

IMPORTANT NOTICE

This judgment is covered by the terms of an order made on 28th February 2022 pursuant to Practice Direction 4C – Transparency. It may be published on condition that the anonymity of the incapacitated person and members of her family must be strictly preserved. Failure to comply with that condition may warrant punishment as a contempt of court.

Case No: 13893717

COURT OF PROTECTION

MENTAL CAPACITY ACT 2005

BEFORE: Her Honour Judge Hilder sitting at Tier 3 as a Deputy High Court Judge

First Avenue House
42-49 High Holborn,
London, WC1V 6NP

Date: 7th March 2022

[2022] EWCOP 10

S

Applicant

and

- (1) BIRMINGHAM WOMEN'S AND CHILDREN'S NHS TRUST**
(2) BIRMINGHAM AND SOLIHILL MENTAL HEALTH TRUST

Respondents

Hearing: 28th February 2022

Mr. J. McKendrick QC (instructed by Bindmans) appeared for the Applicant
Mr. D. Lawson (instructed by Capsticks) appeared on behalf of the Respondents

The hearing was conducted in public subject to a transparency order made on 28th February 2022. The judgment was handed down to the parties by e-mail on 7th March 2022. It consists of 20 pages, and has been signed and dated by the judge. The numbers in square brackets and bold typeface refer to pages of the hearing bundle.

JUDGMENT

1. At 3pm on Monday 28th February, at the end of a hearing which had started at 9am that day, I made a declaration that S has capacity to consent to a termination of her pregnancy.
2. The Abortion Act 1967 sets limits on the stage of pregnancy at which termination can be lawfully brought about. The parties are agreed that the relevant time limit in this matter is the end of Tuesday 1st March 2022.
3. Such were the time constraints on actions which may flow from the declaration of capacity, that not even an ex tempore judgment was practically possible. Instead, this written judgment sets out the reasons for my decision, handed down as quickly as possible given the requirements of other court business.
4. It is to be noted that S has conducted these proceedings without a Litigation Friend. Her solicitor and counsel, both very experienced in Court of Protection proceedings, were satisfied that the presumption of capacity to conduct the proceedings was not rebutted by the evidence available and that they were appropriately instructed. When I raised at the outset of the hearing that it would be very unusual for a person to have capacity to litigate proceedings but lack capacity to decide the issue which was the object of those proceedings, S's representatives confirmed that they would welcome an opportunity to reconsider the position if/when the Court concluded that S lacks capacity to consent to termination of pregnancy and before addressing best interests. In the event, such further consideration was not necessary.

Background

5. S is 38 years old and 23 weeks pregnant. She is presently detained under section 3 of the Mental Health Act.
6. In 2010 she was diagnosed as having bipolar affective disorder. There have been sustained periods when this condition has responded well to Lithium treatment. There have also been four hospital admissions, including one under section and two very serious overdoses that resulted in admission to intensive care.
7. Nonetheless, S has achieved much in her life. She has a degree in modern languages from Cambridge University, a job in marketing, and her own business in language tutoring. She is in the process of buying a house, expecting completion on the Friday following the hearing. Her sister, C, has worked hard to ensure that her old flat is vacated and her belongings will be moved in for her.
8. On the other hand in domestic terms S's experience has not yet lived up to her expectations. She has a powerful sense of time running out for it to do so. She has a strong wish to become a mother by the time she is 40. She would have liked a baby with her partner last summer but he did not share that goal and so the relationship ended. In anger and distress, S determined to conceive a child by IVF using a sperm donor.
9. S did not discuss her IVF plans with her family but she did discuss them with her Community Psychiatric Nurse. With her agreement, S stopped taking her medication. By late August/early September S felt herself to be experiencing sensory disturbance but she did not tell anyone because she did not want the IVF process paused. In fact the process was successful at the first attempt and S learned that she was pregnant on 13th October 2021.

10. S's mental health deteriorated until, on January 31st 2022, she was sectioned. It is recorded in her hospital notes of the next day that she was voicing doubts about continuing with the pregnancy, which was then nineteen and a half weeks advanced.
11. On 9^h February 2022 S had a face to face meeting with her Obstetric Consultant (Ms. Pretlove). S said that she wanted to consider a termination.
12. A 'best interests' meeting was held on 18th February 2022. Conclusions were reached that S lacked capacity to consent to termination of her pregnancy, and that it would not be in her best interests to have a termination. No one in the treating teams proposed to take any further steps in respect of the issue.
13. On 22nd February 2022, via her Mental Health Tribunal solicitors, S instructed Bindmans.
14. At 2.26pm on 24th February, it was confirmed to Bindmans by e-mail that the respondents would not be making any application to the Court.
15. These proceedings were then brought by S, by a COP1 application dated 25th February 2022 with a request for an urgent hearing. That afternoon Morgan J made an order [B15] which gave directions and listed this matter before me at 9am on Monday morning.

Matters considered

16. I have considered a hearing bundle prepared over the weekend, including:
 - a. an unsigned statement by S;
 - b. four documents called "capacity assessment" dated respectively 1st, 9th, 15th and 27th February 2022; and
 - c. draft minutes of the 'best interests' meeting held on 18th February 2022.
17. I heard oral evidence from:
 - a. Dr. Jancovic, Consultant Perinatal Psychiatrist;
 - b. Ms Pretlove, Consultant Obstetrician;
 - c. C, a sister of S; and
 - d. S.
18. I had the benefit of written position statements and oral submissions from Mr. McKendrick and from Mr. Lawson.

The evidence

19. The earliest 'Record of Capacity Assessment' [D1] records – in a form clearly designed for that purpose - that an assessment was undertaken by 'Rapson, Alec (FORH1W)(Raeside Clinic)' at 06.34 on 1st February 2022. The decision under consideration is identified as 'capacity for admission to psychiatric hospital.' It is recorded that S 'understands information presented' and is 'able to recall held under MHA' but cannot use and weigh up

the information in order to make this decision – “assessment from multiple AMHPS/consultants today, thought disorder and behaviour in keeping with acute mania present preventing ability to weigh up information.” The conclusion recorded is that S lacks capacity to make the decision.

20. The next document relied on as a record of an assessment of capacity [D4] is less obviously such a thing. It appears to be just a computer records entry, as opposed to a specifically designed form for recording capacity assessment. The top line reads ‘Assessment of capacity on 09/02/2022’ but the first heading is ‘SPECIALIST REVIEW’. The process was conducted by Ms Pretlove, Obstetric Consultant on 9th February. The document records:

“...Wanting to consider termination of pregnancy. We discussed termination of pregnancy including medical and surgical options and complications such as bleeding, infection and uterine perforation.

Long discussion with [S] summarised: [S] is wanting to consider termination of pregnancy but is unsure. She is concerned about her finances as she is unable to earn whilst an inpatient in a psychiatric unit. She is worried about the emotional pressure of being a single parent and there will be no one to help her. She wants to ‘scrap this now and move to [new property] free’. She would like to try and meet someone again and have a relationship and do things ‘the conventional way.’ She feels she jumped into the IVF without support from her family and that she was unwell with mania when she started the IVF process.

She also stated she wanted to be a mother and have something to love.

[S] discussed that she was not mentally unwell, it was the pressure of the decision to end or continue the pregnancy that was making her feel like this.

She doesn’t feel a connection to the baby and described herself as ambivalent towards the baby.

Assessing [S]’s capacity was complex. She is articulate and plausible.

She is able to understand and retain information. After prompting, she was able to recall the ultrasound scan in fetal medicine on Tuesday 8th February and other information she had been given during pregnancy.

[S] appeared to be weighing information by discussing the pros and cons of ending vs. continuing the pregnancy. However, prior to the pregnancy, over a sustained period of time, [S] demonstrated a wish to be pregnant evidenced by attending pre-pregnancy counselling and subsequently sought IVF with sperm donor. The request for a termination of pregnancy appears to be new and impulsive and her desire appears to become (*sic*) pregnant again but in better circumstances.

She is able to express her views and is very clear she would want a surgical termination of pregnancy and would not want a medical TOP.

Currently I do not believe [S] has capacity to make the decision about termination of pregnancy. She is experiencing mania and this has markedly altered her beliefs about the pregnancy. Prior to becoming unwell there was a sustained period where she actively sought pregnancy.

Additionally, [S] is very unsure about whether she should pursue termination of pregnancy. Although these decisions are difficult, I would

not usually advocate booking or sending a woman for termination who had this degree of uncertainty.

Lastly, [S] is likely to recover from this manic episode wherein her weighing process may reverts (*sic*) back to her pre-pregnancy decision making and then she may be devastated to find she has opted for termination of a wanted pregnancy.”

21. The third document which is called in the hearing bundle a ‘capacity assessment’ [D7] is a form which says on its face that it should be used “when a service user is admitted...or when capacity-related information comes to light.” It records that S has not executed any Lasting Powers of Attorney or made any advance decisions about future care and treatment. It does not take any further the consideration of S’s present capacity to give consent to a termination of her pregnancy.
22. The final document included in the bundle as a ‘capacity assessment’ [D21] originates from Dr. Jancovic, Perinatal Consultant Psychiatrist. Again it appears to be a computer records entry, rather than a form designed to record capacity assessment. It is dated 27 February 2022 15.24. In so far as is material, it states as follows:

“..I attended [the ward] today to have a discussion with [S] about her decision-making process as to whether to continue with pregnancy or not in preparation for Court hearing tomorrow (as Dr Clarke, RC is on leave)

Overall there has been an improvement in [S]’s mental health, and level of agitation and irritability have significantly improved (as compared to the admission), we had a long discussion and she was able to focus on discussing pros and cons with me

She pointed out several times that she was very unhappy about being in hospital on a section of MHA without leave, that she found it very difficult and she feels it had a negative impact on her ability to make a decision about pregnancy

We had a discussion about pros and cons of continuing with pregnancy and [S] made a list in her notebook that we discussed with the most prominent cons being feeling guilty for not providing a baby with a father figure (she has spent significant time on the ward contacting people on co-parenting website trying to find a ‘father figure’ for the baby), worry of not being able to cope on her own with a baby, implication on lifestyle and finances of being a single parent, potential difficulties of meeting a new partner once she already has a child etc. On the pros side she wants to be a mother (but would prefer to have a child in a relationship) and has also considering (*sic*) ‘whether ending his (baby’s) life is worth it’, ‘it is not his fault.’

I am not an Obstetrician thus I was not able to discuss specific details/risks of termination of pregnancy procedures with [S] (Miss Pretlove has done that assessment on 9th February) but based on my assessment today it is unlikely that [S]’s ability to understand and retain information and communicate decision is affected by her mental illness.

However in my opinion her mental illness, on the balance of probabilities is having significant impact on her ability to weigh pros and cons of a decision whether to continue with pregnancy or not.

[S] is recovering from relapse of Bipolar affective disorder (she experienced mixed affective episode) and has significant antenatal bonding difficulties and although her mental health has significantly improved and many of her concerns are rational (about financial impact of having a child as a single parent and impact that having a child has on lifestyle etc) her decision making process seems to be profoundly affected by feelings of guilt, low self-confidence and negative cognitions about herself (feeling that she has failed a baby because she is not providing a father figure for the baby, of being ashamed of conceiving by IVF without a partner, and worry of not being able to cope on her own with a baby. At the same time she is finding it very difficult to consider in this decision-making process potential consequences of termination such as reduced chance of becoming a mother ([S] considers women over 40 years old who do not have children to be failures and still has a strong wish to be a mother but feels reassured that she has 34 frozen eggs and therefore that she will be able to conceive again) or emotional consequences as she feels she has not bonded with a baby and thus she may not have any difficult feelings following termination (she has however named the baby and described feelings of guilt towards the baby as above).

As of today [S] has not decided whether she wants to terminate the pregnancy or not but today is leaning more towards the termination. However [S] told me that she would like reassurance that termination is the right decision in order to proceed (that neither health professionals nor her family have been able to give her)..."

23. The written documents were supplemented by oral evidence. From Dr. Jancovic's oral evidence, the following key points in respect of capacity assessment emerged:
- a. Dr. Jancovic gave some advice by e-mail in July 2021 about S ceasing to take Lithium as she embarked on IVF but she first met S in the process of her admission on 31st January 2022;
 - b. she is not the Responsible Clinician for S but stepped in the day before the court hearing because the RC was unavailable;
 - c. she spent an hour and 15 minutes with S the day before the hearing and formed the impression that S's mental health "has improved greatly;"
 - d. she has general experience with psychiatric patients but acknowledged that this was her first experience of assessing capacity to consent to termination of pregnancy: "*what I did yesterday was assess [S's] mental health and its impact on her decision-making process. The decision as to capacity lies with the obstetrician.*";
 - e. she had formed the view that '*guilt, shame, extreme anxiety and panic....part of depressive conditions, associated with a depressive episode*' were the driving force behind S's weighing of the pros and cons of termination, but she

subsequently agreed with Mr. McKendrick that ‘social factors’ were a specific driving force of S’s decision-making in respect of pregnancy, and moreover that such considerations were ‘*not irrational*’;

- f. she pointed to S’s efforts to find a father figure as indicating a link between S contemplating termination and an underlying motivation of feeling inadequate. When asked if that link indicated incapacity, she answered that it was, in her opinion, very difficult to say: “*I’d need an obstetrician to make the ultimate decision, so I focussed on weighing pros and cons. Yesterday on the balance of probabilities she was not able to weigh because negative cognition affected her.*”
 - g. she considered that this is “*a difficult professional decision for me*” and she agreed that the professional conclusion may be wrong.
24. In terms of mental health prognosis, Dr Jancevic deferred to the RC but thought it likely that “*within the next couple of weeks, with medication, S will improve to have leave and be discharged.*” She specifically did not agree that S would still be detained for “months” and thought that a 3- 4 week timescale (including leave) seemed “*reasonable.*”
25. Dr Jancevic considered that the risk to S’s mental health was greater in terminating than in continuing the pregnancy. She explained that came to this view on the basis of ‘*method of conception – [S] now regrets it but it indicates a profound wish to be a mother. She still sees women without children as failure.*’ She agreed that the relative harm as between terminating or continuing pregnancy was for S finely balanced. She did not agree that lesser harm was likely if S’s wishes and feelings were determinative, because she considered that S’s wishes and feelings are a symptom of her depressive condition. Her evaluation of risks to S in continuing the pregnancy was based on her experience that the majority of women she has worked with are successful parents, and support could be provided to S, including through a mother and baby psychiatric unit from 38 weeks of pregnancy.
26. From the oral evidence of Ms. Pretlove, the following key points in respect of capacity assessment emerged:
- a. Ms. Pretlove has completed a ‘*small number*’ of formally documented capacity assessments but she regularly assesses capacity in her weekly ante-natal clinics for women with mental illness;
 - b. she spent over an hour with S on 9th February;
 - c. Ms.Pretlove found the conversation ‘*difficult*’ – S was often wanting to ask about leave (over which Ms Pretlove has no authority), and sought Ms. Pretlove’s opinion about what she (S) should do about the pregnancy;
 - d. they discussed the surgical and medical methods of termination. S did not want to hear the explanation of the medical procedure;
 - e. she assessed the risks of surgical termination as a small (*less than 5% or even 1%*) risk of a catastrophic outcome;
 - f. she was concerned about S’s ability to use and weigh information, because this had changed with the deterioration in her mental health – for a long period before she was unwell S had actively sought pregnancy;

- g. she was concerned that S was ‘unsure’ about termination, and was clear that she personally would not arrange a termination for any woman who was only 75% sure she wanted it (by ‘sure’ Ms. Pretlove meant having a ‘*confirmed, settled belief that this is the action they want to take even if it is difficult/upsetting/they are concerned about what people may think*’);
 - h. she considered that a decision to undergo termination of a pregnancy which was conceived by IVF would be ‘*very unusual*’ (although she acknowledged that this did not of itself make it incapacitous);
 - i. she considered S’s hope that her social circumstances would change significantly for the better so as to permit later pregnancy within S’s preferred terms to be ‘*quite unrealistic*’;
 - j. she set out her ‘*big concern*’ that S’s bipolar disorder is treatable – she will get better – her original system of wanting pregnancy/IVF will return – she’ll be devastated to understand that whilst unwell she had chosen to terminate a pregnancy;
 - k. she has not seen S since 9th February and so felt unable to agree or disagree with Dr. Jancevic’s observation that S’s mental health has significantly improved since then;
 - l. when asked if she considered that the psychiatrists (as opposed to an obstetrician) were best placed to assess S’s capacity to make the decision in question, she answered “yes”;
 - m. she ‘*remains concerned about [S]’s ability to weigh, and how different it is to her pre-morbid stance*’ and ‘*was trying to elicit the point that capacity is linked to mental health status. Her continued detention is a marker of how unwell she remains*’;
 - n. she had discussed with S the ‘pathological’ considerations of termination (risks of heavy bleeding/injury to cervix, uterus or adjacent organs/ subsequent need for hysterectomy and risks related to anaesthesia) but had not discussed with her the possible involvement of social services if the pregnancy continued to live birth.
27. S’s sister C gave oral evidence next. She was clear that S’s mental health issues placed strain on her wider family but C seemed to me to be trying very hard to be supportive. She gave a clear and helpful account of S’s life experience so far. She confirmed that S has been very focussed for several years on wanting to become a mother, and has been very conscious of the passage of time in that regard, including saying that she could not continue with life if she is not a mother by 40.
28. C confirmed that the question of termination only surfaced when S became unwell, towards the end of January. She acknowledged her observation recorded in the draft minutes of the ‘best interests’ meeting that the situation is all “*a bit of a mess.*” She acknowledged her own ethical position in respect of abortion and that this made the current situation very difficult for her but she described trying ‘*to honour [S]’s wishes*’ from before she relapsed, and ‘*not push our views to determine her outcome.*’ She is afraid that S will blame her [C] if she [S] comes to regret a termination and C did not object at the time. She observed that, even the

night before the hearing, S was saying that, if the Court says it is possible for her to make the decision about termination, she [S] does not know what decision she will make about termination.

29. S took the affirmation and confirmed her statement. She said she was *'a little bit nervous'* about the hearing. She spoke quickly but lucidly. She described herself as *'terrified'* of the situation she is in. She is *'daunted'* and particularly *'frustrated'* about the evidence she had heard in the hearing concerning involvement of Children's Social Services. This prospect horrified her: *'abortion 100% please.'* She described great frustration at the conditions of her detention, not having left the hospital even for a walk, and being under close observation even when showering.
30. When asked about considering termination of pregnancy S explained that she *"feel[s] a lot of anguish about the thing I can't repair"*, namely the *'lack of a father figure.'* She feels guilty about this, and *'one way of sorting it out is not to complete it.'* She now sees the IVF as *'a bit of a mistake'* – she says that anger about the end of her relationship drove her to it; it felt like an empowering step at the time; her resentment of men has now settled; and she now sees the gap for the baby. She acknowledged that she had indeed talked in the past of suicide if she can't become a mother but she itemised present concerns about not being psychologically ready to be a parent now, about her house move having been delayed, about the financial pressures of sole parenting, about being unsure if she could do a good job of parenting and not wanting to do a *'rubbish'* one. She wants to put more *'cushioning'* around herself before she embarks on motherhood. She is reassured by having frozen embryos and eggs to fall back on in the future.
31. S was clear that she can't say 100% that she wants a termination. She questioned whether it was ever possible to be 100% certain of this type of decision. She said *'overall I want this but I'd be hoping for reassurance....somebody telling me for X, Y reason this will work out.'* She would prefer another option - to go back in time and *'make it that the pregnancy never happened, or the baby just never developed.'* She acknowledged that she *'doesn't know how things will pan out – I might meet someone; I might not'* but at the moment she wants pregnancy to be *'not just my bump but our bump'* and she just cannot picture raising a child by herself. She finds disapproval from others *'toxic'* – she struggles if she lets people down and *'I'll let the baby down.'*

Law and Procedure

32. The Abortion Act 1967 provides (in so far as is presently relevant) as follows:

1(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two medical practitioners are of the opinion, formed in good faith –

- (a) That the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family;
or
- (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

or

(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated;

or

(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection 1 of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

.....

33. Consent, either by the pregnant woman capacitously or by the Court of Protection in the best interest of a non-capacitous pregnant woman, is fundamental to the lawfulness of abortion, as it is to any medical procedure. It is not, however, sufficient. Ultimately, lawful termination of a pregnancy depends on their being two medical practitioners who are satisfied that the conditions of the Abortion Act are met and one who is willing to perform it. Ethical considerations arise. The Court of Protection cannot *require* a clinician to perform this (or any) procedure if s/he is unwilling to do so.
34. The Court was informed that there are only three medical practitioners in England who undertake late-stage surgical abortions, and one of them is presently out of the country on leave. The other two are based in London. Despite Morgan J's clear emphasis on the need to have established over the weekend whether the surgical procedure under consideration is even practically possible, in the sense of there being two medical practitioners satisfied that the conditions of the Abortion Act are met and one who is willing to perform it, even at the conclusion of this hearing that information is not available.
35. S's representatives took the position that it was "essential" for the Court to consider the evidence and formulate its conclusions, even if the availability of termination as a practical option is unknown. Given the statutory time limits, I concurred.
36. The Mental Capacity Act 2005 ("the Act") is underpinned by five principles set out in section 1. It is to be hoped that these principles are now engrained in every aspect of medical practice but they bear repetition. The Act uses the male pronoun to signify universal application but in the context of termination of pregnancy this feels very artificial, and a more specific approach helps focus. The principles then are as follows:
 - a. A person must be assumed to have capacity unless it is established that she lacks capacity.
 - b. A person is not to be treated as unable to make a decision unless all practicable steps to help her to do so have been taken without success.
 - c. A person is not to be treated as unable to make a decision merely because she makes an unwise decision.
 - d. 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 her best interests.

- e. 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 freedoms of action.

37. Capacity considerations are set out in sections 2 and 3 of the Act:

2 People who lack capacity

2(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time she is unable to make a decision for herself 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 if 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 hers, or an aspect of her behaviour, which might lead others to make unjustified assumptions about her 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 herself if she 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 her 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 she is able to understand an explanation of it given to her in a way that is appropriate to her 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 her 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.

38. Mr. Lawson referred me to the Court of Appeal decision in *PC v. City of York* [2013] EWCA Civ 478, where it is stated in particular:

“[35] The determination of capacity under MCA 2005 Part 1 is decision specific...all decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of MCA 2005, ss1 to 3 which requires the court to have regard to ‘a matter’ requiring ‘a decision’. There is neither need nor justification for the plain words of the statute to be embellished.”

and

“[54] there is a space between an unwise decision and one which an individual does not have the mental capacity to take and ... it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual’s autonomy operates.”

39. I have also reminded myself of the helpful summary of the approach to be taken to considerations of the ability to use and weigh information in the decision-making process, as set out by the Vice-President, Hayden J in *London Borough of Tower Hamlets v. PB* [2020] EWCOP 34:

“12. Intrinsic to assessing capacitous decision taking is the ability to weigh and sift the relevant information. In **PCT v. P [2011] 1 FLR 287, AH and The Local Authority [2009] COPLR Con Vol 956** at [35] Hedley J, with characteristic conciseness, analysed the capacity to use or weigh information thus:

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

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

14. Even when an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself justify a conclusion that P lacks capacity. Smoking, for example, is demonstrably injurious to health and potentially a risk to life. Objectively, these facts would logically indicate that nobody should smoke. Nonetheless, many still do. In **Kings College NHS Foundation Trust v. C and V [2015] EWCOP** at [38] MacDonald J stated:

“It is important to note that s3(1)(c) is engaged where a person is unable to use and weigh the relevant information as part of the process of making the decision. What is required is that the person is able to employ the relevant information in the decision-making process and determine what weight to give it relative to other information required

to make the decision. Where a court is satisfied that a person is able to use and weigh the relevant information, the weight to be attached to that information in the decision-making process is a matter for the decision maker. Thus, where a person is able to use or weigh the relevant information but chooses to give that information no weight when reaching the decision in question, the element of the functional test comprised by s3(1)(c) will not be satisfied. Within this context, a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision-making process.”

40. The application of these capacity provision to a decision to terminate pregnancy has not as yet been set out comprehensively in case law but Mr. McKendrick referred me to the decision of Holman J in *Re SB (A patient; capacity to consent to termination)* [2013] EWHC 1417 (COP). From this judgment I note:
- a. the Court was obliged to make a decision under great time pressure. (paragraph 23)
 - b. the reason for the proceedings was that the pregnant mother herself was requesting termination, so the issue was capacity. The judge was at pains to point out that the case had nothing whatsoever to do with a quite different issue which sometimes arises of termination without the actual consent of the pregnant woman: “..if a termination does take place, it will only take place because she personally has strongly requested it and consents to it right up to the moment when the procedure begins.” (paragraph 5)
 - c. the procedure could only take place if doctors, in the exercise of their own professional judgment, voluntarily decide to perform the abortion that the mother is requesting. (paragraph 6) A doctor who was willing to perform the termination attended the hearing. (paragraph 23)
 - d. any power or right of the Court to trespass into consideration of the pregnant woman’s best interests arises only if the Court has first determined that she herself lacks capacity in relation to the decision and subject matter in question. (paragraph 11)
 - e. the case could not be more fact specific. No precedent or indication of general proposition of law or statutory construction is intended. (paragraph 12)
 - f. SB had a diagnosis of bipolar disorder, characterised over years by periods of stability, relapse and remission. The pregnancy was initially positively wanted. For the first trimester, SB meticulously attended antenatal scans and appointments. Her attitude towards the pregnancy changed only in the fourth month of pregnancy. (paragraphs 20 & 21)
 - g. SB had a strong view about the abortion procedure she sought, seeking induced labour by medication. She had failed to attend an appointment for surgical abortion. (paragraph 22)

- h. SB maintained her wish to have an abortion in the circumstances of Mental Health Act detention.
- i. SB's treating clinicians considered that the pregnant woman lacked capacity to make her own decision to undergo a termination. Their evidence was that the reason she lacked capacity was that SB had current persecutory or paranoid beliefs as a result of the bi-polar illness. (paragraph 24 and 32)
- j. the proceedings were issued by the hospital in which the pregnant woman was detained. (paragraph 25)
- k. the Official Solicitor had initially been invited to act as Litigation Friend for the pregnant woman but she had already instructed solicitors herself. The OS instructed that solicitor. The OS obtained an urgent assessment by an independent psychiatrist (Dr. Smith), who concluded that the pregnant woman had capacity to conduct the proceedings. Only after that did the pregnant woman attend the hearing, having already expressed a strong desire to do so. She gave oral evidence. The judge granted an application to discharge the appointment of the Official Solicitor as Litigation Friend. (paragraphs 28, 29 & 30)
- l. The independent psychiatrist concurred with her treating clinicians that SB lacked subject capacity (even though she had litigation capacity). Dr Smith was in no doubt that SB understood:
 - i. 'what is involved in the termination'
 - ii. 'the procedure and what would be involved'
 - iii. 'the finality of the event'
 - iv. 'any risks to her from undergoing a termination.'

Dr Smith considered that SB lacked capacity because 'there has been this marked change of attitude between her apparent pleasure at being pregnant in the early stages of pregnancy, and her more recent desire to seek termination... there is a strong temporal relationship between the patient stopping medication, developing paranoid ideas about her husband or mother and deciding to opt for a termination of her pregnancy.' (paragraphs 34 & 35)

- m. The judge accepted the medical evidence 'insofar as it is evidence within their professional domain', specifically the diagnosis. However he restated that overall assessment of capacity is a matter for the court, and he disagreed with the psychiatrists as to 'the level of the bar as to capacity.' (paragraphs 37 & 38)
- n. What weighed most significantly was that, even if SB had paranoid or delusional views, she gave many other reasons for desiring a termination. Those reasons included unhappiness in her situation of detention, rejection of adoption as a resolution ("why should I have a child just to give it up?") and worry about her ability to bring up a child. (paragraphs 42 & 43)
- o. Without concluding that SB's reasons were "good" reasons, or any agreement with her decision, the judge reminded himself a person is not to be treated as unable to make a decision because it is an unwise decision, and concluded that "it would be

a total affront to the autonomy of this patient to conclude that she lacks capacity to the level required to make this decision.” (paragraph 44)

41. As to when applications of this nature should be made to court, Mr. McKendrick pointed me to the Vice-President’s guidance of 17th January 2020, which applies where a decision relating to medical treatment arises. As set out paragraph 3, the Guidance is directed to those acting for providers and commissioners of clinical and caring services, and makes very clear the “expectation ... that providers/commissioners should be responsible for bringing any application that is required.”

42. Paragraph 6 of the Guidance sets out as follows:

“6. If the provisions of the Mental Capacity Act 2005 are followed, any relevant professional guidance observed and relevant guidance in the Code of Practice followed, including as to the undertaking of the decision-making process, then, if there is agreement at the end of the decision-making process as to:

- (a) the decision-making capacity of; and
- (b) best interests of the person in question,

then in principle, medical treatment may be provided to, withdrawn from or withheld in accordance with the agreement, without application to the court, in reliance upon the defence in section 5” [of the Mental Capacity Act 2005]

43. Paragraphs 8 – 12 of the Guidance set out “**Situations where consideration should be given to bringing an application to court**”. Paragraphs 8 and 10 are pertinent:

“8. If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:

- (a) **finely balanced**, or
- (b) there is a **difference of medical opinion**, or
- (c) a **lack of agreement** as to a proposed course of action from those with an interest in the person’s welfare, or
- (d) there is a **potential conflict of interest** on the part of those involved in the decision-making process.

(not an exhaustive list)

Then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration **must** always be given as to whether an application to the Court is required.

9.

10. In any case which is not about the provision of life-sustaining treatment, but involves the serious interference with the person’s rights under the ECHR, it is ‘highly probable that, in most, if not all, cases professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of [capacity and] best interests, with [the person] having the benefit of legal representation and expert independent advice.’ This will be so even where there is agreement between all those with an interest in the person’s welfare.”

Positions of the parties

44. S's position is that she has capacity to make a decision to terminate her pregnancy. Her representatives assert that there is no evidence sufficient to rebut the statutory presumption of capacity. In particular they contend that:
 - a. there has been no clear identification of the information relevant to the decision;
 - b. clinicians have been in contact with social services with regard to prospective steps should there be a live birth, but no discussion at all of this with S;
 - c. it is not clear what practical steps, if any, have been taken to assist S to have capacity to make this decision;
 - d. a conclusion of capacity requires that S is unable to make it because of the bipolar disorder, not because she struggles in her current situation to be sure of what is a very grave decision;
 - e. such evidence as there is that bipolar disorder causes S to be unable to use and weigh information, rather than social factors identified by S being the basis of a capacitous decision by her, is insufficient to displace the statutory presumption.
45. In very brief closing submissions, Mr. McKendrick suggested a non-exhaustive list of information relevant to the termination decision:
 - a. the physical risks to S in the termination procedure (in particular, in respect of a surgical procedure, a very small risk of a catastrophic harm);
 - b. the risk of harm to S's mental health, both in having a termination and in continuing the pregnancy in the circumstances which exist;
 - c. the risk of harm of safeguarding measures in the event of a live birth, including potentially the mother and baby unit.
46. On behalf of the medical bodies, Mr Lawson emphasises that all clinicians are of the same view, that S presently lacks capacity to make a decision about termination because the depressive aspects of her bipolar disorder render her unable to use and weigh relevant aspects of the decision. He suggests that the information relevant is rather wider than Mr. McKendrick suggested, without formulating an alternative list. He identifies that S is presently unable to use or weigh realistically the difficulties of her becoming pregnant in the future, the prospects of being in any better social circumstances in the future, the likelihood of forming a partnership with a father figure, or the complications of the abortion process. Such reasons as S gives for considering termination are not, he says, good ones. He concludes that, putting together:
 - a. what he says S is unable to use and weigh, with
 - b. the overall decision being "a huge change of position" linked in time to her relapsing mental health, and
 - c. the steps S has taken to fill the gap which she perceives,

S's inability to make the decision in question is clear.

Discussion

47. The process of undertaking an assessment of capacity is different to the record of such assessment. It is important that such distinction is borne in mind because conflating the two risks both forgetting that assessment is a process which needs to be continued until it is possible to draw a conclusion and also giving an impression that the outcome was pre-loaded. I am concerned that the two documents relied on in this matter as records of assessment of capacity in the relevant domain, that is the document by Ms Pretlove after meeting S on 9th February [D4] and the document by Dr. Jancevic after meeting S on 27th February [D21], evidence the realisation of both these risks in this matter.
48. It is very far from clear that S was made aware that she was being assessed when she met either Ms. Pretlove or Dr. Jancevic. Both of the documents of record refer to "discussion" and not to assessment.
49. The two clinicians regarded their individual "discussions" with S as clearly distinct and separable parts of the process of assessment. Dr. Jancevic gave oral evidence first and told the Court unequivocally that she was assessing S's mental health and its impact on her decision-making process but the decision as to capacity lay with the obstetrician. Ms. Pretlove was subsequently equally unequivocal in confirming her view that the psychiatrists were best placed to assess capacity. The agreed order of events (discussion with obstetrician first, best interests meeting second, and discussions with psychiatrist last) lays bare a poorly constructed approach to assessment between the treating teams of clinicians. The suggestion that they should have done a joint assessment seemed to come as a surprise.
50. This unsatisfactory approach is exacerbated by the lapse of time between Ms. Pretlove's discussions with S (9th February) and the best interests meeting (18th February), and again before Dr Jancevic's discussions with S (27th February). Dr. Jancenic was very clear that S's mental health had "improved greatly" since she was admitted on 31st January. Ms. Pretlove was unable to agree or disagree with that account, and unable to comment on whether there had been improvement since her own meeting with S (just 9 days after Dr. Jancenic's initial engagement but 18 days before the meeting when Dr Jancovic observed the 'great improvement'). Dr Pretlove fell back on the fact of continued detention as "the marker of how unwell she remains." The test for detention under the Mental Health Act is not the same as the test for capacity to decide to have a termination. However valid Ms. Pretlove's conclusions *may* have been on 9th February, they are seriously undermined by the subsequent psychiatric evidence of great improvement.
51. There is nothing in the written records which clearly identifies the information which S's treating clinicians considered to be relevant to the process of S deciding whether to have an abortion. When asked by Mr. McKendrick to explain the relevant information to be used and weighed, Dr. Jancovic replied that she did not understand the question. Ms. Pretlove agreed with Mr. McKendrick's itemisation of the risks of the procedure – "pathological risks" as she termed them – but she identified no other relevant information. She did accept that the possibility of safeguarding measures after a live birth was relevant but she was also clear that she has not discussed this with S.

52. In my judgment and specifically in respect of *this* case, the relevant information for the purposes of assessing whether S has or lacks capacity to decide to undergo termination of her pregnancy is:
 - a. what the termination procedures involve for S ('what it is');
 - b. the effect of the termination procedure / the finality of the event ('what it does');
 - c. the risks to S's physical and mental health in undergoing the termination procedure ('what it risks');
 - d. the possibility of safeguarding measures in the event of a live birth.
53. Mr. Lawson pointed out that discussions with S ranged more widely than this. I accept that they did but I consider that the wider discussions were exploration of reasons for deciding one way or the other, rather than information foundational to making the decision. Information about safeguarding measures in the event of a live birth is different in kind to consideration of the likelihood of finding a father figure for the baby, or the likelihood of financial circumstances improving, or the prospects of achieving pregnancy again. It is not trying to guess the future; it is definite information about powers and practices that demonstrably exist.
54. It is accepted that information about safeguarding measures in the event of a live birth has not been clearly given to S as part of a process of assessment. It is also clear that, such information about safeguarding measures as she has now gleaned is alarming to S and highly material to her thinking about termination.
55. Notwithstanding the lack of clarity as to what information the assessing clinicians considered relevant to S's decision-making capacity, they agree that S is able to understand and retain it, and to communicate a decision. They consider that she fails the statutory test for capacity only because she is unable to 'use and weigh' it. I have not been able to identify from the evidence any information of a type which I have identified as relevant to the decision which S is said to be unable to use or weigh.
56. Ms. Pretlove observed S as "weighing information by discussing the pros and cons of ending vs. continuing the pregnancy". Dr Jancevic notes that S made a list in her notebook of the "pros and cons" they discussed, attributing prominence to some over others. In the end, the very clear impression given is that it is not that the clinicians identify information which S cannot use or weigh, but rather that they disagree with the weight that S attributes to the various factors identified.
57. The clinicians note that S's wish for a termination is a marked change of position to her wish to become pregnant in the first place; and that this change of position coincides with a deterioration in her mental health. They conclude that the wish for termination is a reflection of the negative cognitions of S's mental health condition and therefore S lacks capacity to make the decision. In my judgment this reasoning is not sufficient. A person can change their mind. I do not agree that S's consideration of termination is "new and impulsive". It has been maintained at least since the point of detention. A month is a long time in the context of abortion time limits. Moreover S has articulated reasons for her current stance, consistently, and Dr. Jancevic "completely agree[d]" that those reasons are not irrational. The clinicians may not agree with the S's reasons for seeking

termination. They are free to disagree but their disagreement does not justify a conclusion that S's decision-making is incapacitous.

58. Taking into account all the evidence in this matter, all that I have read and heard, I am satisfied that S has amply enough 'pieces of the jigsaw to see the whole picture.' Even if aspects of her weighing are influenced by symptoms of her diagnosed condition, I am not satisfied that S is unable to use or weigh the information relevant to making a decision about termination of her pregnancy. Rather, in my judgment she is demonstrating the application of her own values to the decision in question.
59. I am conscious that S may not yet have reached a final decision as to whether she wishes to terminate her pregnancy or not. She has told clinicians that she is 70 or 75% sure. Learning of safeguarding procedures during these proceedings may have increased her resolve. It is not necessary that she is "sure" (as Ms. Pretlove means it) of what her decision will be for her to retain capacity to make the decision. Perceived ambivalence will doubtless inform the opinion of any clinician asked to undertake the termination procedure as to whether the statutory conditions are met but I do not consider that S's expression of less-than-certainty amounts to inability to make a decision. Rather, in my judgment, it reflects S's understanding of the magnitude of the decision she contemplates. The reality is that no one can reassure S that things "will work out fine" if she has the termination or if she does not. Decisions have to be taken without the benefit of a crystal ball.
60. I am not satisfied that the statutory presumption of capacity has been rebutted. How S chooses to exercise her capacity is a matter for her and her alone.

A post script on the proceedings

61. The decision having been given, and the reasons for it now set out, I turn to a few observations about these proceedings.
62. This issue should have been referred to the Court much more promptly and by one or both of the health bodies. It is a distortion of reality to say – as representatives of the First Respondent did in a letter dated 24th February 2022, exhibited to the statement by S - that at the conclusion of the best interests meeting on 18th February there was "unanimous agreement" either that S lacked capacity to make a decision regarding termination of pregnancy or that it was not in her best interests to undergo termination. The draft minutes record that S was only admitted to that meeting at the end, when decision had apparently already been made, but she voiced her objection clearly. Neither detention under the Mental Health Act, nor professional conclusion of lack of capacity, justify the negation of S's voice in this way.
63. Even if a narrow interpretation of paragraph 8 of the Vice-President's Guidance of 17th January 2020 permits the exclusion of S from "those with an interest in [her] welfare" for the purposes of paragraph 8(c), the clinicians acknowledged that this was a difficult decision and their view may be wrong. It must surely therefore fall within paragraph 8(a), as a finely balanced decision.

64. Even if there is scope for debate about whether paragraph 8 of the Guidance points to this matter being referred to the Court by the medical bodies, this matter falls squarely within paragraph 10. The decision whether or not to terminate a pregnancy must surely involve one of the most serious interferences with a person's rights under the EHCR. It is deeply regrettable that S was left, in a situation of detention by the state and at the cost of incurring personal debt, to bring these proceedings herself. Credit is due to the solicitors who ensured that this was even possible.
65. The failure to issue proceedings more promptly has meant that Court has been required to make a decision on an issue of utmost gravity and sensitivity under extreme time pressure. One of the manifestations of this is that the hearing had to be conducted remotely. Although I sat in the courtroom and the hearing was 'in public' (subject to a reporting restrictions order), it was listed at too short notice for inclusion in the Courtel notices and so there was no real opportunity for the kind of public observation which is usually a feature of matters before the Court of Protection in general and matters of this nature in particular.
66. Remote conduct of hearings of this nature was a matter of necessity in circumstances of global pandemic. However, as we emerge from pandemic, the limitations of such hearings are more difficult to accept. S was in a room on her own in the hospital. There was a nurse outside the door, and both S and her representatives were keen to proceed on that basis as the best possible in the circumstances. However it was very unsatisfactory when information emerged of which S had not previously been fully aware, and when - on several occasions - her camera failed. Mr. Lawson was obliged to reload the bundle part-way through questioning a witness. With the clinicians choosing to be in the same room together for the hearing, the image I had of each of them on my computer screen was extremely small and my ability to discern non-verbal communications correspondingly diminished. It is my view that hearings of issues such as arose in this case are much better determined at a face to face hearing.

HHJ Hilder

7th March 2022

Approved by HHJ Hilder, 7/3/22