



Neutral Citation Number: [2014] EWCOP 11

Case No: 12505653

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 04/07/2014

Before :

MR JUSTICE COBB

Between :

**The Mental Health Trust
The Acute Trust
&
The Council
- and -
DD
(by her litigation friend, the Official Solicitor)
BC**

Applicants

Respondents

John McKendrick (instructed by Bevan Brittan LLP) for the Applicants
Michael Horne (instructed by Solicitor agents, on behalf of the Official Solicitor) for the First
Respondent, DD
The Second Respondent, BC, was neither present nor represented

Hearing dates: 1 & 2 July 2014

Approved Judgment

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

.....
MR JUSTICE COBB

This judgment was delivered in public. 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 incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

The Honourable Mr. Justice Cobb :

Table of contents

1	Introduction	1-7
2	The hearing	
	▪ Public hearing	8-9
	▪ Issues for determination	10-11
	▪ The Applicants	12-13
	▪ DD	14
	▪ BC	15-17
	▪ Oral and written evidence	18
3	Summary of decision	19
4	Relevant background	
	▪ Early life history	20
	▪ Child 1	21-22
	▪ Child 2	23
	▪ Child 3	24-25
	▪ Child 4	26-28
	▪ Child 5	29-30
	▪ Summary of acute complications of pregnancy/child-birth	31
5	Current pregnancy & ante-natal care	32-38
6	19 June 2014 ante-natal appointment and ultra-sound scan	39-44
7	DD: Mental state and Functioning	45-54
	Capacity	
8	General legal principles and their application to these facts	55-63
9	Capacity to litigate: the evidence	64-68
10	Capacity to decide on mode and timing of delivery of baby: the evidence	69-79
11	Capacity to decide on assessment to test capacity to make decision on contraception	80-84
12	Capacity: Conclusions	85-89
	Best interests	
13	Approach in law	90
14	Mode of delivery of the baby: The Applicants' Plan	91-96
15	Consideration of competing proposals	97-100
	▪ VBAC (Vaginal Birth After Caesarean) in hospital – spontaneous	101-106
	▪ VBAC in hospital - induced	107-108
	▪ VBAC at home	109-115

▪ Planned Caesarean	116-120
16 DD's ascertainable views on mode of delivery	121-127
17 BC's ascertainable views on mode of delivery	128
18 Achieving the admission to hospital: use of reasonable force & deprivation of liberty	129-134
19 Conclusion on best interests on method and timing of delivery	135-137
20 Date of intervention. Should DD (and BC) know?	138-144
21 Should DD undergo the assessment to establish whether she can decide on issues of contraception?	145-160
22 The unborn baby	161-164

Introduction

1. DD is 36 years old. She is at an advanced stage of pregnancy. She has had an extraordinary and complex obstetric history and is now expecting her sixth baby. She has a mild to borderline learning disability, and an autistic spectrum disorder.
2. By application dated 23 May 2014, the Applicants seek declarations and orders in relation to the care and health of DD during the final stage of her current pregnancy, and in the safe delivery of the unborn baby.
3. Specifically, and significantly, they seek a declaration as to the lawfulness in arranging for DD's baby to be delivered by planned caesarean section.
4. The Applicants seek a further order authorising the conduct of an assessment of DD's capacity to make decisions about contraception, following the imminent birth. DD's five older children are all cared for by permanent substitute carers; four of the children have been adopted.
5. The rulings sought in this case challenge the most precious and valued human rights and freedoms. Authorisation for the deprivation of DD's liberty and for the use of restraint (even for a short time) is sought, as is permission to intrude, by force if necessary, into the privacy and sanctity of her home. Steps to promote her physical health and well-being, it is argued, require a physically invasive medical procedure, to be conducted under general anaesthetic. I am acutely aware of the unusually onerous responsibility which falls upon me sitting as a Judge of the Court of Protection in determining this application.
6. As will be apparent from the judgment below, I have reached the conclusion that it would be right to authorise and render lawful the course proposed by the Applicants in relation to the planned caesarean; I do so in DD's best interests, even though I am conscious that this course will inevitably have profoundly distressing consequences for DD, a woman who I find lacks capacity to make these decisions for herself.

7. The need for a decision and reasoned judgment is urgent. The proposed assessment of DD's capacity to make decisions about future contraception is scheduled to take place in the next few days; the planned caesarean shortly thereafter. I have had the opportunity to reflect on the evidence and submissions which concluded on 2 July, before giving this judgment today, 4 July.

The hearing

8. **Public hearing:** This hearing has taken place in public pursuant to the provisions of *rule 92(1)(a)* of the *Court of Protection Rules 2007*. As this case gives rise to issues involving serious medical treatment, consideration has also, of course, been given to §16 of *PD9E* to the *Court of Protection Rules 2007*.
9. A widely drawn Reporting Restriction Order pursuant to *rule 92(2)* *Court of Protection Rules 2007* was made on 4 June 2014 by Mostyn J; it has been modestly expanded at the last hearing on 18 June 2014 (before Pauffley J).
10. **Issues for determination:** This hearing was set up by the Order of Mostyn J (4 June 2014) specifically for me to consider applications for declarations that:
 - i) DD lacks capacity to litigate in respect of the issues below;
 - ii) DD lacks capacity to make decisions in respect of whether to undergo a caesarean section and to make decisions generally about her care and treatment in connection with her impending labour, including the place and mode of delivery of her unborn child;
 - iii) It is in DD's best interest to undergo a planned caesarean section in hospital with all necessary ancillary treatment;
 - iv) DD lacks capacity to consent to be subject of an assessment of her capacity to make decisions in relation to contraception (by way of *sections 48 or 15 Mental Capacity Act 2005*);
 - v) It is in DD's best interest to be subject of a one day assessment of her capacity to make decisions about contraception;
 - vi) The Applicants may take such necessary and proportionate steps to give effect to the best interests declarations above to include, forced entry, restraint and sedation.

11. A further hearing is scheduled to take place imminently, for me to determine the issue of whether DD has the capacity to make decisions about contraception, and if not, to adjudicate upon future contraception in her best interests.
12. **The Applicants:** The First Applicant is the relevant healthcare body which provides, and will continue to provide, DD with mental health services; the Second Applicant will, it is proposed, provide the proposed medical obstetric treatment for DD, and the Third Applicant is the relevant local authority charged with safeguarding responsibilities for DD (and the unborn child).
13. It is evident from all that I have read and heard that these three public bodies have worked closely and collaboratively in seeking to resolve the exquisitely difficult issues in this case. I was impressed by the considerable effort, and conspicuous care, which they have brought in formulating and presenting this application. There is ample evidence (which I refer to below §32-34, §37) that since February 2014 they have sought to engage DD in their discussions and plans, though at almost every turn they have been frustrated. I am equally satisfied that they have anxiously considered all of the possible options, furnishing the court with careful ‘balance sheet’ analysis of the risks and benefits of the competing options on all issues. They plainly feel driven to recommend a course to me which they recognise will cause considerable distress to DD.
14. **DD:** DD was not present at this hearing but was represented by the Official Solicitor as her litigation friend. By the conclusion of the hearing, and having tested thoroughly the evidence, the Official Solicitor accepted, on DD’s behalf, that:
 - i) DD lacks capacity to litigate this application insofar as it relates to the delivery of her baby;and that, significantly,
 - ii) DD lacks the capacity to make a decision about mode of delivery of her unborn baby.The Official Solicitor felt unable to make any recommendation on DD’s behalf about the best interests of DD in relation to the mode of delivery of the unborn baby. The Official Solicitor opposed the proposed assessment of DD’s capacity to make a decision about future contraception.
15. **BC:** BC was neither present nor represented. BC has significant learning difficulties, and is said to have a lower IQ than DD. Although he and DD have been in a reasonably long-term relationship, it is said to be characterised by frequent arguments and shouting; BC’s behaviours around medical treatment for DD have not always been constructive.

16. I was satisfied from what I have heard and read that BC had notice of this hearing. He has not attended previous hearings before Mostyn J or Pauffley J. The Official Solicitor was at one time asked to consider representing him but declined, indicating that there was no proper information available to reach a view about litigation capacity.
17. I regarded it as of considerable importance that BC should take part in these proceedings, and that he be encouraged to do so. What is proposed by these Applicants represents a considerable intrusion into his life, i.e. not just the life of DD. I am conscious that I have not had the benefit of hearing from him, or of receiving his views through a representative; this interferes considerably with his *Article 6 ECHR* rights. However, the relief sought requires urgent adjudication, and it is neither appropriate nor proportionate that I should defer decision making at this stage, given the imminence of the birth and the very serious potential consequences of that critical event for DD and the unborn baby.
18. **The oral and written evidence:** For the purposes of making my determination, I have read a considerable volume of reports and statements. I heard oral evidence from
 - i) Dr. F (Community Consultant Psychiatrist for adults with learning disabilities);
 - ii) Mr. A (Consultant Gynaecologist and Obstetrician), the consultant who, it is proposed, will be in charge of DD on the labour suite;
 - iii) Mrs. C (safeguarding midwife);
 - iv) Mr. D (social worker, and Approved Mental Health Professional);
 - v) Dr. Richard Latham, Consultant Forensic Psychiatrist, instructed on behalf of DD by the Official Solicitor.

The evidence was thoroughly tested over two court days.

Summary of decision

19. By this judgment, I explain my reasons for my decisions in relation to DD. I summarise the outcome thus:
 - i) I have concluded on the evidence that DD lacks the capacity to litigate in relation to the relevant issues (see §64 to §68 below);

- ii) In my judgment, DD lacks capacity to make decisions in respect of her healthcare; in particular she lacks capacity to decide where to give birth to her unborn child and to decide how to give birth to her child (vaginal delivery or caesarean section) (see §69 to §79 below);
- iii) I have concluded that it is in DD's best interest, and therefore lawful for her to be conveyed to the Second Applicant Trust's Hospital and for the medical, nursing and midwifery practitioners attending upon her to carry out a planned caesarean section procedure and all necessary ancillary care, in the view of treating clinicians, for that procedure and to provide DD with all necessary ancillary pre-operative care and treatment (to include the administration of prophylactic steroids) and post-operative care and treatment (to include clexane) and treatment, in the view of the treating clinicians (see §135 to §137 below);
- iv) I authorise the Applicants to take such necessary, reasonable and proportionate measures to give effect to the best interests declaration above to include forced entry into her home, restraint (so that she does not leave the ward pending treatment and/or until it is clinically appropriate for her to be discharged) and sedation (see §129 to §134, and §135 to §137 below).
- v) I require the Applicants to take all reasonable steps to minimise distress to DD and to maintain her dignity
- vi) There are reasonable grounds to believe that DD lacks capacity to consent to an assessment of her capacity to make decisions in relation to contraception (see §80 to §84 below)
- vii) While I considered that a court could exceptionally direct an assessment in P's best interests, notwithstanding the Mental Capacity Act 2005 Code of Practice, I do not regard it to be in DD's best interest that she should be subject of a one day assessment of her capacity to make decisions about contraception at this stage (see §145 to §160 below), and refuse that part of the application.

Relevant background

- 20. **Early life history:** DD has been known to social services for almost all of her life, the subject of a child protection plan as an infant as a result of concerns about her ill-treatment at the hands of her own parents. It is apparent that from an early age that her intellectual functioning was impaired. She was provided with special education, and benefited from the equivalent of a statement of special educational needs. She left home in 2002, aged 24 to live with a partner, TJ, a man with mild learning difficulties.
- 21. **Child 1:** Later in 2002, DD gave birth to her first child (male), born by emergency caesarean section (required as a result of foetal distress in labour). DD and TJ cared

for Child 1 for 4 months, supported by local authority social services; they struggled to cope. A sequence of incidents of escalating seriousness caused Child 1 to be removed, and he was placed with his paternal grandparents where he remains. DD has not taken up contact with Child 1 for many years. During the public law proceedings, DD was assessed by Dr. Lindsey as having a mild learning disability and demonstrating impairment in three key areas (“the triad”) of autism (see §49 below).

22. DD and TJ later separated. In 2008 DD and BC met and began a relationship.
23. **Child 2:** DD was soon pregnant again. Professionals from adult services (Learning Disability Team) working with the couple suspected the pregnancy, although DD and BC denied it, did not engage with professionals, and rejected advice. They ignored efforts to support them. Towards the end of the pregnancy, DD visited the local hospital with a urinary tract infection; the midwife services were alerted. An ante-natal check at that time confirmed the pregnancy and revealed that the unborn baby was in the breech position. DD was persuaded that the baby would need to be delivered by caesarean section; she was however determined that the operation should not take place before the due date. The due date arrived and the caesarean section was performed. Given the concerns about the mother’s care of her first child, Child 2 (female) was the subject of an Emergency Protection Order at birth, and removed from the parents. Public law proceedings followed. The parents were legally represented (though no finding of incapacity was sought or made, it appears: see §66 below). The parents were assessed comprehensively, but ultimately with negative outcomes. They denied that they had learning difficulties and wished for any social work record which asserted this to be destroyed. The parents missed contact sessions with Child 2 and did not attend the final hearing of the application. During these proceedings, DD displayed some delusional beliefs. She identified a well-known actor as her father and an equally well-known opera singer (who is actually younger than DD) as her mother; she said that she had been born in New Zealand and kidnapped by the adults who raised her. The mother would take a photograph of the opera singer to contact with Child 2 and show it to her daughter – “*this is your grandmother*”. Child 2 was subsequently adopted.
24. **Child 3:** By March 2010, staff in Children’s services who had come into contact with DD believed that she was pregnant once again; DD denied this and sought to conceal the pregnancy from the authorities. In June 2010, on a home visit, DD was found cradling a baby born in her home; the baby was believed to be 5-10 days old. Child 3 (male) was at that point seriously dehydrated and undernourished (it appears that the parents had sought to feed him with cup-a-soup), with lesions on his head believed to be caused by Bar-B-Q tongs which (from information provided by DD and BC at the time) BC had used to assist in the delivery (DD denies this). Following Child 3’s birth, DD became mentally and physically unwell. She was diagnosed as suffering from a delusional disorder (she was commenced on oral anti-psychotic medication); she suffered a seriously distended bladder which required catheterisation. Child 3 was admitted to hospital for treatment, where he was discovered to have a hole in his heart.

25. DD and BC were formally cautioned for child neglect. BC was reported to be ashamed about his actions; DD was not. Following public law proceedings, care and placement orders were obtained, and Child 3 was subsequently placed for adoption.
26. **Child 4:** In 2011, DD became pregnant again. Mother again denied this, when challenged. On a routine visit to DD's and BC's home in July 2011, DD was observed to be very unwell; she was fitting, and unconscious. It later transpired that she had suffered an intracerebral embolism causing fitting (status epilepticus), probably brought about by the pregnancy. BC was unable to say for how long DD had been in this dire state. DD was admitted to hospital as an emergency; her fitting could not be controlled, and she was therefore given general anaesthetic and ventilated on the intensive care unit. Monitoring of the unborn baby revealed evidence of foetal bradycardia (slowing of the heart and consequent distress). In order to treat the patient (DD) and relieve the foetal distress, an emergency caesarean section was therefore performed. DD suffered significant post-partum haemorrhage, and required a 2 unit blood transfusion. Child 4 (female) was born very prematurely at 29 weeks.
27. Following the birth, neither parent sought to see Child 4, nor did they engage with child care proceedings. Child 4 was made the subject of a care and placement order and placed for adoption.
28. Significantly, DD resisted prophylactic injections to prevent further blood clots. The occurrence of the embolism means that any future pregnancy carries an increased risk of stroke and of haemorrhaging.
29. **Child 5:** Later in 2012, DD became pregnant again. The pregnancy was once again concealed from the professional agencies (including social workers from the adult and child services) which were endeavouring to work with the parents. The parents withdrew from engagement with professionals, and on occasions refused entry to their home. In mid-July, an unannounced visit by child care social workers was made to the home; BC declined their request to enter. Following protracted negotiations (involving discussion of police attendance to obtain access to DD), BC relented. On entering the property, DD was seen attempting to breast feed a baby (Child 5: female), swaddled in a dirty pillow case soiled with blood. The home was dirty; there was no sign of baby clothes, blankets, bottles, nappies or anything suggesting preparation for a child. DD was evasive when asked where the afterbirth was; there was concern that it may not have been delivered. DD looked unwell. BC handed Child 5 to the social workers, and gave permission to have her examined in hospital.
30. Public law proceedings were issued. DD and BC did not ask to see Child 5, and indicated that they would not register her birth. Attempts by social workers to meet with DD and BC failed; the parents refused access to their home. Public law (care and adoption) proceedings in relation to Child 5 inevitably followed.

31. **Summary of acute complications of pregnancy / child-birth:** I have set out the early obstetric and associated social history in a little detail (above) to highlight the various complications, with potential life-threatening consequences, experienced by DD thus far in pregnancy and child-birth, including:
- i) The need for emergency caesarean (Child 1) due to foetal distress;
 - ii) Baby in breech position requiring caesarean (Child 2);
 - iii) DD displaying signs of a delusional disorder immediately following birth of Child 2;
 - iv) Delusional disorder following the birth of Child 3;
 - v) Seriously distended bladder which required catheterisation (Child 3);
 - vi) Intracerebral embolism causing fitting (status epilepticus), probably brought about by the pregnancy (Child 4); refusal to take prophylactic injections to prevent further blood clots;
 - vii) Significant post-partum haemorrhage (Child 4).

Current pregnancy & ante-natal care

32. In January 2014 the Adult Social Care Team was advised of the possibility that DD was once again pregnant; efforts were made to engage her in receiving services. A multi-agency plan was drawn up and implemented, and a mental health social worker was allocated. Over the course of the last six months, there has been regular (fortnightly) social work meetings and discussions aimed at engaging constructively with DD and BC, in order to:-
- i) Monitor the progression of the pregnancy,
 - ii) Provide necessary obstetric care if possible;
 - iii) Respond to the risks of early labour or other complications including cerebral embolism.
33. However, this plan has been frustrated at every turn. None of the professionals involved has been able to gain access to the parents' home. DD and BC have been rarely sighted in the community.

34. Between late February and early April, twenty-five social work visits were made to DD and BC's home. Even allowing for the fact that on occasion DD will undoubtedly have been out, the social workers were not able to obtain access on even a single occasion. Occasionally, DD and BC have been sighted at the windows within the property, but have not responded to knocking at their front door. On one occasion, BC responded to the knocking by telling the visitors (through the locked door) that DD was "*not pregnant*"; DD was heard shouting in the background.
35. Given the level of concern, and belief in the advancing pregnancy, the Adult social services sought and obtained a warrant under *section 135 Mental Health Act 1983* which authorised them to enter, with police presence and if need be by force, DD's home, and, if thought appropriate, to remove her to a place of safety with a view to making an application in respect of her under *Part II of the Mental Health Act 1983*. Mr. D told me that there was reasonable cause to suspect that DD (a person believed to be suffering from mental disorder) was being kept otherwise than under proper control.
36. On 8 April 2014, the warrant was executed. On entering the flat that evening (17:00hs), there was an overwhelming smell of cats' urine; the home was dirty and dingy. DD and BC were initially distressed, but (according to Mr. D and Mrs. C, who were both present) the situation was soon calmed, and DD was conveyed to a mental health unit for full mental and physical assessment. DD co-operated with a physical examination, an ultrasound scan, and blood sampling.
37. Following this assessment, fifteen further attempts were made to see DD at home. On none of those visits did DD or BC answer the door. DD did not attend pre-booked ante-natal appointments on 23 April, or on 21 May 2014; transport had been offered and provided. The letter reminding her of the ante-natal appointment was returned with a message on the envelope '*return to sender, moved away*'.
38. To add context to this level of ante-natal intervention, NICE (National Institute for Health and Care Excellence) Guidelines recommend nine appointments for a high-risk pregnancy (which this is – see §97(vii) below); by this time, DD had had one appointment, and only (as is apparent from the history above) when she had been removed from her home following court order.

19 June 2014 ante-natal appointment and ultra-sound scan

39. Within its application, the Applicants sought orders permitting them to arrange an ante-natal assessment and placental location ultrasound scan. Evidence was filed in this respect, and the Official Solicitor was given permission to obtain expert assistance from Consultant Obstetrician and Gynaecologist, Mr. Malcolm Griffiths.
40. That application was determined by Pauffley J on 18 June; after a hearing at which oral evidence was called, orders were made (ultimately by consent) on the day. In a

reserved judgment delivered following that hearing, Pauffley J summarised the relevant evidence; as is apparent from that judgment, Mr Griffiths supported the proposed assessments, and the Official Solicitor consented to the application, including – notably – the potential for deprivation of DD’s liberty and restraint in achieving the ante-natal appointment (see *The Mental Health Trust, The Acute Trust & The Council v DD (by her litigation friend the Official Solicitor)*, BC: *In the matter of DD* [2014] EWCOP 8).

41. On the following day, a team of professionals employed the Applicants attended at DD’s home, together with the police. DD and BC were initially significantly distressed by the presence of the team who had to use force to gain access to the home (as had been foreshadowed in the application, following their experience on 8 April 2014). The home conditions were very poor; there was a low level of hygiene, many animals, and evidence of a significant amount of cat faeces. There was a strong smell of ammonia. The RSPCA were notified and later that day removed most of the animals.
42. Within a short time of the arrival of the social work and health care team, DD was calm, and was amenable to being conveyed to the hospital for the scan and ante-natal appointment. No restraint or force was needed, and DD was co-operative on the ward. An ultrasound scan took place, to which DD did not object. Blood tests were performed, again with her co-operation. Mr. A had the benefit of a consultation with DD, who told him that she would be soon leaving for Australia, and was taking her cats with her (but not, ostensibly, BC).
43. During this meeting Mr. A informed DD that it was likely that he would be asking the court to authorise a caesarean section; DD rejected outright any suggestion that the baby would be born in hospital.
44. Mr A describes the consultation (my note of his evidence) as:

“a positive one ... I was able to establish a level of engagement with her ... she did in fact co-operate with every intervention requested of her, including the scan, blood test, urine sample, and a lengthy conversation with myself. At no point was physical restraint required.”

DD: expert opinion of mental state and functioning

45. I turn now to discuss DD’s mental state and level of functioning.
46. I have been greatly assisted in this case by the opinions of Dr. F, and of Dr. Richard Latham who was instructed by the Official Solicitor, who both gave oral evidence before me. I also read reports *inter alia* from Dr. E (Consultant Psychiatrist) and also

from Dr Mary Lindsey, Consultant Psychiatrist (dated 2003, prepared in the context of proceedings concerning Child 1).

47. Dr. F is a consultant psychiatrist with a specialism in learning disabilities (and considerable experience in the diagnosis of autism). Dr. Latham is a consultant forensic psychiatrist.
48. Both agree that DD has mild to borderline learning difficulties; she has a full scale IQ between 67 and 75.
49. They agree that DD has an Autistic Spectrum Disorder. This was diagnosed in 2003 by Dr Lindsey. She identified in her full and helpful report, which I have read, a triad of developmental impairments which have to be present for a diagnosis to be made, including:
 - i) Impairment of social understanding and interaction;
 - ii) Impairment of understanding and using communication;
 - iii) Impairment of flexibility of thinking and behaviour.
50. Dr. Lindsey made the important point (relevant now to *section 2(3)(b) MCA 2005* – i.e. lack of capacity cannot be established by reference to “*a condition ... which might others to make unjustified assumptions about capacity*”) that individuals with an autistic spectrum disorder are very different from one another, reflecting differences in the severity of the autism, any additional disorders, the level of language ability and the personal qualities of the individual.
51. She made the following further important observations (I cite these passages in full, as it is apparent that this assessment made a significant impression on both Dr. F and Dr. Latham):

“Therefore, although my impression was that [DD] only has a mild learning disability (moderate learning difficulties in educational terms), and may be functioning in the non-learning disabled range in some areas, when the autistic features of her thinking and behaviour are taken into account, she does have considerable difficulties that will have a big impact on her ability to cope and to adapt.”

“She also had difficulty in explaining herself and in seeing things from other points of view and her rigidity in thinking and understanding makes it much more difficult for her to see the situation in the usual way and she is likely to be perceived as self-centred and selfish. However she has a genuine difficulty in empathising with others.”

“Flexible problem solving appears to be another area of difficulty for [DD]. This involves being able to imagine the consequences of various courses of action and in weighing up the “pros and cons” in order to make a decision about the best course of action. This is a considerable problem for most people with autism and decision making tends, instead, to be based on rote learnt responses derived from teaching or learnt from previous similar situations.”

52. Dr F, in his assessment of DD, which took place on 8 April 2014, confirmed the diagnosis of autism. He opined that:

“[DD] suffers from an impairment in the functioning of her mind/brain. [DD] has a diagnosis of childhood Autism (code F84, International Classification of Diseases version 10 (ICD-10), World Health Organisation 1992) and her current presentation is consistent with this. Her Autism is characterised by an extremely rigid style of thinking with difficulty in cognitive flexibility, a repetitive and stereotyped style of speech, abnormalities in non verbal communication (eye contact and facial expressions), difficulties in social interactions and forming relationships and a restrictive interest pattern. Her Autism significantly impairs her ability to think flexibly and adapt her beliefs.” (emphasis by underlining added)

Adding, specifically relevant to one of the key issues under consideration:

“[DD] presents with a mental disorder, namely Autism Spectrum disorder and borderline learning disabilities. [DD] was unable to demonstrate the ability to use information regarding antenatal care and the safe delivery of her baby due to her lack of cognitive flexibility and rigid thinking style, both of which are caused by her mental disorder. The fixed belief that she can have natural labours made her incapable of weighing any information regarding the potential risks that she might face during her pregnancy. On the balance of probabilities she lacks capacity as she is unable to weigh up information regarding her need for obstetric care and the risks associated with not engaging in this care...

... Her inability to weigh information regarding these decisions is unlikely to be susceptible to improvement through input from professionals.”

53. After a detailed review of the records, Dr F set out more fully the features of the diagnosis of autism in relation to which he placed weight. In oral evidence he attached particular significance to the concept of ‘theory of mind’ to which he had made reference in his reports. This, he opined, was a core deficit in autism. Those who present with this ‘mind blindedness’ (which is often associated with autism), including DD, lack an ability to infer or understand the full range of mental states which cause action in themselves and in others. DD further displays, he opined, a rigidity of thought process which results in her being unable to weigh up and use the relevant information.

54. Dr. F speculated that DD has a psychotic mental illness, namely a delusional disorder. Dr. F is clear that DD's autism is an impairment of the mind and the impairment of the mind causes her functional inability to make health care decisions (i.e. he had no difficulty in establishing the two-fold test of *section 2(1) MCA 2005*). Dr. Latham did not dissent from these conclusions.

Capacity

General legal principles and their application to these facts

55. I approach my decision making by starting with the assumption that DD has capacity to make the necessary decisions (*section 1(2) MCA 2005*).
56. Only if I find that she does not have capacity can I possibly make orders under the *MCA 2005*. I am conscious that I should not allow what may be natural anxieties about the general or specific well-being of DD or the unborn baby, particularly in light of DD's obstetric and social history, to influence or affect my determination of capacity. I have considered the evidence with care, and applied the law relevant to each 'matter' for determination in considering the question of capacity.
57. The assumption of capacity is buttressed by a requirement that "*all practicable steps to help [her]*" make a decision must have been taken without success (*section 1(3) MCA 2005*).
58. The facts of this case cause me to review with particular care whether DD's decision making is simply 'unwise' rather than evidence of her incapacity; if it were merely the former (i.e. unwise decision-making) I would have no right under the *Mental Capacity Act 2005* to intervene.
59. Lack of capacity is demonstrated by reference to the two-stage 'functionality' ("*unable to make a decision for himself in relation to the matter*") and 'diagnostic' ("*because of an impairment of, or a disturbance in the functioning of, the mind or brain*") test of *section 2* of the *MCA 2005*. Again, it is of relevance – given that there is evidence in the papers of higher levels of functioning at other times, to note that impairment can be permanent or temporary (*section 2(2)*), and that I should therefore consider (on the balance of probabilities: *section 2(4)*) what the current evidence reveals.
60. In making the assessment of capacity, I have applied the provisions of *section 3 MCA 2005*, notably the fourfold 'functionality' test which focuses on DD's:
- i) Ability to understand the information relevant to the decision;
 - ii) Ability to retain that information;

- iii) Ability to use or weigh that information as part of the process of making the decision, and
 - iv) Ability to communicate her decision.
61. In this case, there is no real question that DD has ability to understand the information, retain it, and communicate her decision. It is DD's ability to *weigh* the *relevant information* which has attracted the closest attention.
62. I am conscious not to set the threshold in relation to capacity to understand unduly high. As Baker J remarked in *PH and A Local Authority v Z Limited & R* [2011] EWHC 1704 (Fam) at paragraph 16 (xi):
- “[the] courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability.”*
63. The approach of Macur J in *LBJ v RYJ* [2010] EWHC 2664 (Fam) as adopted by Baker J in *CC v KK & STCC* [2012] EWHC 2136 (COP) further steers me in providing that 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”* (paragraph 69).

Capacity to litigate: the evidence

64. In considering this question, I apply the test in *Masterman-Lister v Brutton & Co. (No.1)* [2002] EWCA Civ 1889, [2003] 1 WLR 1511, in which Chadwick LJ said:
- “... the test to be applied ...is whether the party to legal proceedings is capable of understanding, with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case may require, the issues on which his consent or decision is likely to be necessary in the course of those proceedings. If he has capacity to understand that which he needs to understand in order to pursue or defend a claim, I can see no reason why the law – whether substantive or procedural – should require the interposition of a next friend or guardian ad litem (or, as such a person is now described in the CPR, a litigation friend ...*
- ... a person should not be held unable to understand the information relevant to a decision if he can understand an explanation of that information in broad terms and simple language; and ... he should not be regarded as unable to make a rational decision merely because the decision which he does, in fact, make is a decision which would not be made by a person of ordinary prudence.”* (emphasis added).
65. At Para 39 of *Sheffield Crown Court v E & S* [2005] Fam 236, Para 34 Mr Justice Munby (as he then was) further said:

“The capacity to litigate is not something to be determined in the abstract. One has to focus on the particular piece of litigation in relation to which the issue arises. The question is always whether the litigant has capacity to litigate in relation to the particular proceedings in which he is involved. ... Someone may have the capacity to litigate in a case where the nature of the dispute and the issues are simple, whilst at the same time lacking the capacity to litigate in a case where either the nature of the dispute or the issues are more complex.” (emphasis added)

66. I am conscious that DD has been a respondent to, and has to a limited extent participated in, four sets of proceedings under *Part IV* of the *Children Act 1989* and under the *Adoption and Children Act 2002* (care order and placement order proceedings) without a litigation friend; an assessment of capacity (based only on the documents, not on interview) was made in 2009, but (so far as I can tell) no finding was made in relation to this issue. I am aware that she has made a number of decisions relating to medical treatment in the past on the basis that she is capacitous.
67. Given Dr. F’s clear opinion (and indeed the Official Solicitor’s concession) that DD lacks litigation capacity in relation to these proceedings, I asked Dr. F if he could explain whether the ostensibly contradictory picture (of her ability to participate without a litigation friend in the relatively recent past compared with the position now) reflected:
- i) a deterioration in the impairment of the functioning of DD’s mind or brain, or
 - ii) materially different issues arising on this application compared with the earlier proceedings; or
 - iii) some other factor.

Dr. F was unable to offer a confident explanation, save to observe that the stroke in 2011 may have had an impact on her overall level of functioning; he further postulated that her fixed beliefs – a characteristic of her autism and identified as long ago as 2003 – have evolved over time, gaining in strength and resolution. He volunteered that this is “*probably*” what has happened here.

68. In any event, I must, as Munby J observed in *Sheffield Crown Court*, focus on *this* particular piece of litigation, and while remaining alert to the evidence that DD apparently had litigation capacity in the relatively recent past, consider only the evidence relevant to such a conclusion now.

Capacity to decide on mode and timing of delivery of baby: the evidence

69. In considering the mode of the delivery of the baby, I suggest that a prospective mother would need to be able to understand, retain and weigh the information relevant to:

- i) Ante-natal care and monitoring, including blood tests to check for anaemia and diabetes; urine tests to check for infections; the benefits of discussion with health services about delivery options;
- ii) Ante-natal monitoring of the foetus; the value of an ultra-sound imaging;
- iii) Mode of delivery of the baby, including vaginal delivery, and caesarean section;
- iv) Natural and/or induced labour;
- v) Anaesthesia and pain relief;
- vi) The place of delivery – e.g. at home or in a hospital – and the risks and benefits of each option;
- vii) The risk of complications, arising from conditions relevant to the mother or the baby;
- viii) Post-natal care of mother and baby.

I do not intend this to be a comprehensive list. Plainly individual cases may warrant further or other ‘relevant information’ to be considered and weighed.

70. On the important issue of DD’s capacity to make a decision about mode of delivery, I have received direct evidence from:
 - i) Dr. E, a Consultant Psychiatrist;
 - ii) Dr. F, Consultant Psychiatrist;
 - iii) Dr. Richard Latham, Consultant Forensic Psychiatrist, instructed by the Official Solicitor.

71. Dr. E approached his evaluation with the benefit of having met with and assessed DD in 2010, when she was admitted on to a ward in his care for a period of 28 days immediately following the birth of Child 3. He jointly assessed DD again on 8 April 2014.

72. In 2010, DD was diagnosed as suffering from a delusional disorder (believing herself to be the daughter of celebrity artistes – see §23 above), and borderline learning disability. BC was seen on the ward at the time, and was observed to be threatening and intimidating, aggravating DD’s presentation. DD was found to be lacking capacity to make decisions around her maternity needs and medical care due to a lack of understanding and processing of the relevant information to make decisions. She did not co-operate with post-inpatient treatment, and was discharged from Secondary Mental Health Services.
73. The medical records reveal that in 2011, following the birth of Child 4 (see §26 above), the locum consultant formed the view that she lacked capacity to consent to medical treatment for her intracerebral embolism / cerebro-vascular accident. At that time, a historical diagnosis of autistic spectrum disorder in childhood was made.
74. In the assessment on 8 April 2014, DD is reported to have shared with the consultants that:
- i) It was difficult “*having a foreign accent*”, as this made it difficult for her to fit in (I am told that she does not have a foreign accent; Mr D explained that because third parties do not readily engage with her in conversation she ascribes this to having a foreign accent);
 - ii) She was planning to live in Australia;
 - iii) She would have the baby in Australia, and all the arrangements had been made for this;
 - iv) She would not engage in ante-natal care as it was “*too much hassle*”.
75. Dr. E and Dr. F assessed DD for between 1½ and 2 hours on that date. They formed the view that DD understood that she was pregnant and had been pregnant in the past. However,
- i) DD had some element of grandiosity (she claimed to have counselling skills, she purported to be the progeny of well known artistes);
 - ii) She lacked capacity in relation to obstetric care, not being able to weigh up the risks to her and her baby’s health;
 - iii) She had an underlying autistic spectrum disorder, leading to “*rigid and concrete*” thinking. She followed a set pattern of behaviours and had a limited repertoire “*she struggled to process [the information] properly by not*

weighing up the pros and cons of any decisions that were required of her". She chooses the path of least resistance.

- iv) She demonstrated "*a complete lack of understanding of the risks of her current pregnancy on her health and safety, and was also rigid in her thinking around the ante, peri and post natal care...*" (Dr. E);
- v) She could not process information about post-partum haemorrhage, and denied that it was possible as she "*knew her body 100%*".

76. DD was assessed again on 19 June, but not by psychiatrists. Dr. F was able to review a full note of the more recent interactions and discussions with DD; from the information provided (and acknowledging the limitation of the process, interpreting information collated by others), he observed that:

"[DD] continues to demonstrate a lack of ability to weigh in the balance the Relevant Information that she is presented with. She remains fixed in her beliefs and is unable to use the Relevant Information she is presented with to consider those fixed beliefs. Due to those fixed beliefs, she is unable to apply the Relevant Information to herself. She is fixed and rigid in her statements that she will have the baby at home and is unable to use the Relevant Information regarding potential risks, to weigh that decision. This rigidity is caused by her ASD. The concrete thinking that she demonstrates prevents her from accepting that there is a possibility that the risks she is told about could apply to her. Her previous baby was born at home with no medical intervention, therefore to her this shows she is at no risk in a future delivery. When the consultant obstetrician tried to convey that he was concerned for her health and wellbeing, [DD] demonstrated her inability to apply that information to herself with her response: "my brother says I am fit and fine – he rang me when I had [Child 3] – I'm a twin, he's abroad and he's coming to get me with my mother. Normal people have normal lives and can't get on with freaks. I'm normal leave me alone". This demonstrates [DD's] inability to weigh in the balance the information regarding a delivery at home as opposed to in a hospital setting".

77. Dr. Latham gave oral evidence before me, having provided two detailed reports. The important features of his evidence can be summarised thus:

- i) There is sufficient evidence to lead to a diagnosis of autism, specifically having regard to the comprehensive assessment of DD in 2003 by Dr. Lindsey – which went into some detail into the behaviours, the communication problems, and cognitive flexibility, her 'theory of mind' and empathy;
- ii) He considered that DD was at the 'mild' end of the Autistic Spectrum, though plainly at a level to cause "*functional impairment*";

- iii) He accepts that DD “*lacks the ability to weigh relevant information and therefore must conclude that she lacks the mental capacity to make decisions about the mode of delivery of her child – I accept that autism contributes to this inability to weigh although do not believe that it wholly explains it (there is in my view some refusal to weigh)*”. In this respect, he further told me (evidence in chief) that:

“Autism goes to her ability to weigh information – goes to her inability to consider the information on risk. Having looked at the interviews where this is assessed, she is not willing or able to accept that the information may possibly be true. The exclusion of that information is significant”.

- iv) He felt that the conclusion on capacity was a finely balanced decision. He considered that DD is able to understand, retain and communicate information (see *section 3 MCA 2005*); however, he accepted that she lacked the capacity to “*use or weigh*” (*section 3(1)(c)*) information. His view was that her lack of capacity is in the circumstances ‘marginal’.

78. The difference between Dr. F and Dr. Latham essentially lay in describing where on the autistic spectrum DD falls to be considered, and whether her lack of capacity is regarded as ‘marginal’. In resolving this conflict of evidence I prefer the evidence of Dr. F for:

- i) He had, in my assessment, greater experience in assessing women with autism; I accept his evidence that:

“...the diagnosis of ASD in women is often more difficult than in men. Women tend to have less marked abnormalities in social interaction as they seem better able to observe and imitate others. Their ASD becomes “masked” as they imitate others, and can superficially present as having normal social interaction. However, these interactions lack the emotional understanding that is found in those without ASD”;

and

- ii) He had had the benefit (a benefit properly acknowledged by Dr. Latham) of meeting with DD in order to perform his assessment.

Pauffley J described ([2014] EWCOP 8 §23) Dr. F as “*an expert of the highest integrity*”. I respectfully agree.

79. Moreover, a conclusion of incapacity is not necessarily a ‘marginal’ one simply because P demonstrates an inability in relation to only one of the functionality criteria

in *Section 3(1)*. I felt that Dr. Latham's evidence, taken as a whole, tended to reflect that thinking, whereas Dr. F was clearer, and his reasoning more cogent, in his analysis of the discussion about DD's inability to "use or weigh" the information.

Capacity to decide on assessment to test capacity to make decision on contraception

80. The Applicants have thus far been unable to assess DD's capacity to make decisions in relation to contraception. They have a duty to provide appropriate healthcare services, including contraception to DD and if she is unable to make a decision for herself, one must be made in her best interests.
81. I was asked by the Applicants to determine whether DD lacked capacity to decide whether she should submit for assessment of her capacity to make decisions relevant to the issue of contraception, a decision which in due course will need to take account of the factors adumbrated by Bodey J in *A Local Authority v Mrs A (by the OS) and Mr A* [2010] EWHC 1549 (Fam) at §64.
82. I received evidence (from Dr. F) that DD's rigid thinking – a feature of her Autistic Spectrum Disorder – impacts on her ability to weigh the immediate issues around contraception. He told me (evidence in chief):
- "I have not directly assessed this. My view based on my assessment, she has made a blanket choice not to engage with professionals and that choice is not down to weighing up the pros and cons, there is a high probability that she lacks capacity to make the decision about assessment of contraception."*
83. This is important evidence. It goes to the question of capacity to consent to an assessment, and bears on (but does not determine even for an interim declaration) capacity to make decisions about contraception.
84. This evidence gives me, for the purposes of *section 48* of the *Mental Capacity Act 2005*, reason to believe that she lacks capacity to consent to an assessment of her capacity to make decisions in relation to contraception.

Capacity: Conclusions

85. I am satisfied that "all practicable steps" (*section 1(3) MCA 2005*) have been taken to help DD to make a decision as to litigation, and mode of delivery, but that such steps have been unsuccessful – not just because of the low level of co-operation, but because she has displayed such rigid and unshakeable thinking ('mind-blindedness') about the information provided.
86. Her decision-making is undoubtedly "unwise", but it is not, in my judgment, just "unwise"; it lacks the essential characteristic of discrimination which only comes when the relevant information is evaluated, and weighed. I am satisfied that in relation to each of the matters under consideration her impairment of mind

(essentially attributable to her autistic spectrum disorder, overlaid with her learning disability) prevents her from weighing the information relevant to each decision. While anxious that in the past DD has ostensibly participated (albeit in a limited way) in public law proceedings without any finding of the court as to her capacity to do so (which causes me to reflect yet more carefully on the issue under consideration now) I must consider the issue with regard to this particular piece of litigation (*Sheffield Crown Court v E & S* – supra).

87. Moreover, on the evidence laid before me, there is reason to believe (*section 48*) that she lacks capacity in relation to whether to participate in an assessment of her capacity to decide on future contraception.
88. In these conclusions, I am fortified by the fact that the Official Solicitor, on DD's behalf, does not seek to persuade me otherwise.
89. These conclusions can be drawn as declarations reached pursuant to *section 15 Mental Capacity Act 2005*, save for the conclusion in relation to capacity to consent to an assessment of decision-making relevant to future contraception, which will be drawn as a declaration under *section 48 MCA 2005*.

Best interests

Approach in law

90. In determining the issue of best interests in this case, I have adopted the approach helpfully distilled by Hayden J in *Sheffield Teaching Hospital NHS Foundation Trust v TH and Another* [2014] EWCOP 4 at paragraphs 36 and 55 and 56:

“The issues involved in determining 'best interests' in medical cases have relatively recently been considered in the Supreme Court in Aintree University Hospital NHS Foundation Trust v James [2013] 3 WLR 1299. *There Baroness Hale, with whom the other Supreme Court Justices agreed, emphasised the following:*

- i) The MCA is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but goes no further (see paragraph 18);*
- ii) The fundamental question is whether it is lawful to give the treatment (see paragraph 20) and the focus is whether it is in the patient's best interest to give the treatment rather than on whether it is in the best interest to withhold or withdraw it (see paragraph 21);*□
- iii) The MCA emphasises the need to see the patient as an individual with his own values, likes and dislikes, and to consider his best interest in an holistic way.*

.....

I must record that the Official Solicitor's lawyers appear not to share my analysis of the cogency and strength of TH's wishes regarding his treatment. I confess that I have found this surprising. If I may say so, they have not absorbed the full force

of Baroness Hale's judgment in Aintree and the emphasis placed on a 'holistic' evaluation when assessing both 'wishes and feelings' and 'best interests'. They have, in my view, whilst providing great assistance to this court in ensuring that it has the best available medical evidence before it, focused in a rather concrete manner on individual sentences or remarks. To regard the evidence I have heard as merely indicating that TH does not like hospitals as was submitted, simply does not do justice to the subtlety, ambit and integrity of the evidence which, in my judgment, has clearly illuminated TH's wishes and feelings in the way I have set out.

I reiterate that whatever the ultimate weight to be given to TH's views it is important to be rigorous and scrupulous in seeking them out. In due course the clarity, cogency and force that they are found to have will have a direct impact on the weight they are to be given. 'Wishes' and 'best interests' should never be conflated, they are entirely separate matters which may ultimately weigh on different sides of the balance sheet."

Mode of delivery: the Applicants' plan

91. When the proceedings were first initiated in late May 2014, a detailed plan was filed providing for DD to be admitted to a residential unit in the next few days in anticipation of the birth ('the original plan'). Having had sight of the scans following the assessment on 19 June, it was not felt that the obstetric risks were of such severity as to warrant such a prolonged pre-birth placement prior to the caesarean, and would in the circumstances represent an unjustified interference with her liberty.
92. The Applicants have therefore presented a second, detailed, plan. This similarly involves arranging for DD's baby to be born by caesarean section.
93. A team of highly trained and experienced professionals has been assembled to facilitate the transfer of DD from her home to the hospital. This will involve gaining access to her home (if necessary, by force), and conveying her from her home to the hospital by private ambulance. Some resistance by DD to their objectives is predictable, though it is felt by those who have had experience of managing a similar situation on 8 April and 19 June to be achievable. The plan appropriately emphasises the importance of using the least degree of restraint of DD, and encroaching on DD's human rights, dignity and autonomy to the minimum extent necessary and only as a last resort to save her life, or prevent a serious deterioration in her mental health.
94. It is proposed that DD will be conveyed from her home to the hospital on the day before the caesarean section procedure, when she will be some weeks' short of full-term gestation; she will be admitted onto the suite for pre-operative assessment, administration of steroids, and anaesthetic assessment.
95. The plan provides for DD to receive support throughout the process, and is safely able to undergo necessary pre-operative and post-operative assessments and interventions, with appropriate medication and sedation.

96. The caesarean section procedure is to be conducted by Mr. A. It is hoped that DD will remain in hospital for 4 days post-operatively.

Consideration of competing proposals

- **VBAC ('Vaginal Birth After Caesarean') in hospital – spontaneous**
- **VBAC in hospital – induced**
- **VBAC at home**
- **Caesarean section**

97. In resolving the issue of mode of delivery, in DD's best interests, I pay particularly close attention to the following general important points:

- i) That 'best interests' are not limited to best *medical* interests, but the wider best interests of DD. It must be in the best interests of any woman carrying a full-term child whom she wants to be born alive and healthy that such a result should if possible be achieved (see *Re MB* [1997] EWCA Civ 3093 §36, now essentially enshrined in *section 4(6)(b) MCA 2005*: "*the beliefs and values that would be likely to influence his decision if he had capacity*");
- ii) Whatever the ethical arguments engaged, I do not have the jurisdiction to take the interests of the unborn baby into account (*Re MB* §39);
- iii) That I must have regard to the statutory principle of least restriction (*section 1(6)*);

And to the following specific points, relevant to the instant case:

- iv) That it is plainly in DD's best interests (both physically and mentally) that her baby is born alive, healthy and safely;
- v) DD and BC's wishes are for a home birth without social or health care assistance (see §121-128 below);
- vi) A vaginal delivery is one which most accords with DD's wishes, and interferes least with her rights;

And further:

- vii) That the Trust's antenatal guideline for risk assessment categorises DD's pregnancy as "*high risk*", so described because:
 - a) She has had a previous pre-term baby (Child 4);

- b) She has had more than four pregnancies (this is the sixth);
 - c) She has had three previous caesarean sections;
 - d) She has had previous thrombo-embolic disease.
98. Mr. A (Consultant Gynaecologist and Obstetrician) brings a wealth of general professional experience to this case, and has valuable historic experience of DD dating back to 2010 (post-delivery, Child 3) and 2011 (when DD was admitted as an emergency, fitting, and Child 4 was delivered as an emergency). Mr. Malcolm Griffiths, Consultant Obstetrician and Gynaecologist, was instructed on behalf of the Official Solicitor to prepare a second opinion.
99. Both experts discuss the relative merits of the options.
100. The factors in §97(v) and (vi) above are plainly important considerations. They must be weighed against (among other factors) the chance (which Mr A considered to be at 1-2%) of rupture of the previous caesarean section scars in such a delivery; such a rupture can cause catastrophic haemorrhaging and would be life-threatening.
101. **VBAC in hospital - spontaneous:** Spontaneous vaginal birth in the hospital would of course require DD to present at hospital, in labour.
102. Mr. Griffiths was of the view that if it were possible to arrange for DD to have a planned vaginal birth with the involvement of relevant professionals and in a consultant-led obstetric unit, then DD's best interests would be served. These (not insignificant) qualifications are further hedged as follows:
- “I do though recognise the practical organisational difficulties in achieve (sic.) such an outcome, and that such a plan would require a degree of co-operation, compliance and acquiescence from [DD]”.*
103. In my judgment, there is vanishingly little prospect of DD providing that level of “*co-operation, compliance and acquiescence*” enabling plans to be made for her baby to be delivered by spontaneous vaginal delivery in hospital. DD has made clear her resistance to engaging with professionals and the health services in the past; no professional, organisation or agency has been able to establish contact and engagement with DD in recent times, and it seems unlikely that she will engage with services at the point of delivery.
104. Moreover, vaginal delivery would require constant intra-partum care and monitoring, which it is felt that DD would find it difficult to accept. There is evidence that she

resists physical contact with health care workers, and would (it is felt) be reluctant to comply with vaginal examinations, even palpation of the abdomen.

105. Any vaginal birth carries a 0.5-4% risk of scar rupture; this may (as indicated above) have catastrophic consequences.
106. While a vaginal birth would be unlikely to require the administration of general anaesthetic, and would be less likely to cause post-operative complications (which is significant, given that DD would be unlikely to comply with post-operative care generally), if problems did arise in the course of a vaginal delivery (as has happened in the past – Child 1), and emergency caesarean were required, this has a higher risk to the individual than a planned caesarean.
107. **VBAC in hospital – induced:** All the considerations relevant to spontaneous vaginal delivery apply in relation to induced vaginal delivery.
108. Additionally, induced labour would significantly increase (by 2 – 3 times) the risk of scar rupture, because of the particular drugs used. Monitoring of an induced vaginal labour would be very difficult. It is feared that DD would resist this; if she resisted, then restraint or sedation would need to be considered, which would be highly problematic (and in my judgment inappropriate) for the duration of the labour.
109. **VBAC at home:** The risks of vaginal delivery in the home increase significantly over the risks of vaginal delivery in the hospital.
110. There is a history of DD suffering acute medical conditions associated with pregnancy, the concealment thereof, and child-birth (see §31 above), and in respect of some of these medical attention has not been sought. For example, prior to the birth of Child 2 she suffered a cerebro-vascular embolism causing status epilepticus; no medical attention was sought by BC (DD was incapable of doing so). Following the birth of Child 3, DD was found to have suffered a seriously distended bladder; this was fortuitously discovered, and treated.
111. Mr A advises that “*it is very possible, indeed probable, that if medical assistance were not sought in the event of a risk materialising [DD] could die...*”.
112. The risks to DD’s health must surely need to be viewed in the context of the poor levels of hygiene apparent in the home on 19 June (see §41).
113. Quite apart from the high risks associated with rupture of the caesarean scars (see §100 above), given that DD classifies (having had five previous pregnancies) as a grand multiparous, she is at an increased risk (assessed by Mr A at 5-10%) of post-partum haemorrhage which could also be catastrophic. She suffered such a

haemorrhage after the birth of child 4. If she were at home, this would not be monitored, or susceptible to emergency treatment.

114. I bear in mind too the evidence (information vouchsafed to the medical professionals at the time, but disputed now) of BC performing amateur obstetrics on DD in order to achieve the delivery of Child 3 (using Bar-B-Q tongs as makeshift forceps). Were this action to be repeated, there is surely a risk of him causing harm to DD.
115. There is real cause for concern that neither DD nor BC would seek hospital assistance in the event that DD became unwell (indeed she told Mr A that she would not do so, when she spoke with him on 19 June).
116. **Planned Caesarean section:** There are plainly risks associated with a caesarean section; these have been fully described in the risk analysis table included in the filed papers. Key among those risks is the risk of intra-abdominal injury from adhesions caused during the operation, but Mr A assesses this (from his own clinical experience) at 0.1%. There is also the greater risk of wound infection, and inevitable additional abdominal pain. Post-operative recovery is slower and more difficult. Operative treatment now will cause additional scarring on the uterus, thus making subsequent pregnancies potentially more at risk from scar rupture; in short, if this infant is delivered by caesarean section, there are enhanced risks to DD for any future pregnancy (a vaginal delivery becomes less advisable with each delivery).
117. Plainly I must attach significance to the impact on DD's mental health in the short term and the long term if the baby is born by caesarean section, given her opposition to this procedure.
118. That all said, DD has successfully undergone three previous caesarean sections. Delivery of her baby in this way avoids putting the existing scars under threat of rupture.
119. Caesarean section is regarded as the safest mode of delivery for a 'high-risk' pregnancy (which this is – see §97(vii) above). Planned intervention by a specialist and well-briefed team in fulfilment of a carefully crafted plan enables DD to benefit from an optimal environment in which to deliver the baby with the least risk of harm to DD.
120. I, of course, weigh heavily in the evaluation of benefits and risks the substantial interference with DD's physical and emotional well-being and bear in mind the substantial deprivation of her liberty and her rights under *Article 5* of the *ECHR*.

DD's ascertainable views on the mode of delivery

121. *Section 4(6)(a) MCA 2005* requires me to consider the wishes and feelings of DD, and “*in particular, any relevant written statement made by him when he had capacity*”. As

Baroness Hale stated in *Aintree University Hospitals NHS Foundation Trust v James* [2013] 3 WLR 1299, §45:

“The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. ... But in so far as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.” (emphasis by underlining added).

122. Perhaps the clearest indication of DD's wishes and feelings are set out in the letter ostensibly written by DD (undated, but received by the health services on 15 May 2014) in response to enquiries about ante-natal appointments:

“I am OK and I do not wish to come to hospital for any appointment. Thank you for your letter. I do not wish to see anyone. Please allow me to be LEFT alone. I do not want any services from you or Hospital. Thank you.” (capitals in the original)

123. I interpolate here to observe that Dr. F was asked to comment on the letter and whether it demonstrated a capacity to 'weigh' information. He opined:

“There is no evidence within her letter to suggest that [DD] has been able to weigh up the risks and benefits of engaging with antenatal care in reaching this decision. Indeed, her desire to be left alone by services outweighs information that she was given about potential risks related to her pregnancy and the safe delivery of her child.”

124. The Official Solicitor's agent managed to speak with DD on 19 June both in person and on the telephone; at that time, DD told her:

- i) That she does not have a disability; *“I have passed every test and I will win”*;
- ii) It was *her* body and she did not want anyone doing anything with it;
- iii) She wanted to have the baby *“naturally”*;
- iv) She was able to make her own mind up;
- v) She wanted to have the baby in peace.

125. As is apparent from the history narrated above, DD has also consistently adhered to unrealistic notions surrounding the birth and her future, including
- i) Her plan for the baby to be born in Australia. She has at various times explained her lack of ante-natal attention because she would not be in this country for the birth; she said that a friend had organised it, including a passport with a passport photograph from when she was in foster care (this would have been when she was a child)
 - ii) That she will be a career woman with 2 children;
 - iii) She would have easy normal births, because her brother had told her this when they were in foster care (when she was a child).
126. During the course of the hearing (on the evening of 2 July), DD communicated with the Official Solicitor's agent, by leaving a voice-mail message at the solicitor's office. DD is reported to have said "*I am normal. I am not on social services books*"; she asked to be left alone, stating (as she has before) that she was going to Australia and is "*perfectly fine*". She stated that she did not want to be contacted by the Official Solicitor's agent again. The message was said to be abusive in tone.
127. What weight do I attach to these views? They are a 'significant factor' to which I pay close regard (see *ITW v Z* [2009] EWHC 2525 (Fam)). I am conscious that her views may be informed by her experiences of having had her five children removed from her care. I am bound to attach not inconsiderable weight to her views given the strength and consistency in which these views have been expressed. However, unlike Dr. Latham, I do not find the capacity issue to have been resolved on a fine balance (plainly "*the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings*": *Re MM; Local Authority X v MM (by the Official Solicitor) and KM* [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at para [124]).

BC's ascertainable views on the mode of delivery

128. There is no clear and/or direct evidence of BC's ascertainable views on the mode of delivery of the baby. I have assumed for the purposes of this judgment, that BC would associate himself with DD, and would want to be left alone, for DD to be able to have the baby at home.

Achieving the admission to hospital: Use of reasonable force & deprivation of liberty

129. I am conscious that steps may need to be taken to give effect to the decision which I make, if compelled attendance at hospital is required (for caesarean or induced vaginal delivery) in the face of DD's objection. The extent of reasonable force, compulsion and/or deprivation of liberty which may become necessary can only be judged in each individual case and by the health professionals.

130. On two recent occasions forcible entry has had to be made to DD's home in order to achieve some form of assessment: once with the authorisation of the lay justices (*section 135 MHA 1983*: 8 April 2014) and once pursuant to an order of Pauffley J (*section 48 MCA 2005*: 19 June 2014).
131. Any physical restraint or deprivation of liberty is a significant interference with DD's rights under *Articles 5* and *Article 8* of the *ECHR* and, in my judgment, as such should only be carried out:
- i) by professionals who have received training in the relevant techniques and who have reviewed the individual plan for DD;
 - ii) as a last resort and where less restrictive alternatives, such as verbal de-escalation and distraction techniques, have failed and only when it is necessary to do so;
 - iii) in the least restrictive manner, proportionate to achieving the aim, for the shortest period possible;
 - iv) in accordance with any agreed Care Plans, Risk Assessments and Court Orders;
132. On each previous occasion, after DD's (and BC's) understandable initial distress at the intrusion, DD has been calm and co-operative; BC less so. The presence of the police has not aggravated the situation; on the contrary, I was advised by Mr. D that DD sees the police as neutral and therefore helpful in maintaining peace. DD does not see the police as a risk; indeed, it was felt, the presence of police (in fact, uniformed police underline for the concrete thinker the visual confirmation of authority) creates a brake on her anxiety, anger, frustration and fear. The police add a 'message' to DD that the situation is 'serious' (according to Mr D) and has the effect of calming DD and BC.
133. In fulfilment of the plan as a whole, it is critical that the particular team of trained and briefed professionals is involved.
134. I recognise that sedation may be needed to ensure that DD does not cause herself harm at the time of the transfer to, and in-patient stay, in the hospital. General anaesthesia is likely to be necessary in my judgment to facilitate the caesarean section given the risks to herself if she were to interfere with the surgical procedure, or choose to be non-compliant with localised anaesthetic.

Conclusion on best interests on method and timing of delivery

135. In this judgment I have sought to highlight some of the key features of the relevant evidence on risk and benefit of each option. I have weighed these, and the additional competing considerations which were rehearsed in the evidence, with considerable care.
136. As indicated at the outset of this judgment, my decision impacts on many of the most precious and valued human rights and freedoms enjoyed by any citizen, and I am acutely conscious of the fear and confusion, the possible outrage (even if short-lived) and upset, which DD is likely to experience in having to deal with these overwhelming and distressing events.
137. While giving due weight to her wishes, and her fundamental rights, and those of BC, I have nonetheless come to the clear conclusion that it would be in her best interests that she should be delivered of her baby by caesarean section, and grant the Applicants the ancillary authorities they seek in order to achieve this.

Date of intervention. Should DD (and BC) know?

138. The Applicants propose that neither DD nor BC should be advised of the date planned for the caesarean procedure, but should be provided with partial information: they are aware of this hearing, and it is proposed that they should be informed of the Applicants' plan to arrange a caesarean section for her.
139. It should be noted that neither DD nor BC were advised in advance of the date of the localisation scan which took place two weeks ago.
140. There are plainly risks associated with providing DD and BC with full information (i.e. about the planned date), and, in the alternative, providing them with partial information. The professionals consider that the risks associated with providing them with full information are greater given DD's likely raised stress and anxiety levels as the date approaches; this may have a serious impact on her mental health. This concern is underlined by the fact that she was adamant that she should not have her planned caesarean at the time of the birth of Child 2 until the exact due date.
141. There is a further risk that in advising DD and BC of the date of the caesarean, that they may seek to leave their home, and disappear. This in itself would create risks to DD, in that:
- i) There is no guarantee that the specialist team local to her current home which has been identified to look after DD on the appointed date could be assembled on short notice, once DD and BC have been located;

- ii) Health professionals in any new area would be unfamiliar with her situation, and less well equipped to deal with her, and her particular needs;
 - iii) Managing a safe transition from the community to hospital may be less easy or (if she is located in a public place) dignified.
 - iv) If she attempts a vaginal delivery at home (particularly any temporary home which is unfamiliar), she may be putting herself at additional risk.
142. If DD and BC are given partial information (omitting specific dates) the levels of anxiety are likely to be lessened and DD may have difficulty relating the information to herself given her autism spectrum disorder. This condition may make it difficult for DD to see how the information relates to her until concrete actions take place. Recent experience (8 April and 19 June) has demonstrated that while DD has been initially distressed, this reduces quite quickly and effectively using skilled de-escalation techniques.
143. I acknowledge that giving full information to DD and BC about the plans for the delivery of the baby would most fully observe their *Article 8* and *Article 6 ECHR* rights.
144. However, in my judgment the provision of only partial information (i.e. that the plan is for a caesarean section, but not giving her a date) is a justified interference with her potent *Article 8* rights on the facts of this case, as necessary in the interests of her health and the health of her unborn child. Moreover, I am of course satisfied that her *Article 6* rights have been observed by her full and effective representation – with the fullest opportunity for her engagement – in this hearing.

Should she undergo the assessment to establish whether she can decide on issues of contraception?

145. The Applicants wish to obtain the most reliable current evidence of DD's capacity to make decisions about contraception, so that (if relevant) appropriate measures can be taken at about the time of, or following, the birth of the baby.
146. The Applicants propose that, in the next few days, DD should be conveyed from home to a Community Health Care Centre where she shall receive (during the course of a morning) relevant information and education about contraception, and then (in the afternoon) will be assessed as to her capacity to weigh the relevant information on contraception. Education and information will be provided through a range of mediums in order to maximise DD's ability to understand the information.

147. I am quite satisfied that there should be a degree of education first before any assessment takes place. The locum consultant psychiatrist in 2011 had opined that suitable and appropriate psycho-social approaches and de-escalating techniques should be used to engage DD in meaningful conversations; this approach should, in my judgment, surely be followed. It is accepted by the Applicants that people with autism may take longer than others to understand and process information.
148. It is proposed that within the next few days the multi-disciplinary team of professionals (many of whom know DD) will be assembled in order to transfer DD (if necessary by force) to the Health Centre. It is proposed that she will be conveyed there by private ambulance.
149. The Applicants consider that such an assessment is necessary and proportionate given that consideration of future contraception has to be considered as a matter of urgency and priority. They draw attention to the fact that history has shown that without contraception DD is likely to become pregnant again in the near future (indeed, they point to the fact that the day after DD was discharged from hospital following the birth of Child 4 by emergency caesarean she consulted her GP asking for the morning after pill).
150. They invite me to consider the ultimate benefits of achieving effective contraception at the time of the planned caesarean (by sterilisation), but I plainly cannot give that weight when the capacity question is unresolved.
151. They further refer to the risk of future pregnancy as not trivial; it is considerable, and potentially life-threatening. I accept this, just as I accept that there is a long-history of non-engagement with care services. Mr. McKendrick acknowledged in final submissions that it appeared ‘heavy-handed’ but sought to persuade me that there is ‘no other way’.
152. The two psychiatrists expressed an opinion on this proposal. Dr. F indicated (evidence in chief) that:

“... any assessment is going to be difficult, because of her lack of engagement. My assessment on 8 April went quite well and engaged well with the process, and she answered our questions fully... as such if she presents in this way, we will be able to make a valid assessment at that stage” (evidence in chief)

He was diffident about expressing any strong professional expert opinion about this issue, but felt when pressed (cross-examination) that he would wish DD to have some opportunity for education (even though he felt that the prospects of success of education was ‘low’), and added that although he would “prefer” DD to have the assessment at this stage, as a best interests decision he “would remain neutral whether it is before or after” the imminent delivery of the baby.

153. Dr. Latham advised in his written report that this assessment “*might be better delayed*” until after her delivery. He firmed up that view when giving his evidence orally to me.
154. The Official Solicitor opposes this course. The Official Solicitor understandably and properly relies upon the Mental Capacity Act Code of Practice, and identifies that issue is joined between the parties as to the weight that must be attached to it in the best interests assessment. The Code provides as follows (§4.58-4.59):

“There may be circumstances in which a person whose capacity is in doubt refuses to undergo an assessment of capacity or refuses to be examined by a doctor or other professional. In these circumstances, it might help to explain to someone refusing an assessment why it is needed and what the consequences of refusal are. But threats or attempts to force the person to agree to an assessment are not acceptable.

If the person lacks capacity to agree or refuse, the assessment can normally go ahead, as long as the person does not object to the assessment, and it is in their best interests (see chapter 5).

Nobody can be forced to undergo an assessment of capacity. If someone refuses to open the door to their home, it cannot be forced. If there are serious worries about the person’s mental health, it may be possible to get a warrant to force entry and assess the person for treatment in hospital – but the situation must meet the requirements of the Mental Health Act 1983 (section 135). But simply refusing an assessment of capacity is in no way sufficient grounds for an assessment under the Mental Health Act 1983 (see chapter 13).”

155. Plainly the Code provides valuable Guidance. That is what it is - ‘Guidance’, and if the circumstances of the case dictate an alternative view, then I should not regard myself bound to follow the Guidance in preference. This much is clear from the introduction to the Code, which includes the following paragraphs:

“How should the Code of Practice be used?

The Code of Practice provides guidance to anyone who is working with and/or caring for adults who may lack capacity to make particular decisions. It describes their responsibilities when acting or making decisions on behalf of individuals who lack the capacity to act or make these decisions for themselves. In particular, the Code of Practice focuses on those who have a duty of care to someone who lacks the capacity to agree to the care that is being provided.

Who is the Code of Practice for?

The Act does not impose a legal duty on anyone to ‘comply’ with the Code - it should be viewed as guidance rather than instruction. But if they have not followed relevant guidance contained in the Code then they will be expected to

give good reasons why they have departed from it. Certain categories of people are legally required to 'have regard to' relevant guidance in the Code of Practice. That means they must be aware of the Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and they should be able to explain how they have had regard to the Code when acting or making decisions."

156. However, *section 42(4)* and *section 42(5)* do not impose on me a 'duty' to have regard to the relevant code. This point was addressed by Roderic Wood J in *SBC v PBA and Others* [2011] EWHC 2580 (Fam), [2011] COPLR Con Vol 470 (§67), where he concluded:

- i) *"the words of the statute are the essential provisions laid down by Parliament;*
- ii) *whatever its genesis and weight, the Code of Practice is indeed only guidance;*
- iii) *there is a reasonable expectation in the Code that its provisions should be followed;*
- iv) *departure from it, if undertaken, should require careful explanation;*
- v) *... it remains essentially guidance – however weighty and significant – and is not the source of the relevant power which is to be found only in the statutory provision;..."*

157. On this point, I was also referred to *R (ota Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58; [2006] 2 A.C. 148 (dealing with the Code of Practice to the *Mental Health Act 1983*), where Lord Bingham held at paragraphs 21:

"It is in my view plain that the Code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction."

Mr. Horne submits (with force) that the Code referred to in *Munjaz* attracted a lesser status than the Code in issue, because it does not place a *duty* on the First Tier Tribunal to take account of its provisions.

158. Having listened carefully to the arguments and the evidence, I have reached the conclusion that it would not be in DD's best interests to authorise an assessment of her capacity to decide about future contraception *at this stage*. I emphasise those last three words. I do not consider, for the avoidance of doubt, that I could not make such an order (either under *section 48* or *section 15*) in spite of the Code of Practice, although on that issue I will invite (if thought appropriate) further argument at the next hearing.

159. I so conclude for the following reasons, in combination:

- i) There is evidence that DD and BC were more distressed and angry by the forced entry to their home on 19 June 2014 than they were on 8 April 2014. There was nothing about the forced entry in itself which could have caused this elevated reaction. I fear (and this is a fear shared to some extent by Mr D) that each forced entry is likely to give rise to greater and greater levels of distress. The Applicants appear to concede this (opening position statement: “*it seems to be the case that any limited engagement and involvement with [DD] is causing, on each occasion, an increased response*” §8 ... and “*after 19 June assessment ... she was certainly more oppositional and angrier*” §44). It is imperative, in my view, not to take any step now which would jeopardise the arrangements for the transfer of DD to hospital for the planned caesarean procedure.
- ii) It would be in DD’s best interests (and indeed more consistent with the obligations of statute: *section 1(3)*) for her to have the opportunity for education about contraception, and the ability to digest the same before assessment; this was in fact part of the ‘original plan’ (see §91 above). Some education could/should be offered to DD in hospital when she is admitted for the caesarean section; written and illustrated materials can be provided to her at home;
- iii) There is a risk that DD will be in a state of heightened anxiety about the forthcoming birth, and the arrangements for it, reducing her ability to receive and benefit from education; this anxiety may in any event contaminate or distort the proposed assessment thereby rendering it less valuable or reliable;
- iv) There is a real prospect (identified by Dr. Latham and I accept) that DD would need to undergo a second assessment of capacity after the imminent birth in any event;
- v) There is some cause to believe that DD’s ability to recognise the reality of pregnancy and child-birth will be heightened following (rather than before) the imminent birth of her baby;
- vi) It would be in DD’s best interests that those who offer the contraceptive education have some knowledge/understanding about DD’s contraceptive history; she plainly *has* a history, and has received contraception in the past. At present the records from the GP and family planning clinic are not widely available and/or complete;
- vii) There is a prospect that in 2 months DD may be more receptive of the information (this was Dr. F’s view). It may be counter-productive to attempt the exercise now, which may be more confusing than helpful;

viii) While the issue of contraception for DD is undoubtedly urgent, it is not so exceptionally urgent that it can only be determined in the next few days. The risk of DD falling pregnant is (having regard to the history) to be measured in months rather than days or weeks.

160. I am of the view that the issue of assessment of capacity to make decisions about contraception will need to be addressed as a matter of urgency (within 2 months or so) following the birth, and will receive further evidence, and hear further submissions, about this at the forthcoming hearing.

The unborn baby

161. I have no jurisdiction in relation to the unborn baby.

162. The Applicant Council has indicated an intention to issue *Part IV CA 1989* proceedings in respect of the baby.

163. I exhort the Council to make sure that any application for orders fully engages DD, so that she can be represented by her litigation friend, the Official Solicitor. It is plainly important, in DD's best interests, that plans for the baby are formulated and presented to her in a way which engages her to the fullest extent.

164. That is my judgment.