



Neutral Citation Number: [2024] EWCOP 5

Case No: 13961414

**IN THE COURT OF PROTECTION**

Date: 8 February 2024

**Before:**

**MR JUSTICE POOLE**

**Re EE (Capacity: Contraception and Conception)**

**Between:**

**SHEFFIELD CITY COUNCIL**

**Applicant**

**- and -**

**EE (By her Litigation Friend, the Official Solicitor)**

**Respondent**

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**Eloise Power** (instructed by the Applicant Council) for the Applicant  
**Joseph O'Brien KC and Hannah Bakshani** (instructed by BHP Law) for the Respondent

Hearing dates: 29-30 January 2024  
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This judgment was handed down remotely at 10.30am on 8 February 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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This judgment was delivered in public but a transparency order is in force. 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 anonymity of the Respondent must be strictly preserved. All persons, including representatives of the media and legal bloggers, must ensure that this condition is strictly complied with. Failure to do so may be a contempt of court.

## Mr Justice Poole:

### Introduction

1. EE is a 31 year old woman who wants to become pregnant and have a baby. These are amongst the most fundamental decisions a woman can make but EE's capacity to engage in sexual relations, to decide about contact with others, and to make decisions about contraception, are all in issue and require the court's determination. EE was born with a genetic condition called Tuberous Sclerosis which causes benign tumours to develop in different parts of her body, including her brain. She has been diagnosed with autistic spectrum disorder with mild learning disability, an emotionally unstable personality disorder, and recurrent psychotic disorder. She is on anti-psychotic and other medication.
2. This judgment follows a one and a half day hearing to determine EE's capacity to make decisions about engaging in sexual relations, contact with others, and contraception. Prior to the hearing I met EE in the company of her solicitor and Junior Counsel who made a note which I have approved and which has been shared with the Applicant. I explained to EE my role, the issues the court had to determine, and how she could attend the hearing, which she did throughout the first day, the second morning being devoted only to oral submissions. I am very grateful to Counsel for engaging so helpfully with the difficult issues of capacity which I have to determine.
3. The parties agree that EE has capacity to make decisions to engage in sexual relations and lacks capacity to make decisions about contact with others. The Applicant Local Authority submits that EE lacks capacity to "make decisions about whether to use contraception". The Official Solicitor (OS) submits that EE has capacity to make "decisions about contraception". The fact that the parties used different formulations for the matter in respect of which the court must evaluate P's capacity to make a decision for herself concerning contraception, points to an important issue for the court to address, namely what *is* the matter in relation to contraception which EE has to decide.
4. I am concerned in this judgment with issues of EE's capacity, not her welfare. If she is found to lack capacity to make decisions about contraception or other matters then the court will have to consider what decisions might be made on her behalf, in her best interests.

### The Factual Context

5. EE's history includes the following:
  - a. In June 2007, at the age of 14, EE was referred to the Sexual Exploitation Team following concerns around risk-taking behaviour relating to sex and alcohol. A brain MRI scan at the time revealed small bilateral giant cell astrocytomas and multiple cortical tubers in keeping with a diagnosis of Tuberous Sclerosis.
  - b. In 2009, EE experienced psychosis due to the use of solvents. In the same year, superficial self-harm, bullying, and low mood were noted.
  - c. In 2010, EE experienced auditory and visual hallucinations.

- d. In January 2012, EE was admitted as an inpatient following command hallucinations asking her to kill herself and others, together with telepathy and gustatory and olfactory hallucinations. She was diagnosed with Organic Delusional Schizophrenia-like Disorder.
  - e. In 2014, EE was charged with assault.
  - f. In August 2014, EE was admitted as an inpatient following an overdose of Olanzapine.
  - g. In early 2015, EE was noted to be trying to conceive. In August that year she was noted to be suffering from insomnia, racing thoughts and persecutory ideas together with depressive symptoms, following a separation from her then boyfriend.
  - h. In November 2016, EE was arrested for threatening behaviour.
  - i. In November 2017, EE was noted to have used crack cocaine on a daily basis over several weeks and to have threatened her grandmother with a knife to obtain money for crack cocaine. She reported command hallucinations instructing her to end her own life.
  - j. In June 2019, EE reported auditory hallucinations commanding her to end her own life.
  - k. In September 2019, EE was arrested following allegations of threatening her niece with a knife, attempting to throw boiling water on her and “hitting her brother-in-law with the boiling water”. She was admitted to a crisis house and thereafter detained under the Mental Health Act 1983 in an in-patient ward.
  - l. On 12 July 2021, EE was discharged from section to a residential placement.
  - m. On 1 April 2022, Sheffield City Council granted a standard authorisation for EE to be deprived of her liberty.
  - n. In August 2022 EE moved to her current, supported living placement.
6. EE’s current circumstances are referred to in a care plan dated 23 October 2023. She requires prompts to take her medication, but she is currently compliant. Her health anxiety requires monitoring and she has encouragement to maintain a structured routine to promote sleep hygiene. She has support to make her own meals. She also requires support to establish and maintain relationships with others. She has supervision in the community on a one-to-one or two-to-one basis, support accessing the internet and social media, and she requires management of her finances. EE has displayed challenging behaviour including verbal aggression, making unfounded allegations against staff, and purposefully blocking a toilet to cause a sewage spillage. She has engaged in risk-taking behaviour such as absconding, and making contact online with men who may exploit her. She has sent pictures of herself online to strangers and has fallen victim to a scam which involved her giving her smart phone to a man with whom she had had contact online.

7. For some years, EE has expressed a wish to have a child. In 2023 she was in a relationship with another resident, but that relationship has now ended. She has been sexually active for some years and has previously conceived but underwent a termination of her pregnancy.

### **The Current Proceedings and Evidence**

8. The current proceedings were issued on 24 June 2022 as a s21A Mental Capacity Act challenge to placement X. In August 2022, EE was moved to her current, supported living placement after the court authorised that move. In December 2022, EE expressed a wish to have children. The Court gave directions for expert evidence from Dr Todd, Consultant Clinical Psychologist. He has produced an initial report followed by two Addendum Reports. I later directed expert evidence from Dr Alex, Consultant Psychiatrist and made the Council the Applicant given the outstanding issues regarding capacity.
9. Dr Alex reports that EE currently takes prescribed anti-depressants, sleeping tablets, and Aripiprazole which is an antipsychotic administered by monthly depot injection. Whilst there are risks associated with the use of her current medications during pregnancy, including risks of withdrawal symptoms to the new-born infant, Dr Alex's opinion is that the likely advice to EE would be to continue with her medications during pregnancy because of the benefits they bring to her. Her mental health would become unstable if she were to cease any of the medications.
10. Helpfully, Dr Alex describes EUPD as being characterised by a tendency to act impulsively and without consideration of the consequences. There is a liability to outbursts of emotion and incapacity to control behavioural explosions. When impulsive acts are thwarted or censored there is a tendency to conflicts with others.
11. Dr Todd gave oral evidence. I found him to be thoughtful and measured but he did add to his written evidence in ways which went beyond mere clarification, for example in relation to the effect of pregnancy on EE's mental health or psychological condition even in the event that she continued with her current medication. Dr Todd confirmed that at his interviews with EE, he had not discussed with her whether she had been provided with the relevant information in relation to decisions about sexual relations, contact, or contraception. Furthermore, prior to his visits, EE had not known what issues he was going to discuss with her.
12. Previously, Dr Todd has advised, and the court has found, that EE lacks capacity to conduct this litigation, and to make decisions about care and residence.
13. It is important to record that in the letter of instruction to Dr Todd in advance of his First Addendum report dated 29 September 2023, solicitors for the OS properly recorded what the Judge had directed his further report should address, namely:
  - a) EE's capacity to make decisions in respect of contraception;
  - b) EE's capacity to make decisions around conceiving/becoming pregnant;
  - c) EE's capacity to engage in sexual relations.

As I shall discuss later in this judgment, I am not sure that the second of those questions was appropriate to the case. However, Dr Todd followed the instructions given and concluded,

“EE does have the mental capacity to make informed decisions about engaging in sexual relations. However, she does not have the mental capacity to make informed decisions in relation to contact with others. A best interests decision supported by a background check and a safety plan detailing how she would keep herself safe from harm in the broadest sense would support EE to have a sexual relationship in the future... [On] the balance of probabilities, EE currently does have the mental capacity to make informed decisions in relation to contraception. She has made a clear preference for the use of the injection and weighed it against the other options from her knowledge and experience. I recommend that this preference is followed and she is involved in this process.... [In] my professional opinion, on the balance of probabilities, EE does not have the mental capacity to make informed decisions about conceiving/becoming pregnant.”

14. For his Second Addendum Report dated 19 January 2024, Dr Todd was asked to address the following questions,

“Does EE have the capacity to decide whether or not to use contraception?”

Please consider the following sub-issues: i. EE’s understanding of the process of pregnancy and giving birth, and ii. EE’s understanding of the potential effects of any pregnancy on her mental health including, if relevant, the use and cessation of psychiatric medication.”

He concluded,

“EE currently does not have the mental capacity to make an informed decision whether to use contraception to prevent the risks associated with pregnancy to her mental health and the risks to her baby of a mental health relapse and the use of psychotropic medication during pregnancy.”

I have also received written evidence from social workers, from lawyers instructed by the Official Solicitor, and minutes of meetings concerning EE.

## Legal Framework

15. The test of capacity in ss2 and 3 of the Mental Capacity Act 2005 (MCA 2005) and the principles in s1, apply to the decisions which I have to consider. Assessments of capacity are decision specific and are made under that Act and not for the purposes of the criminal law. For the sake of economy, I shall not set out the provisions of ss1 to 3 of the MCA 2005 which have been repeated in many previous judgments. However, I stress that in this case, as in all cases concerning capacity, it is assumed that P has capacity unless it is established that they lack capacity. The burden is on the Applicant to establish a lack of capacity in relation to any decision-making. The Supreme Court’s decision in *A Local Authority v JB* [2021] UKSC 52, [2022] 3 All ER 697 (“*JB*”), and the Court of Appeal judgment of Baker LJ in the same case, [2020] EWCA Civ 735, [2021] 1 All ER 1103, lay down a definitive guide for assessing capacity to make decisions about engaging in sexual relations. Theirs J’s judgment in *LBX v K* [2013] EWHC 3230 (Fam) provides guidance as to the information relevant to decisions about contact with others. In *A Local Authority v Mrs A and Mr A* [2010] EWHC 1549 (Fam) Bodey J considered the proper approach to determining whether a woman has capacity to make decisions about contraceptive treatment.
16. I considered the Supreme Court’s judgment in *JB* in *Re PN (Capacity: Sexual Relations and Disclosure)* [2023] EWCOP 344 and need not repeat the whole of paragraphs [7] to [11] of that judgment. In short, MCA 2005 s2(1) provides a single test for capacity which falls to be interpreted by applying the remaining provisions of ss2 and 3:

“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.”

The “material time” is the specific time when the decision has to be made. There is a sequence in which questions must be considered. The court must identify “the correct formulation of “the matter” in respect of which it must evaluate whether P is unable to make a decision for himself” ([68] of *JB*), and the information relevant to the decision, which will include the reasonably foreseeable consequences of making or not making the decision (MCA 2005, s3(4)). Having done so, the first question is whether P is unable to make a decision for himself in relation to the matter. If so, the second question is whether that inability is ‘because of’ an impairment of, or a disturbance in the functioning of, the mind or brain.

17. In relation to decision-making about sexual relations, *JB* establishes that the correct formulation is whether P has capacity to make decisions to engage in sexual relations, not whether P has capacity to consent to sexual relations. At [84] Lord Stephens approved the formulation of the information relevant to a decision to engage in sexual relations given in the Court of Appeal by Baker LJ at paragraph [100] of his judgment:

“... the information relevant to the decision [to engage in sexual relations] may include the following:

- (1) the sexual nature and character of the act of sexual intercourse, including the mechanics of the act;

- (2) the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity;
- (3) the fact that P can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;
- (4) that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant;
- (5) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.”

Baker LJ did not purport to give an exclusive or exhaustive list and, as I set out in *PN* (above), my reading of the judgment of Lord Stephens in the Supreme Court is that not all of the information listed by Baker LJ will be relevant in every case. Furthermore, in any particular case there may be additional relevant information that is not within Baker LJ’s list. Lord Stephens held at [70]:

“I consider, and the Court of Appeal in this case held at para 48, that the court must identify the information relevant to the decision “within the specific factual context of the case”: see also *York City Council v C* at para 39.”

And at [73]:

“The information relevant to the decision includes information about the “reasonably foreseeable consequences” of a decision, or of failing to make a decision: section 3(4). These consequences are not limited to the “reasonably foreseeable consequences” for P, but can extend to consequences for others. This again illustrates that the information relevant to the decision must be identified within the factual context of each case.”

18. In respect of decisions about engaging in sexual relations, the “specific factual context of the case” will dictate whether:
  - a. The decision is or is not person-specific: the decision for P might be whether to engage in sexual relations with Mr or Ms A, or whether to engage in sexual relations more generally.
  - b. All, or only some, of the information listed by Baker LJ will be relevant. For example, if P is male and wishes to engage in sexual relations only with other males, then there is no risk of pregnancy.

- c. The court should consider if any additional information is relevant, for example in a case where there would be a reasonably foreseeable, high risk of “serious or grave consequences” of the decision, see para. 4.19 of the MCA 2005 Code of Practice referred to at [74] of *JB*:

‘Relevant information must include what the likely consequences of a decision would be (the possible effects of deciding one way or another) ... But a person might need more detailed information or access to advice, depending on the decision that needs to be made. If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision.’

I pause to note that insofar as the Code of Practice is inconsistent with the MCA 2005, I must apply the statutory provisions.

19. Lord Stephens warned against setting the bar for capacity too high by stretching the “reasonably foreseeable consequences” too far:

[75] ... there should be a practical limit on what needs to be envisaged as the ‘reasonably foreseeable consequences’ of a decision, or of failing to make a decision, within s 3(4) of the MCA so that ‘the notional decision-making process attributed to the protected person with regard to consent to sexual relations should not become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity’: see *Re M (An Adult) (Capacity: Consent to Sexual Relations)* at para [80]. To require a potentially incapacitous person to be capable of envisaging more consequences than persons of full capacity would derogate from personal autonomy.”

20. Lord Stephens’ emphasis on the need to identify relevant information within the specific factual context of the case and on there being “practical limits” to what needs to be envisaged as reasonably foreseeable consequences of a decision, or not making a decision, surely applies to all areas of decision-making in relation to which capacity is being assessed.
21. In, *LBX* (above) Theis J held that information relevant to decisions about contact with others included (i) who the others are and in broad terms the nature of P’s relationship with them; (ii) what sort of contact P could have with each of them, including different locations, differing durations, and differing arrangements regarding the presence of a support worker; and (iii) the positive and negative aspects of having contact with each person. P’s own evaluations will only be irrelevant if they are based on demonstrably false beliefs. Relevant information will not include abstract notions like the importance of family ties or the nature of friendship, the long term possible implications of contact decisions, or risks that are not in issue.



22. In *A Local Authority v Mrs A and Mr A* (above), in which case Mr J O'Brien KC, who appears before me for the OS on behalf of EE, appeared for the OS on behalf of Mrs A, Bodey J rejected the Local Authority's submission that the information relevant to a decision whether or not to use contraception included foresight of the consequences of bringing up a child. He warned against blurring the line between capacity and best interests:

“[A] wider test would create a real risk of blurring the line between capacity and best interests. If part of the test were to involve whether the woman concerned understood enough about the practical realities of parenthood, then one would inevitably be in the realms of a degree of subjectivity, into which a paternalistic approach could easily creep. What exactly would the woman have to be able to envisage about parenthood, who would decide, and just how accurate would her expectations have to be? Butler-Sloss LJ put it this way in *Re B (consent to treatment: capacity)* 2002 1FLR1090:

“... if there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision.”

This translates into the statutory embargo in S.1(4) against finding incapacity on the basis that a given decision would be ‘unwise’.”

He went on to hold,

“63. Contrary to my initial view as to the very wide ambit of the words “the reasonably foreseeable consequences” of deciding one way or another on contraception, I have concluded that the Official Solicitor’s submissions on this are correct. Although in theory the ‘reasonably foreseeable consequences’ of not taking contraception involve possible conception, a birth and the parenting of a child, there should be some limit in practice on what needs to be envisaged, if only for public policy reasons. I accept the submission that it is unrealistic to require consideration of a woman’s ability to foresee the realities of parenthood, or to expect her to be able to envisage the fact-specific demands of caring for a particular child not yet conceived (let alone born) with unpredictable levels of third-

party support. I do not think such matters are reasonably foreseeable: or, to borrow an expression from elsewhere, I think they are too remote from the medical issue of contraception. To apply the wider test would be to ‘set the bar too high’ and would risk a move away from personal autonomy in the direction of social engineering. Further, if one were to admit of a requirement to be able to foresee things beyond a child’s birth, then drawing a line on into the child’s life would be nigh impossible.

64. So in my judgment, the test for capacity should be so applied as to ascertain the woman’s ability to understand and weigh up the immediate medical issues surrounding contraceptive treatment (“the proximate medical issues” - per Mr O’Brien), including:

- (i) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse);
- (ii) the types available and how each is used;
- (iii) the advantages and disadvantages of each type;
- (iv) the possible side-effects of each and how they can be dealt with;
- (v) how easily each type can be changed; and
- (vi) the generally accepted effectiveness of each.

I do not consider that questions need be asked as to the woman’s understanding of what bringing up a child would be like in practice; nor any opinion attempted as to how she would be likely to get on; nor whether any child would be likely to be removed from her care.”

23. In *Mental Health Trust and ors v DD* (No.2) [2014] EWCOP 13, Cobb J added to the list of relevant information set out by Bodey J in *A Local Authority v Mrs A and Mr A* (above) by including information about medical risks to which P would be exposed upon becoming pregnant. He observed that Bodey J’s list was not exhaustive or exclusive and that any significant medical risks associated with P’s pregnancy would be sufficiently proximate to be included in the relevant information. In the case he was dealing with, those risks were certainly “serious and grave” since they included significant risks of fatal complications.

## Analysis and Conclusions: Sexual Relations and Contact with Others

24. Dr Todd has advised, and the parties agree, that EE has capacity to make decisions to engage in sexual relations. I am not bound so to find. I have regard to the legal framework set out earlier in this judgment and, crucially, the authority of *JB*. Baker LJ's formulation of the information relevant to a decision to engage in sexual relations included "that a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant." He did not include information about the possible consequences to P, or, if P is male, to P's female sexual partner, of becoming pregnant to P or the possible risks to the baby if conceived. However, the "specific factual context", including the existence of "serious or grave consequences" of a decision, or not making the decision, needs to be considered and Baker LJ did not purport to give an exhaustive or exclusive list of relevant information that would apply in every case. If a woman of child-bearing age were to have a high risk of suffering serious or grave complications of pregnancy of the kind to which P in *DD* was vulnerable, then it is arguable that the information relevant to her decisions to engage in sexual relations would include not only the prospect of her becoming pregnant but also that consequently she and her baby would be at a high risk of grave harm. These kinds of reasonably foreseeable consequences were not addressed by Lord Stephens in *JB*, but he was concerned with a man not a woman, and in any event it would not have been possible for him to have addressed every kind of information that would be relevant to every potentially incapacitous person's decisions to engage in sexual relations. Instead, he set down the general requirement for the court to consider the specific factual context of each case.
25. However, having noted that it is at least arguable that in some cases where there are serious or grave risks of harm consequent on a pregnancy, the information relevant to engagement in sexual relations might include those risks, it is right to note that Lord Stephens warned that there were "practical limits" on what P should be expected to envisage as the "reasonably foreseeable consequences" of a decision or failing to make a decision. A line must be drawn so as to avoid imposing too high a requirement on persons who may potentially lack capacity to make a particular decision.
26. In the present case, I consider that in the context of decision-making about engaging in sexual relations it would exceed the practical limits to require EE to envisage the risks to her or her baby should she become pregnant following intercourse. Firstly, the evidence does not establish that she or her baby would be at serious or grave risk of harm were she to become pregnant. The evidence suggests that there would be some risks to her, but they are not of a direct and severe kind. I address this more fully below. Secondly, many women will put their physical or mental health at risk by becoming pregnant. Some may consider those risks before engaging in sexual relations, some might not. To require EE to understand and weigh or use information about risks to her health during pregnancy or labour, in particular risks which were not grave, would stray beyond the practical limits to which Lord Stephens referred and would set the bar too high. Thirdly, and similarly, many women will engage in sexual relations with a view to conceiving when there is a risk that their baby will suffer harm in utero or be born with a congenital disability. Again, some women will consider those risks in advance of engaging in sexual relations, some will not: the bar should not be set too high for EE. Finally, these matters – risks consequent to pregnancy – have not featured significantly or at all in the case law regarding the information relevant to decisions about sexual relations including older authorities about capacity to consent to sexual relations. I proceed on the basis that it would only be in cases

where there was a clearly identified, high risk of grave harm consequent on pregnancy or childbirth, that information about that might have to be envisaged by P and be included in the list of relevant information.

27. I have found it necessary to address the question of information relevant to decisions to engage in sexual relations, notwithstanding the agreement of the parties as to EE's capacity in that respect, because it is necessary to consider the consistency between the determinations of capacity I have to make.
28. In my judgment the information relevant to EE's decisions to engage in sexual relations is that set out by Baker LJ in *JB* and I do not consider that any further relevant information should be added in this case. Dr Todd's written reports correctly address EE's ability to understand, retain, and weigh or use the relevant information. EE's responses in interviews with Dr Todd are conspicuous for the detailed understanding and ability to weigh and use information that she demonstrates. As Dr Todd said to the court, EE offered the information she knew and her opinions about decision making, largely unprompted. I have no hesitation in finding that she has capacity to decide to engage in sexual relations as Dr Todd and the parties have agreed.
29. There is no dispute that EE lacks capacity to make decisions about contact with others. The primary reason EE lacks capacity regarding contact is her inability to use or weigh the risks that others pose to her. She has exposed herself to exploitation and harm from those with whom she has had contact but who has not previously known. For example, recently she handed her smart phone to a stranger who had offered her money for it on the internet. She met him and he made off with her device without paying her for it. She had been unable to weigh the risks and benefits of this contact. Applying *LBX*, EE is unable to weigh and use information about the positives and negatives of having contact with people with whom she is not already familiar. Dr Todd has advised that this is "owing to a combination of developmental, organic, and mental health problems." These are the diagnosed conditions set out above and they prevent her from being able to weigh and use the relevant information to which I have referred. I am satisfied that the presumption of capacity has been displaced and that it is established that EE lacks capacity to make decisions about contact with others with whom she is not yet familiar.
30. I should comment briefly on whether the agreed positions regarding capacity to make decisions about sexual relations and about contact with others, which I endorse, are consistent with each other. In *Hull City Council v KF* [2022] EWCOP 33, I said at [24],

"It is difficult to see how a person who lacks capacity to decide to have contact with a specific person could have capacity to decide to engage in sexual relations with that person. Sexual intimacy is a form of contact with another or others."

However, in *PN* (above) I was concerned with determining capacity to engage in sexual relations generally, not with a specific person and I found that *PN* lacked capacity to make decisions about contact with others but had capacity to engage in sexual relations with others. For the reasons set out in that judgment, in particular at [28], I did not consider those determinations to be inconsistent. Likewise, in the present case, I am content to find that EE lacks capacity to decide on contact with others, specifically those

with whom she is not already familiar, but has capacity to decide to engage in sexual relations with others. EE's carers have devised and adopted a care plan which has been based on those positions in relation to capacity. It follows an approach of the kind set out by Baker J in *A Local Authority v TZ* [2014] EWHC 973 (COP) and discussed in his oral evidence by Dr Todd when he referred to "positive risk taking". The approach involves encouraging EE to consider the risks and benefits of meeting any particular person and the form of contact with them but ultimately to make best interest decisions to protect her from harm, or the risk of harm from contact with a person with whom she is unfamiliar, and to allow for interventions by a carer. However, once she has familiarity with a person and wishes to have sexual relations with them, her capacity to make that decision would have to be respected. The fact that JB had been found to lack capacity to make decisions relating to contact with others did not preclude the Court of Appeal and the Supreme Court from considering whether he lacked capacity to engage in sexual relations. The courts were clearly prepared, in principle, to find that he had capacity to engage in sexual relations notwithstanding that he lacked capacity to decide to have contact with others.

### **Analysis and Conclusions: Contraception and Conception**

31. As noted, when Dr Todd was asked whether EE has capacity "to make decisions in respect of the use of contraception", he concluded that she "does have the mental capacity to make informed decisions in relation to contraception", but when asked whether she had capacity "to make decisions regarding conceiving/becoming pregnant" he concluded that she did not. Although the word "contraception" means the intentional prevention of conception, the questions were put to him as though they related to two separate decisions, not as different ways of describing the same decision, and he must have viewed them as such because he came to different conclusions about EE's capacity to make each decision. I have considered whether it is appropriate to consider EE's capacity to decide to conceive or to become pregnant alongside decisions about her capacity to make decisions about engaging in sexual relations and the use of contraception.
32. Mr O'Brien KC complained that in his second Addendum Report, Dr Todd strayed beyond his instructions, the relevant part of which is set out at paragraph 14 above, by introducing information that he considered to be relevant, namely the impact on EE of being a new mother and the impact on the baby of EE having mental health difficulties. Those were not matters he had been asked to take into account because the case law did not support those matters being included in the relevant information. I have sympathy with Dr Todd because of the difficulty of identifying the matter for decision and the relevant information, but Mr O'Brien's observation was correct and an expert witness should pay close regard to their letter of instruction which has often been the subject of intense discussions by experienced lawyers and/or approval of the court.
33. In relation to contraception and/or conception it is necessary to identify the matter about which EE has to make a decision, whether there is more than one matter, and what information is relevant to any decision.
34. Ought the court to be even considering the question of EE's capacity to make decisions about conception given its determination that EE has capacity to decide to engage in sexual relations and that it will determine her capacity to decide on the use of contraception? In

*JB* no distinction was made between decisions about engaging in sexual relations with a view to trying to conceive, and decisions about sexual relations which are not for any reproductive purpose. It is sufficient for P to understand, retain, and weigh or use information that sex might result in pregnancy. There was no suggestion in *JB* that the relevant information concerning pregnancy differs according to whether P and their consenting sexual partner wish to have sex without contraception. Furthermore, the non-exclusive list of information relevant to decisions to engage in sexual relations set out in *JB* does not include the risks consequent on pregnancy or childbirth to P or, if P is a man, to a woman with whom P has sex, or to a conceived child. Such information was not included within the “practical limits” of what needs to be envisaged. In the present case I have found that those matters were not part of the information relevant to EE’s decision to engage in sexual relations. The freedom to make decisions about conceiving and having children, subject to the unavoidable restrictions imposed by biology, is a fundamental part of anyone’s Article 8 right to respect for their private and family life and, in my judgment, it would be irrational, unnecessary, and an unjustified interference with EE’s Article 8 rights, to find that she has no capacity to make decisions about conception on the grounds that she cannot understand, retain, or weigh or use that same information. Dr Todd and the Applicant have, I believe, fallen into that error.

35. Clearly there is some overlap between decisions about contraception and decisions about conception, but they are different. Without needing to decide the matter, there may be cases, for example where P wishes to undergo IVF, in which P’s capacity to make a decision about conception has to be determined. But in most cases, including EE’s case, those specific considerations will not apply. EE has capacity to engage in sexual relations and that means she has capacity to engage in sexual relations with a view to becoming pregnant. I shall also consider her capacity to make decisions about the use of contraception. In the circumstances, no separate consideration of capacity to decide about conceiving or conception is required or justified.
36. For those reasons I do not consider it necessary or appropriate to frame the matter for decision as being about “conceiving/getting pregnant” as Dr Todd expressed it, or about conception at all. In relation to the issue of contraception, in my judgment the appropriate formulation of “the matter” in respect of which the court must evaluate whether EE is unable to make a decision for herself, is “the use of contraception”. Both Bodey J in *A Local Authority v Mrs A and Mr A* and Cobb J in *DD*, approached the matter on which P had to make a decision as being not only about modes of contraception but also whether to use contraception. At [65] Bodey J described the issue for him to determine as being, “does Mrs A have capacity to decide whether or not to have contraceptive treatment?” and the first of his list of relevant information relates to the consequences of not using any, or any adequate, contraception. Cobb J referred to decisions “about contraception” but clearly took into account the foreseeable consequences of choosing not to use any or any effective contraception because he added to the relevant information the consequences of P becoming pregnant. Neither framed the question as being whether P had capacity to decide to try to conceive and I have already dismissed any suggestion that I should consider EE’s capacity to make decisions about conception. In my judgment it is necessary for me to determine whether EE has capacity to make decisions about the use of contraception which includes not only consideration of what form of contraception to use, but whether to use contraception at all.

37. In order to identify the information relevant to the decision in question, I turn to the particular factual context within which EE would make such decisions. Dr Alex has identified that EE is currently prescribed anti-anxiety medication, sleeping tablets, and an anti-psychotic. He advises that the probable advice to EE would be to continue with each of these during pregnancy. EE has said that that is what she would do. She has been compliant with her medication for some time and has not suffered a psychotic episode for a while. Dr Alex does warn that if EE were to continue her medication throughout pregnancy, then at birth the baby might initially have to be cared for in the neonatal intensive care unit to monitor for signs of withdrawal from the anti-psychotic medication. There is no evidence that EE does not understand this information or is unable to weigh or use it.
38. At paragraph 14 of this judgment, I set out the questions Dr Todd was asked to address in his Second Addendum Report and his summary conclusions that “[EE] does not have the mental capacity to make an informed decision whether to use contraception to prevent the risks associated with pregnancy to her mental health and the risks to her baby of a mental health relapse and the use of psychotropic medication during pregnancy.” At paragraph 3.2 of the report, he explained his reasoning,

“She stated that it is her right to have a child and all her physical and mental problems will go away once she has a child. This strongly held belief, in combination with her lack of insight into her care and support needs, leads her to be unable to use and weigh the risks to her mental health of becoming pregnant and being a new mother and the impact of the baby on her mental health and the risks to her baby of a mental health relapse and the use of psychotropic medication during pregnancy. In terms of pregnancy and the risks to her mental health, EE believed that she would be able to manage regardless of any impact on her mental health. In terms of pregnancy and the risks to her baby, she believed her mental health would have no impact on the child and any risks caused by psychotropic medication were not significant and, even in the worst case, she would be able to manage the impact on the baby.”

39. In his oral evidence, Dr Todd focused on the risk of EE suffering from a deterioration in her mental health or psychological state due to the combination of her autism and learning disability, and the stress of pregnancy and/or birth. He had not specifically addressed that issue in his written evidence. More importantly, he had not addressed it with EE, so that there was a lack of evidence before me of what she might have said about the risk of a general deterioration in her mental or psychological condition. Dr Todd had written,

“Understanding of the impact of pregnancy on mental health: EE accepted that, for some people, mental health problems get in the way of having a baby but she thought she would be a very good parent regardless of this. She appreciated that, for some people, having a baby is very, very stressful and it makes their mental health worse but she said that she would be fine and would actually enjoy it. EE thought everyone does it and they cope well.

She felt strongly that it was discriminatory to think that she would not be able to have a child because of things that have happened in the past and things she cannot control. EE appreciated it is not a good idea to stop her medication as she needs to take this for her mental health. She accepted there was a risk of relapse if she stopped taking her medication.”

Here, notwithstanding the title “understanding the impact of *pregnancy* on mental health” (emphasis added) the main focus was on the impact of *having a child* on EE’s mental health and then on the issue of continuing or stopping her medication. There followed a further section detailing more discussion with EE about stopping or continuing her current medication and the report of Dr Alex. Then this,

“Impact on decision making regarding contraception: EE reported she did not want to use contraception as she is not in a relationship. She stated she would use contraception at the start of a relationship but then she would want to become pregnant. EE reported that she would not be with someone who did not want children because that is what she wants. She stated that she wants a family guy who she can get along with and wants someone who has a good lifestyle and looks after themselves. EE thought that once she had a child, all the problems in her life, both physical and mental, would go away. She stated that she is 31 and she has the right to have a family.”

In his First Addendum Report, Dr Todd had further reported as follows,

“EE reported that she is longer sexually active so she does not need any contraception. She stated that if she met someone, she would use a condom and also some other form of contraception if she was not ready to have a baby. EE reported that she would prefer the Depo injection as the alternative form of contraception for the reasons outlined above. She stated that even if she used condoms, she would still undertake regular tests for STIs.”

Thus, I have evidence of EE’s views about people with mental health problems having a baby, about continuing her present medication, and about her notional decision-making about using contraception or withholding contraception and trying to conceive, but not about the specific issue of a deterioration in her mental or psychological health during pregnancy.

40. I have virtually no evidence of the likelihood, nature, or severity of any deterioration in her mental or psychological state that EE might suffer as a consequent of pregnancy. Dr Alex does not comment on those matters in his report, Dr Todd does not give such evidence in his written reports, and he did not provide any specific evidence at the hearing, only



referring to having dealt with a patient, whom I did not understand was pregnant at the material time, who had suffered what he called “an autistic meltdown”. I do not doubt that as a woman with autism and learning disability, EE will have some difficulties adapting to the physical and emotional changes caused by pregnancy, but I have no evidence beyond Dr Todd’s implication, that EE is especially vulnerable to suffering a severe crisis of the kind he described should she become pregnant. Furthermore, it does not appear that Dr Todd or anyone else has advised her about such a risk and so she has not had an opportunity to demonstrate her understanding of it, or her ability to weigh or use that information.

41. A relevant aspect of this case is that EE has previously been pregnant. There is no evidence that she experienced an autistic “meltdown” or other deterioration, but I have been given very little information about her previous pregnancy save that it ended with a termination. It cannot be known exactly what support EE would have were she to find that a pregnancy was exacerbating her mental or psychological health. The father might or might not support her, but she would be highly likely to have the support of care staff and therapists.
42. It was clearly material to Dr Todd’s oral evidence about EE’s capacity to make decisions about contraception, that he had found (and no-one disputes) that EE lacks capacity to make decisions about her care. In his first report at paragraph 4.2.2, Dr Todd wrote,

“She was unable to accept, meaning she could not understand or retain, that she required any of the care and support outlined in her care plans. EE believed she was independent in all areas. She was, therefore, unable to use and weigh the benefits of support against the consequences of living without support. EE communicated that she wanted to live independently without support. Her mental capacity is impaired by a combination of impairments in intellectual functioning, social cognition, and executive functioning caused by the combination of developmental, organic, and mental health problems.”

In his oral evidence, Dr Todd indicated that decisions about contraception involve consideration of the effects of pregnancy on EE’s mental health and how she would deal with those. His view appeared to be that because she lacks capacity to make decisions about care, EE cannot understand, or use or weigh, information about her care needs in the event of a deterioration in her mental or psychological health during pregnancy. I do not accept that reasoning. Dr Todd’s interview with EE about care and support focused on her independence and ability to live without day to day support and care, not on medical treatment or support in the particular circumstances of a crisis or deterioration in her mental health or psychological condition caused by pregnancy.

43. There are reasons to avoid setting the bar too high for capacity to make decisions about the use of contraception. As noted, at [75] of his judgment in *JB*, Lord Stephens adopted the caution expressed in *In re M (An Adult) (Capacity: Consent to Sexual Relations)* [2014] EWCA Civ 37, namely that the notional decision-making process attributed to P should not “become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity”. Daily, in GP surgeries and clinics, women make decisions about contraception without considering the risks to them or to the health of their baby if they were to get pregnant. The risk of becoming pregnant following intercourse is

a core piece of relevant information, but not all the many and varied risks which may be consequent on becoming pregnant. Some may envisage all manner of risks, others will not do so.

44. Nevertheless, for some women, there may be certain risks arising from pregnancy that would be highly relevant to their decisions about the use of contraception. Following paragraph 4.19 of the Code of Practice (above), and Cobb J's judgment in *DD* (above), serious or grave consequences of pregnancy to which P would be particularly vulnerable, might be considered to be part of the relevant information. In my judgment, this approach would be consistent with the approach to decision-making about engagement in sexual relations set out by Lord Stephens in *JB* as I have tried to describe earlier in this judgment. The information relevant to a decision is dependent on the specific factual context of each case but must be kept within practical limits so that the bar is not set too high and the requirements on a person who might lack capacity are not divorced from the realities of decision-making for capacitous persons.
45. More remote consequences of pregnancy, labour and birth, such as the impact on the child of being born to a mother with mental health problems, physical illness, or disability, are not part of the relevant information (for a number of reasons including that they are not within practical limits or, as it was put by Bodey J in *A Local Authority v Mrs A and Mr A* (above) they are not proximate medical considerations).
46. Having given very careful consideration to the evidence in this case, the specific factual context in which EE might make decisions about the use of contraception, including whether to use contraception at all, and the need to respect practical limits when determining what reasonably foreseeable consequences should be included, I have decided to adopt the list of relevant information given by Bodey J at [64] in *A Local Authority v Mrs A and Mr A*, with no additions or subtractions. They are set out above in the quotation from his judgment at paragraph 22 of this judgment.
47. I should explain why have not included certain other matters, namely:
  - a. The risks and benefits to EE of continuing with anti-psychotic and other medication during pregnancy. I am not persuaded that serious or grave consequences to EE are brought into consideration. Moreover, I believe that these risks and benefits are not sufficiently proximate to the decision about contraception. The risk of thromboembolic disease which was pertinent to decision making in *DD* would arise directly from a pregnancy. Here, the risks of continuing or discontinuing medication are a secondary consequence of the pregnancy – they arise from a decision that has to be made in the event of the pregnancy. They are therefore further removed from the decision about contraception. If I am wrong and should have included this information, then I am quite satisfied that EE can understand, retain, and weigh or use the information. Dr Todd focused his discussions with EE much more on the potential impact of continuing the medication on any baby she might carry in the future, rather than on the impact to EE herself of ceasing medication, but he went through Dr Alex's report with her and EE appears to have aligned herself with Dr Alex's evidence and his opinion that EE ought to continue taking her current medication during any future pregnancy. I am satisfied that she did so having weighed and used the information provided. To underline my conclusion, EE's ability to weigh and use information in relation to the medical

issues regarding the use of different forms of contraception shows her functional abilities in these areas.

- b. The risks of a deterioration in EE's mental health or psychological condition due to pregnancy or labour. There is no, or no sufficient, evidence before me that this is a serious or grave consequence in the case of EE. I would accept that in principle serious or grave risks might be included as reasonably foreseeable consequences of deciding not to use contraception, but in the specific context of this case, the evidence does not justify treating these risks as serious or grave or as matters which any woman in EE's position would have to consider when making decisions about contraception. Aside from Dr Todd's comments during his oral evidence about the risk of "autistic meltdown", which were not backed up by any references or reliable experience, only by an anecdotal reference to a single case that did not relate to a pregnancy, no other evidence was provided that was relevant to EE's case. If, contrary to my determination, this should be regarded as relevant information then I would need to consider allowing for a further interview with EE in order to afford her an opportunity to address it and thereby to give the court evidence as to her ability to understand, retain, and weigh or use that information. This information has not been discussed with her. I do not need to decide whether I would indeed allow for further evidence to be adduced but I note that the onus is on the Applicant to establish that EE lacks capacity. Whilst the Court of Protection adopts an inquisitorial approach, it does not follow that if, after sufficient time has been given to gather relevant evidence, a party is unable to establish a case, then proceedings must be adjourned to enable more evidence to be obtained.
- c. The potential effects on EE's baby of her continuing to take anti-psychotic and her other current medication during any pregnancy. Dr Alex's evidence is that,
- "Use of aripiprazole [which EE takes] and other antipsychotics throughout pregnancy or near delivery has been associated with withdrawal symptoms in the neonate and/or poor neonatal adaptation syndrome (PNAS). These symptoms are likely to be more severe in infants exposed in utero to more than one CNS acting drug. Delivery should therefore be planned in a unit with neonatal intensive care facilities."

Dr Alex has not said that withdrawal symptoms or PNAS would be a severe or grave condition for the baby. Care must be taken not to insist on P needing to envisage a wider range of risks than a capacitous woman might be expected to envisage, including women taking prescribed or other medication which might affect a baby if they became pregnant.

- d. The effect of EE's mental or psychological health on her newborn baby, the difficulties she might have caring for a baby or coping with the peri-natal period, or the prospects of a child being made the subject of protective orders by the court. Those issues are not "proximate medical issues" and are not within "practical limits" of what needs to be envisaged (*JB* at [75]).

48. Having regard to the relevant information that I have identified, I have no hesitation in finding that EE has capacity to make decisions about the use of contraception. In her interviews with Dr Todd she offered him detailed and thoughtful views about the relevant information. She did so largely unprompted. She retained information between interviews several weeks apart. Her views arose from having weighed or used the relevant information. Dr Todd has advised that EE has capacity to make “informed decisions in relation to contraception” (his First Addendum Report). When he gave that opinion, he was focusing on the relevant information set out by Bodey J (above) because he had been expressly asked to do so in his letter of instruction dated 1 August 2023.

### **Final Conclusions**

49. For the reasons given I conclude that the assumption that EE has capacity to make decisions about the use of contraception has not been displaced. This is, I am satisfied, consistent with the other conclusions I have reached that EE has capacity to decision to engage in sexual relations but lacks capacity to make decisions about contact with others, specifically those with whom she is not already familiar. The conclusions reached and the process of reaching them afford respect to EE’s convention rights.
50. An order will follow that reflects this judgment. I agreed with EE that I would write a letter to her explaining the decisions I have made. With respect to her, although she has thought the matter through, many would think it unwise for her to try to conceive, but it is not for me to advise her, and it is certainly not the role of the Court of Protection to intervene in the autonomous decision-making of an adult who has capacity to make decisions about sex or the use of contraception, however unwise the court may consider the proposed decisions are. Many capacitous people make unwise decisions about sex and contraception, sometimes with awful consequences for themselves and others, but however strong is the impulse to protect, the follies of the capacitous are not the business of the Court of Protection.