



Neutral Citation Number: [2020] EWCOP 20

Case No: COP13583042

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF Z

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/04/2020

Before :

MRS JUSTICE KNOWLES

Between:

**OXFORD UNIVERSITY HOSPITALS NHS
FOUNDATION TRUST**

Applicant

- and -

Z

Respondent

(by her litigation friend, the Official Solicitor)

Claire Watson (instructed by Hill Dickinson LLP) for the Applicant
Bridget Dolan QC (instructed by the Official Solicitor) for Z

Hearing dates: 27 March 2020

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

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This judgment was delivered in public and is published in accordance the with terms of the Transparency Order dated 27 March 2020

Approved Judgment**Mrs Justice Knowles:***Introduction*

1. This application concerns a young woman aged 22 years who I will call Z in this judgment. She has a rare chromosomal abnormality syndrome, known as “chromosome 17q12 microdeletion”, as a consequence of which she suffers from cognitive impairment and a bicornate (or heart-shaped) uterus.
2. Z is currently 35 weeks pregnant with an estimated due date of 30 April 2020. This is her fifth pregnancy. Of her four children, one sadly died when only 6 days old and her other three children have been taken into care. Z developed complications in all her previous pregnancies and this pregnancy is considered to be medically high risk. Due to her bicornate uterus, Z is at risk of preterm birth and fetal malpresentation. Given these risk factors, Z has been booked to deliver her baby by caesarean section on 3 April 2020.
3. Z has a mild learning disability with an assessed IQ in the range 60-69. She has been assessed to have capacity to make decisions about her ante-natal care generally and her mode of delivery specifically. In addition to her learning disability, Z has poorly controlled gestational diabetes, anaemia and a severe vitamin D deficiency.
4. This application was made because Oxfordshire University Hospitals NHS Foundation Trust [“the Trust”] considered that Z lacked the capacity to make decisions about contraception and, in view of her obstetric history and current presentation, her treating team considered that it was in Z’s best interests to have an intrauterine contraceptive device inserted at the time of her caesarean section in order both to reduce the risk of an unplanned future pregnancy and to enable family spacing.
5. This application was not opposed by the Official Solicitor who acts on Z’s behalf as her litigation friend.
6. This application came before me for directions on 20 March 2020. I listed it for an urgent hearing on 27 March 2020. In the light of the crisis caused by the Covid-19 pandemic, that hearing was heard remotely using video-conferencing facilities. Notwithstanding this method of hearing, I provided that the hearing could be attended by the press so that it remained a public hearing as is the custom in the Court of Protection.
7. I am very grateful to counsel and to their respective legal teams for making the arrangements so that this hearing could take place urgently. Their co-operation in the conduct of the hearing and in their focussed submissions made my judicial task a great deal easier. Given the late stage of Z’s pregnancy and the agreement between the parties, I give a short ex tempore judgment and, at the invitation of the parties, I revised that judgment so that it might be publicly available. By a transparency order dated 20 March 2020, I provided that neither Z nor those directly involved in her treatment or care should be identified and this judgment has been written accordingly.

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8. I read the following material which included the position statements of both parties:
- a) a capacity assessment of Z by Dr A, consultant psychiatrist;
 - b) two witness statements dated 18 March 2020 and 23 March 2020 from Dr B, consultant obstetrician and subspecialist in fetal and maternal medicine;
 - c) a witness statement dated 23 March 2020 from Dr A;
 - d) a witness statement dated 24 March 2020 from KB, a solicitor in the Official Solicitor's office;
 - e) a witness statement dated 26 March 2020 from Z's IMCA, Ms C;
 - f) the report of Dr Camden-Smith, consultant psychiatrist instructed by the Official Solicitor, dated 26 March 2020;
 - g) and the report of Professor Walker, Professor of Obstetrics and Gynaecology, dated 26 March 2020.

Z's Participation in the Hearing

9. On 24 March 2020, KB from the Official Solicitor's office made contact by telephone with Z. It was not possible for KB to meet with Z as, being heavily pregnant, Z was self-isolating in response to the threat of Covid-19. Z told KB during their telephone conversation that she would like to be present during the hearing and arrangements were made for KB to speak to her later in the week about the practicalities of joining a remote hearing.
10. Following KB's conversation with Z, efforts were made by both KB and the Trust, including further telephone calls with Z, to put in place arrangements by which Z could participate in the hearing. However, in the event, it was not possible for the arrangements to be finalised prior to the start of the hearing.
11. Shortly after the hearing began, Z made contact with the Trust, wishing to participate in the hearing. I put the hearing on hold whilst the parties considered how best to involve Z. Dr A facilitated Z's participation in the hearing by calling her on his mobile phone and placing that phone so that Z could hear what was being said during the Skype hearing.
12. Z told me that she was willing to have a long-lasting contraceptive injection but did not want to have an intrauterine contraceptive device fitted. She told me that she would be helped by her nurse to go to the regular appointments which would be necessary to maintain her injectable contraceptive. She was unable to articulate why a long-lasting contraceptive injection was her preferred method of contraception other than by saying "*it's my body*". After hearing submissions and before giving my judgment, I told Z that I had decided it was in her best interests for her to have an intrauterine contraceptive device fitted at the time of her caesarean. Z rang off after hearing me say this.

Capacity to Litigate

13. The Trust and the Official Solicitor accepted, on the basis of Dr Camden-Smith's report, that Z did not have the capacity to conduct these proceedings. The Trust's evidence had not specifically addressed the issue of whether Z had the capacity to litigate so the Official Solicitor instructed Dr Camden-Smith to report on this issue.
14. Dr Camden-Smith reviewed Z's psychiatric history, noting that Z was reported in 2015 to have an IQ of 61 which placed her in the mild Learning Disability range. In 2017 Z's diagnosis of mild learning disability was confirmed by the Community Learning Disability team after Z had participated in an assessment using the Wechsler Adult Intelligence Scale (WAIS-IV). Z achieved particularly low scores on the Verbal Comprehension index, the Working Memory index, and the Processing Speed index which indicated that she had substantial comprehension and language difficulties. Additionally, Z's records contained various reports that Z's relatively good social and adaptive functioning, combined with her apparent verbal fluency, had resulted in her abilities being substantially over-estimated. Thus, Z had not always received the care and support she needed since it was evident that her receptive language skills and understanding were significantly below that of her expressed verbal skills. Z's local Learning Disability team had accepted that she has a learning disability with associated mental health needs which cannot be met by mental health services.
15. Dr Camden-Smith interviewed Z by telephone on 24 March 2020 and Z was polite and co-operative although at times annoyed with the questions she was asked. She did not understand why the court might be involved with respect to her decision about contraception; why Drs A and B might be worried about her understanding of that issue; or why Drs A and B had spent significant amounts of time exploring her decision in respect of contraception with her. Furthermore Z did not understand that she had a solicitor to advocate on her behalf and, though Dr Camden-Smith tried to draw parallels with Z's experience of Family Court proceedings, Z did not understand the role of a solicitor despite having had one previously in Family Court proceedings. Dr Camden-Smith concluded that Z lacked the capacity to conduct these proceedings due to an inability to understand the relevant information. She did not understand the court process or the kinds of decisions she might be called upon to make in court. Put simply, Z did not understand that her learning disability might affect her ability to make decisions.
16. I accepted Dr Camden-Smith's evidence. Her conclusions were on all fours with Z's past psychiatric history and it was plain to me from my very brief contact with Z that she did not understand the court process.
17. The key issue in this case was whether Z had the capacity to make a decision about contraception and, in particular, whether or not she should have an intrauterine contraceptive system inserted at the time of her caesarean section.

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18. This application required me to apply the principles contained in part 1 of the Mental Capacity Act 2005 [“the MCA”]. However, both parties recognised that this was not a case in which it could be said that a lack of capacity to make decisions about contraception was an “*obvious and inevitable*” consequence of Z’s mild learning disability.
19. The following general principles, summarised by Miss Watson in the Trust’s position statement for the hearing, were relevant:
- a) A person must be assumed to have capacity unless it is established that she lacks capacity: s.1(2) MCA. The burden is on the party asserting a lack of capacity (here, the Trust) to establish it on the balance of probabilities: CC v KK & STC and Others [2012] EWHC 2136 COP, per Baker J, at para. 18;
 - b) The determination of capacity under Part 1 of the MCA is always “*decision specific*”;
 - c) Any lack of capacity must result from an impairment of, or a disturbance in, the functioning of the person’s mind or brain: s.2(1);
 - d) It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary;
 - e) A person is to be treated as unable to make the decision on the matter in issue for herself if she is unable to (i) understand the information relevant to the decision; (ii) retain that information; (iii) use or weigh that information as part of the process of making the decision; or (iv) communicate that decision: s.3(1);
 - f) 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: s.3(3);
 - g) The “information relevant to the decision” includes information about the reasonably foreseeable consequences of deciding one way or another; s.3(4)(a);
 - h) The Court should guard against overcomplicating what is the “information relevant to the decision” for the purposes of section 3. As Baker J said in para. 69 of CC v KK & STCC (see above), it is not necessary for a person to demonstrate a capacity to understand and weigh up every detail of the respective options, but merely the salient factors. However, the more serious the decision, the greater the capacity required (In re T (Adult: Refusal of Treatment) [1993] Fam 95 at 113B);
 - i) The Court of Appeal in IM v LM, AB & Liverpool City Council [2014] EWCA Civ 37 echoed this theme when stating that, if there were a temptation to expand information relevant to the decision in issue further than that regarded as relevant to inform the decision of a capacitous person, that would be likely to lead to both paternalism and a derogation from personal autonomy;

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- j) A person is not to be treated as unable to make a decision merely because she makes an unwise decision: s.1(4);
- k) A lack of capacity cannot be established merely by reference to an aspect of her behaviour which might lead others to make unjustified assumptions about her capacity: s.2(3).

Capacity to make decisions about contraceptive treatment

20. The test for capacity to decide on contraceptive treatment was set out by Bodey J in In re A (Capacity: refusal of contraception) [2011] Fam 61 as follows:

“... 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; 91) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (2) the types available and how each is used; (3) the advantages and disadvantages of each type; (4) the possible side effects of each and how they can be dealt with; (5) how easily each type can be changed; and (6) the generally accepted effectiveness of each.”

21. Bodey J noted that “the administration of contraception is different from any other medical procedure, since (leaving aside sterilisation) no other medical procedure, or the refusal of it, produces such significant social consequences as the potential creation of a child” (para. 59). Nevertheless, Bodey J recognised that the much wider test being proposed by the applicants in that case, involving understanding the consequences of rearing a child, “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” [para. 61].
22. The test formulated by Bodey J was applied by Cobb J in The Mental Health Trust and the Council v DD and BC [2014] EWCOP 13 who reiterated that “*in a case concerning medical treatment, the “relevant information” (sections 2(1) and 3(1)/(4) is that which contains the “proximate medical issues”, not the wider social consequences of the decision...*”. Cobb J noted in para. 18 that “*if a capacitous woman would be informed when deciding about contraception that pregnancy for her entailed additional risks, this must be information relevant to her decision whether to avoid those risks by taking contraception. Not to include such information as relevant information would disempower decision making*”.

Capacity: Discussion

23. The medical evidence was clear that future pregnancies carried health risks for Z, summarised in paragraph 14 of the Official Solicitor’s position statement as follows:
- a) worsening nutritional deficiencies;
- b) gestational diabetes bringing with it risks of gestational hypertension, stillbirth and cardiovascular and/or renal disease;

- c) the risks associated with repeat pregnancy and caesarean sections including (i) the increased risk of stillbirth and its psychological impact, (ii) abnormal placentation consisting of placenta praevia and abnormally invasive placentation, (iii) an increased risk of haemorrhage, (iv) abnormal or pelvic adhesions, (v) increased risk of wound, uterine or intra-pelvic infection, and (vi) increased risk of venous thromboembolism.
24. Professor Walker's report highlighted Z's status as a high-risk vulnerable adult medically speaking. Her obstetric history was one of yearly pregnancies with an obvious inability to control fertility since yearly pregnancies were suggestive of a failure to use contraception. He observed that her pregnancies were getting more complicated with each one, with increasing problems relating to gestational diabetes resulting in large babies which made delivery more dangerous. After the next delivery, Z would have had two caesarean section deliveries which increased the risk in future pregnancies of uterine rupture, haemorrhage, the need for hysterectomy and the possibility of the baby dying. Pregnancy within two years of a caesarean section made these risks even higher. Z had an increased risk of premature labour thus increasing the risk of rupture. After two caesarean sections, the risk that the placenta was inserted over the old scar (placenta percreta) increased which could lead to severe maternal haemorrhage, hysterectomy and maternal death. Any future pregnancy would require a fully compliant, understanding mother so as to maximise the mother's safety and that of her baby. His stark conclusion was that Z was "*an extremely high-risk individual where any future pregnancy would carry with it a significant risk to her and her baby's health*".
25. Given the medical evidence, both parties accepted that the information relevant to the decision in respect of contraception included the risks to Z's health if she were to become pregnant again. However, both parties differed as to whether the social consequences of any future pregnancies should be considered as information relevant to Z's decision about contraception. I did not need to resolve that difference of view given the overwhelming evidence about the risks to Z's physical health if she were to become pregnant once more.
26. All the reports were agreed that Z lacked the capacity to make the decision about contraception and the insertion of an intra-uterine contraceptive device. The ability to understand and weigh up the nature and degree of the physical risks to her consequent on another pregnancy was fundamental to Z's ability to make a decision about contraception. The capacity assessments of Dr A, Dr B and Dr Camden Smith demonstrated that Z did not have a sufficient understanding of her own health status to enable her to relate the generic risks and benefits of contraception to her individual circumstances. Z's interview with Dr Camden-Smith illustrated her lack of understanding of the risks to her health arising from future pregnancies. When asked to explain why she had decided a contraceptive injection was best, Z was unable to do so, saying "*I just have. I'm having the injection*". She lacked any understanding that her compliance might be in issue, saying "*I will have the injection*", when Dr Camden-Smith pointed out to her that she was not complying with her other medication for diabetes, anaemia and nutritional deficiencies. Z was unable to remember any factors, other than that she might die, which those involved in her care might be concerned about and appeared to be dismissive or unable to remember when Dr Camden-Smith suggested people might be worried about her losing blood,

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developing diabetes, the death of her baby or the need for life-altering surgery such as a hysterectomy.

27. Dr Camden-Smith's conclusion was unequivocal:

“In my opinion, [Z] has an inability to understand all the relevant information, specifically the risks to her health if she were to get pregnant again. [Z] did not appear to understand what an Intrauterine System was or how it would be inserted, despite this having been explained to her at great length and with assisting diagrams by [Dr A]. I am satisfied that clinicians involved in [Z's] care have exerted considerable time and effort in supporting [Z] to understand this information, and am confident that nothing further could be done within the timescale available to enhance [Z's] understanding”.

28. The evidence before me was clear and cogent that Z lacked the capacity to make decisions concerning the insertion of an intrauterine device at the time of her caesarean section for contraceptive purposes and I accept that evidence. I was also satisfied that it was vanishingly unlikely that Z would attain capacity to make decisions about contraception before her planned caesarean section.

Best Interests

29. Having reached my conclusion as to capacity, I now turn to whether it was in Z's best interests to have an intrauterine contraceptive inserted at the time of her caesarean. I note that Z had agreed to have contraception by means of a depo-provera injection. This would necessitate her having to have repeated injections to maintain effective contraception.
30. In coming to my decision on Z's best interests, I have applied the matters set out in s.4 of the MCA. These are well known and I do not repeat them here. I have paid particular attention to Z's present wishes and feelings.
31. It was the clear view of Z's treating team that it would be in her best interests to have an intrauterine device inserted at the same time as her caesarean section. In the absence of effective contraception, it was almost certain that Z would repeatedly become pregnant in the coming years as she was young, fertile and had a strong desire for a baby. Miss Watson submitted that each subsequent pregnancy would carry cumulative risks to Z's health. These risks included the risk of developing long-term cardiovascular and renal disease due to poorly controlled diabetes; the risk of worsening nutritional deficiencies predisposing Z to infection and poor bone health; and the risk of pregnancy-related complications such as stillbirth, life-threatening haemorrhage, uterine or pelvic infection and venous thromboembolic events.
32. Professor Walker agreed with the Trust's clinicians about the risks to Z outlined in the preceding paragraph and concluded that:

“3.2.1 ...the increasing risk to [Z's] health in subsequent pregnancies, with the risk of uterine rupture and placenta percreta, which could lead to haemorrhage, hysterectomy and her death, means that she should be advised not to get pregnant for at least two years and preferably never again.

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3.2.2 Contraception needs to be as efficient as possible and not reliant on [Z] as she has not shown compliance before.

3.2.3 An IUS would be the best balance, it is efficient, has minimal side effects and is reversible if the situation changes.”

33. Whilst I accept that the use of an injectable contraceptive accorded with Z’s wishes and took account of the least restrictive approach set out in s.1(6) of the Act, it did not in my view effectively achieve the purpose for which contraception was sought, namely to prevent the very serious risks to Z’s physical health which further pregnancies would undoubtedly bring. Z’s poor compliance with not only past injectable contraceptives but with medical treatment in this pregnancy militated against me endorsing Z’s wish to have an injectable contraceptive.
34. I conclude that it is in Z’s best interests to have an intrauterine contraceptive device inserted at the time she has her caesarean on 3 April 2020.

Conclusion

35. In conclusion I am satisfied that I should make the declarations and orders sought by the Trust pursuant to sections 15 and 16 of the MCA, namely that Z lacks capacity to make decisions about contraception and that it is in her best interests to have an intrauterine contraceptive device inserted at the time of her caesarean section.
36. That is my decision.