I have noted, CD has not attended this hearing and the court has only an outline of her views on the issues before the court. Within this context, it would appear that CD does not discount entirely the use of contraception for AB but objects to it being utilised at this stage, and specifically objects to the insertion of an IUD immediately following AB's caesarean section, it would appear in part based on what she considers an increased risk of infection. With respect to this risk, the Trust contends that this concern is based on older research and that the risk of infection is now minimal. Whilst I have taken the concerns of CD into account, I am satisfied that those views are not such as

to persuade me that the placement of an IUD should be delayed until after AB's caesarean section.

42. In the assessment of best interests, the question of risk must be weighed, including the risk of future pregnancy and the risks to mental and physical health associated with pregnancy, childbirth and/or the removal of the child. For the reasons set out above, I am satisfied that there is an appreciable risk that AB will have a further unplanned pregnancy unless steps are taken to prevent this. The history of litigation in this matter demonstrates eloquently the devastating impact that a failure to protect AB from the appreciable risk of further unplanned pregnancy that I am satisfied subsists in respect of AB. Further, I have given weight to the opinion of Dr N, endorsed by Professor X, that in light the features of a mood disorder displayed by AB, she is at greater risk of mental health difficulties, including puerperal psychosis following the delivery of a child. There is no reason to believe that this risk would cease to pertain in respect of a further unplanned pregnancy. Finally, I have born in mind the careful evidence of Ms T regarding the upset and distress that AB has experienced as the "dry run" for the upcoming caesarean section has been completed.
43. As I have noted above, the manner in which the identified risk is addressed should be sensible, with the court also seeking the least restrictive or intrusive option. Within this context, the local authority and the Official Solicitor argued until the conclusion of the evidence that the purported safeguarding plan advanced by the local authority was sufficient to eliminate the risk to AB of a further unplanned pregnancy, without the need for recourse to contraception. Whilst neither the local authority or the Official Solicitor ultimately opposed the application of the Trust, I am in any event satisfied that this conclusion was misplaced for the reasons that I have set out above. I am satisfied that the risk factors identified at paragraph 10 above would not be sufficiently mitigated by the supervisory safeguarding plan advanced by the local authority, given the difficulties with that plan that I have detailed in this judgment. Whilst I accept that where P is well supervised at home and in the community, those are factors to be taken into account in the best interests evaluation, I am equally conscious that even a small risk that P will elude the supervision put in place is likewise a factor to be taken into account when considering whether to authorise contraception (see *Re P* [2018] EWCOP 10 at [50]). Within this context, I am entirely satisfied that the current deficiencies in the plan that I have identified in this judgment render that plan unsuitable for safeguarding AB from the appreciable risk of further unplanned pregnancy that I have identified.
44. In considering AB's best interests, I accept that the court must strive for a balance between protection and autonomy and I have listened carefully to the submissions of the local authority and the Official Solicitor with respect to the extent to which further work with AB could increase her ability to participate in the decision making process *before* any decision as to contraception is taken by the court. However, I am satisfied that it is unlikely that further work with AB will increase her ability to participate in decisions concerning contraception notwithstanding her lack of capacity to take the decision for herself. Further, I am satisfied that even if additional work could achieve a small measure of greater insight on the part of AB that might allow slightly fuller participation by her in decisions concerning contraception, once again, in circumstances where this court is concerned with AB's best interests the search for autonomy has to be balanced against the need for protection.

45. In this case, and on the evidence before the court, I am satisfied that further educative work would achieve little or no improvement in AB's ability to participate in the decisions in issue. I am further satisfied that if any minimal gains were achieved, they would be achieved only at the expense of the opportunity to insert the IUD at a point where this would not cause the high level pain and distress to AB that would result in a second invasive procedure being carried out at a later date following further educative work with AB. Within this context, and in circumstances where the evidence is clear that it is extremely unlikely that AB will gain capacity to take decisions in respect of contraception, the case advanced by the local authority and the Official Solicitor was one that sought to pursue at best marginal gains in participation for the price of a later and more painful second invasive procedure at a time when AB will be particularly vulnerable in terms of her mental health and following a period of sub-optimal contraceptive treatment (both in terms of its effectiveness and / or its impact on AB's mood) in the context of an appreciable risk of further unplanned pregnancy. On the evidence before the court, and again in circumstances where the evidence is clear that it is extremely unlikely that AB will gain capacity to take decisions in respect of contraception, I am satisfied that such a course cannot constitute a reasonably practicable means of ensuring AB's participation in the decision making process for the purposes of s 4(4) of the 2005 Act.
46. In identifying AB's best interests in respect of the contraception the court must endeavour to achieve the least restrictive option. Within this context, whilst the insertion of an IUD is an invasive procedure, in this case I am satisfied that it is a less restrictive option than that advanced during the hearing by the local authority with the support of the Official Solicitor. First, if the application of the Trust is granted, the insertion of the IUD will take place during the course of an invasive procedure that this court has already endorsed as being in AB's best interests, rather than by way of a separate, later and far more painful procedure. Second, the ongoing protection provided by the painless insertion of the IUD is in my judgment a far less restrictive means of protecting AB from an appreciable risk of further unplanned pregnancy than the 24 hour programme of intensive supervision proposed by the local authority. I am satisfied that this purported safeguarding plan represents a far greater level of intrusion in and restriction of AB's day to day life, aimed at reducing the risk of further unplanned pregnancy, than the insertion of a readily removable contraceptive device. To put it another way, the painless insertion of an IUD during a pre-planned invasive procedure is in my judgment a measure that is far more proportionate to the risk it is sought to address than is a 24 hour programme of close supervision of AB that will result in her never being left on her own, significantly impacting on her level of autonomy in other areas of her life. This is particularly the case, where the plan of supervision will not, for the reasons I have given, provide effective protection against the level of risk of further unplanned pregnancy that I have identified.
47. Finally, in circumstances where the insertion of an IUD will prevent AB from having children and making a significant choice regarding her own body, AB's Art 8 rights are engaged. As I have noted above, proper consideration of P's Art 8 rights is achieved through the best interests appraisal under s 4 of the Mental Capacity Act 2005. Within this context, I have had regard to the fact that, whilst it is the case that for the duration of its insertion the IUD will prevent AB from conceiving, the evidence before the IUD can be removed at any time should AB's position change in terms of capacity to consent to sexual relations. Having regard to the risks I have

identified, and to the consequences for AB of those risks becoming manifest, I am satisfied that the interference in AB's Art 8 rights constituted by the court decision to authorise the insertion of an IUD as being in AB's best interests is one that is necessary and proportionate for the purposes of Art 8(2).

48. Having regard to the foregoing matters, in all the circumstances, I am satisfied in this case that it is in AB's best interests for an IUD to be fitted during the course of the scheduled caesarean section and I so declare.

## CONCLUSION

49. The local authority and the Official Solicitor sought to characterise the application made by the Trust as simply an argument for medical expediency. Mere expediency would not by itself support a conclusion that it is in AB's best interests for an IUD to be fitted. However, in this case it is not mere medical expediency that justifies such a step. Rather, it is the multitude of other factors set out above that I am satisfied point clearly to it being in AB's best interests for that step to be taken at this stage for the reasons I have given.
50. Within the foregoing circumstances, I am satisfied that AB lacks capacity with respect to questions of contraception. I am further satisfied that it is in AB's best interests to be fitted with an IUD at the time she undergoes a caesarean section in respect of her current pregnancy and I so declare.
51. That is my judgment.