Neutral Citation Number: [2015] EWCOP 4

Case No: 12505653

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 04/02/2015

Before :

MR JUSTICE COBB

- -

Between :

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

Re DD (No.4) (Sterilisation)

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- -

John McKendrick (instructed by Bevan Brittan LLP) for the Claimants
Michael Horne (instructed by the Official Solicitor) for the First Respondent (DD)
BC (not present nor represented)
Hearing dates: 26 & 27 January 2015

- -

Approved Judgment

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

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MR JUSTICE COBB

The Honourable Mr Justice Cobb :

Summary of Judgment

1. These proceedings, brought in the Court of Protection, concern DD, a 36-year old woman with Autistic Spectrum Disorder and mild to borderline learning disability with a full scale IQ of 70. She also displays characteristics consistent with an attachment disorder, likely to have resulted from her experience of physical and possibly sexual abuse as a child or young person. As an adult, DD has had an extraordinary, tragic, and complex obstetric history; she has had six children who are now aged between 6 months and 12 years, all of whom are being raised by permanent substitute carers, five of them in adoptive homes. DD has no continuing contact with any of her children. DD has never demonstrated the desire or capacity to engage with the level of support which is likely to be required to assure a child's safety in her care.

2. DD is currently in a long-term relationship, which includes a sexual relationship, with BC. BC has a significant learning disability, with a full scale IQ in the region of 62, i.e. lower than DD, and displays some traits of an Autistic Spectrum Disorder.

3. Over the last nine months, the Court of Protection has been required on no fewer than five occasions to determine welfare applications under the *Mental Capacity Act 2005* ("the *2005 Act*") in relation to DD's capacity to make important decisions concerning her sixth and final pregnancy, and subsequent short-term contraception, specifically:

    i) Ante-natal care and pre-birth scanning ([2014] EWCOP 8);

    ii) The manner and location of delivery of the baby (caesarean section in hospital) ([2014] EWCOP 11);

    iii) The administration of short-term contraception at delivery, and education about future contraception ([2014] EWCOP 13);

    iv) The administration of short-term contraception post-delivery ([2014] EWCOP 44);

    v) The further administration of short-term contraception pending this hearing (December 2014).

4. It falls to me at this hearing to determine:

    i) DD's capacity to litigate in these proceedings;

    ii) DD's capacity to consider, and make decisions concerning, long-term contraception and/or therapeutic sterilisation, and

    iii) If lacking the relevant capacity, to determine whether it is in DD's best interests to receive long-term contraception or sterilisation, and if so, which specific therapeutic intervention.

    I am further asked to consider (if I were to conclude that such were in DD's best interests) how any such medical procedure can be achieved, given DD's increasingly determined resistance to professional and/or medical advice and support. DD's current opposition to professional intervention in her life causes the Applicants to apply, once again (as they have at previous hearings), for authorisation (in each case

for as short a time as is necessary, and only if necessary) to deprive DD of her liberty, to use restraint, and further to obtain permission to intrude into the privacy and sanctity of her home to remove DD to hospital for the treatment proposed.

5. The ethical, legal and medical issues arising here are self-evidently of the utmost gravity, engaging, and profoundly impacting upon DD's personal autonomy, privacy, bodily integrity, and reproductive rights. The Applicants concede, through their counsel, that the relief which they seek in these proceedings amounts to an exceptional interference with DD's right under *Article 8* of the *European Convention on Human Rights* ('*ECHR*') to respect, in particular, for her private life. That concession is, in my judgment, rightly made. In this respect, I wish to emphasise three important points:

   i) The Court of Protection will intervene in the life of a person who lacks capacity only where it is demonstrated that it is in the best interests of the vulnerable person to do so. Each case will be considered on its own facts;

   ii) Those who lack capacity have the same human rights as everyone else, and are entitled to enjoy those rights without discrimination on account of their lack of capacity. The *ECHR* nonetheless recognises that it may be justifiable to interfere in their private lives, and even deprive them of their liberty, in certain circumstances;

   and

   iii) This is, in my judgment, an exceptional case on its facts; the Applicants seek a range of relief which is likely to arise only in the most extreme circumstances.

6. Any proposal for significant, life-changing surgery in respect of a person who lacks capacity will inevitably be (as it has been in this case) extremely carefully scrutinised, and only authorised where it is clearly demonstrated to be necessary, proportionate and 'best' for the individual involved. In this exercise, the views of the person concerned, of those close to them, and of the professionals will be considered with care; steps will be taken to assist the vulnerable person to make the decision for themselves. The court should (as I have in this case) always have regard to the less restrictive way of achieving the ultimate objective.

7. I have set out my reasons for my decision fully in the judgment below. I have concluded, on what is clear evidence, that DD lacks capacity to litigate; I have further concluded that she lacks capacity to make decisions about contraception and sterilisation, notwithstanding the considerable efforts which have been made to enable her to make the relevant decisions. Moreover, I have reached the view, though not without the most thorough consideration of the complex issues involved, that it is in her best interests that she be sterilised; the Applicants propose that this be achieved by laporoscopic application of Filshie clips across the fallopian tubes to occlude them, while DD is under general anaesthetic.

8. This case is not about eugenics. This outcome has been driven by the bleak yet undisputed evidence that a further pregnancy would be a significantly life-threatening event for DD. The Applicants' obstetric, gynaecological and contraceptive experts

strongly recommend this treatment for DD, jointly expressing themselves in these stark terms:

> "*The risk to [DD] of a future pregnancy, especially if concealed, is highly likely to lead to her death.*"

9. Against the unusual background of multiple births by caesarean section (four of DD's six children have been born by caesarean section) and repeat pregnancies in a short space of time (four children have been born in the last five years), the evidence, presented by both the Applicants and the Official Solicitor, specifically reveals that a further pregnancy would:

    i) Place dangerously unsafe pressure on DD's uterine wall which would be likely to rupture in child-birth (if not during the pregnancy) causing the almost certain death of the infant, and significant intra-abdominal haemorrhaging of DD which would materially threaten her own life. The uterine wall was noted during the last caesarean section procedure performed in July 2014 (pursuant to my earlier order) to be "*tissue-paper thin*" with the baby visible through it; this was a most unusual finding, according to Consultant Obstetrician & Gynaecologist A (Mr. A);

    ii) Pose a significant risk of either placenta accreta or placenta praevia; placenta accreta is a condition in which the placenta is morbidly attached to the uterine lining having invaded into the deeper muscle. Uterine scarring due to caesarean sections predisposes a woman to this condition. If DD were to suffer placenta accreta, it would inevitably lead to massive haemorrhage at the point of delivery of her infant. Placenta praevia involves a low-lying placenta located in the lower segment of the uterine cavity. If DD were to suffer from this condition, as her cervix dilated in labour she would inevitably experience massive haemorrhage such that safe delivery of the baby could not be achieved and her own chances of survival would be compromised.

    Moreover, I am conscious that further pregnancy would inevitably raise the risk of DD suffering a repeat of an intra-cerebral embolism causing her protracted fitting (*status epilepticus*); this is a condition which she suffered during (and was probably a consequence of) her fourth pregnancy. Worryingly, in recent conversations with medical professionals, DD has denied ever suffering this seizure, and has been unable to accept the risk of it recurring.

10. The obvious threats to DD's life discussed above are considerably magnified in my judgment by the combination of three further contextual factors, namely:

    i) That DD has a history of concealing, or attempting to conceal, her pregnancies from professionals; previous pregnancies (certainly the third, fourth and fifth) have only been discovered after the critical 24-week limit during which a termination of pregnancy can normally be considered;

    ii) If DD were to fall pregnant again, she would almost certainly want to (and no doubt take steps to try to) deliver her baby at home, her declared intention in relation to all her recent pregnancies. She actually achieved this in relation to her third and fifth babies, though in grossly unhygienic circumstances;

iii) DD and BC have been, and are, fiercely resistant to medical and professional support. My review of the events of the last seven months (since the involvement of the Court of Protection) reveals very limited levels of co-operation from either; the picture is characterised by opposition to and rejection of help. Illustrative of professional clinical concern in this regard, which I unreservedly share, is the description of events in 2011 when BC failed to take any action when DD suffered her intra-cerebral embolism and began fitting in their home. Only by good fortune did a social worker visit the couple and encounter this grave situation; emergency services were instantly called, and DD was admitted urgently to hospital, where she was placed in an induced coma to control her seizures. BC was unable to say how long DD had been fitting before the social worker had arrived. The baby (which was suffering foetal bradycardia, slowing of the heart and consequent distress, during DD's fitting) was delivered by caesarean section. Following this birth DD suffered significant post-partum haemorrhage, and was hospitalised for nine days.

11. The need to intervene in DD's best interests to prevent further pregnancy is, as I explain further in this judgment, clear. The options for achieving this, for reasons which I explain below, are limited to

i) the insertion of a 'coil', an Intra-Uterine Device ("IUD") ('medicated' with copper) / Intra-Uterine Systems ("IUS") ('medicated' with progestogen hormone) or

ii) laporoscopic sterilisation.

Given that an IUD/IUS has a low failure rate as a long-term contraceptive, and is generally effective to prevent pregnancy (as indeed I discussed in *A Local Authority v K* [2013] EWHC 242 (COP), [2014] 1 FCR 209), it will be a rare case, in my view, in which the more radical alternative of sterilisation will be found to be in the best interests of an incapacitous woman of child-bearing age. This is particularly so given the court's duty to have regard, when considering the best interests of the vulnerable woman, to the less restrictive option under the *2005 Act* (referred to in [6] above).

12. But in my judgment this is such a rare case, because:

i) The risk of pregnancy to DD carries such high stakes; DD could pay for pregnancy with her life. In this unusual circumstance, I have been driven to adopt the statistically most effective form of precluding further pregnancy;

ii) Were a long-term IUD/IUS to be inserted but expelled (or removed), there is every reason to believe that DD would not disclose this to medical or other professionals, thereby leaving her unprotected from the risk of further pregnancy;

iii) Repeat administration of long-term contraception, whether by repeat Depo-Provera injections (her current three-monthly regime of contraception), or repeat insertion of the IUD/IUS, will inevitably cause further professional intrusion into DD's private life, which I am satisfied she finds utterly objectionable.

13. DD is represented in the case by the Official Solicitor. While, at a much earlier stage of these proceedings, he had indicated his likely opposition to the course currently proposed by the Applicants, by the commencement of this hearing last week he had acknowledged on DD's behalf not only that DD lacked capacity to make the relevant decision, but that that sterilisation is indeed in DD's best interests. Whilst there are subtle differences in the route by which each represented party arrived at the key conclusions, there was in the end, no real dispute between them as to the outcome. The ultimate decision, however, remains mine.

Introduction & Summary of Previous Judgments

14. As I indicated above, this judgment follows four public judgments delivered since June 2014 in this case, resolving issues concerning DD's final pregnancy, the birth of her sixth child, and subsequent short-term contraception. I identify them as follows:

    i) [2014] EWCOP 8 (Pauffley J) (18 June 2014); In this judgment, the court explained its authorisation for the Applicants to arrange a placental localisation scan and an ante-natal assessment, and to take such necessary and proportionate steps so as to give effect to the 'best interests' declaration to include forced entry, restraint and sedation;

    ii) [2014] EWCOP 11 (Cobb J) (4 July 2014): I authorised the Applicants to arrange for DD 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 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, and to take such necessary and proportionate steps so as to give effect to the 'best interests' declaration to include forced entry into her home, restraint and if necessary sedation; the court at that hearing refused the Applicant's application for authority to enter DD's home forcibly prior to the delivery of her expected baby for the purposes of conveying her to a clinic to provide education about contraception to her;

    iii) [2014] EWCOP 13 (Cobb J) (15 July 2014): Before the baby was born, I further considered whether DD had the capacity to make decisions about contraception, and on my finding that she did not I adjudicated upon the Applicant's plan to facilitate education for her in relation to contraception once the baby was born. I also authorised future short-term contraception (Depo-Provera) at the point of delivery in her best interests.

    iv) [2014] EWCOP 44 (Cobb J) (2 September 2014): I authorised a repeat administration of the short-term Depo-Provera injection. This judgment was delivered at a hearing which had been set up in order to consider the issues of long-term contraception / sterilisation; however, at that time there were small glimmers of hope that DD may be willing to co-operate with the professionals. I recorded at that time ([6]) that:

> "*Although she has not maintained a consistent position on her future childbearing intentions, it is a source of some reassurance to me, and no doubt a source of some optimism*

> *on the part of the professionals, that she is at least able to and willing to have that sort of discussion about contraception and sterilisation*".

It was hoped that with time, further "*practicable steps*" (*section 1(3) 2005 Act*) could be taken to enable DD to make a decision about contraception and sterilisation. I authorised the Applicants to take steps to effect the contraception in the event that co-operation waned.

v) For completeness, I add that at a further hearing in December 2014, and in the absence of sustained co-operation from DD, I authorised the administration of a further short-term Depo-Provera contraceptive injection and gave case management directions in order to set up this hearing.

15. For the purposes of this hearing, I received and read extensive written evidence. Mr. McKendrick and Mr. Horne prepared detailed and helpful written submissions, and I heard oral argument from both. Neither counsel felt it necessary to test the written material, and no witnesses were therefore actually called to give oral evidence. The authors of the key reports and statements have given oral evidence before me at previous hearings, and I have been able to form positive assessments of them. This judgment was reserved for a short time to give me the opportunity to reflect on the evidence and the arguments; that said, given the issues involved, there is a degree of urgency in my producing this reasoned judgment.

16. Neither DD nor BC attended the hearing. I am satisfied that the Applicants have made all proper efforts to notify them of the time and place of the hearing; given the unlikelihood of their attending or participating (they have not attended any court hearings thus far), I considered it appropriate to proceed in their absence. I have, where possible, had regard to the views of DD and BC as far as they are ascertainable from the documents (see more fully below). In these extremely limited respects I have endeavoured to give some effect to their *Article 6 ECHR* rights.

17. I wish to record my particular gratitude to Ms Y, an experienced solicitor instructed on behalf of the Official Solicitor, who has made determined and repeated efforts to engage with DD during these extended proceedings by visiting her at home and hospital, telephoning her and writing to her; Ms Y has been rewarded in the main by DD's refusals to engage, and occasional hostility. The response to her most recent attempt at contact was a letter from DD dated 19 January 2015 by which DD requested Ms Y to "*back off*"; DD says in the letter that she is "*normal. I was born completely perfect*", and further indicates an intention to move somewhere "*peace*[ful]". She further says "*my body is mine, by human rights*", a sentiment to which I return later (see [118]). Ms Y's efforts, and the efforts of others, amply satisfy me that DD has been encouraged to participate in the decision-making in respect of the issues before me (*section 4(4)* of the *2005 Act*).

18. Moreover, the detailed written evidence reveals a conscientious endeavour on the part of the numerous skilled medical and social care professionals who have been involved in DD's life over recent months to engage her in decision-making; each has discharged, and continues to discharge, their specialist responsibilities with very considerable care and sensitivity, managing, in medical, clinical, legal and human terms, an extraordinarily difficult case. I have been impressed by them all, and am

conscious that this judgment will not fully reflect the diligence and thoroughness of the experts' contributions. I have annexed to this judgment a schedule containing the disciplines of some, but by no means all, of those relevant professionals whose evidence has been included in the voluminous papers before me, or who have been referred to in the evidence; they have been identified by initial only in order to preserve the confidentiality of the location in which DD resides.

19. The hearing took place in open court in accordance with 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 was also, of course, given to *§16* of *PD9E* to the *Court of Protection Rules 2007*. I made a Reporting Restriction Order (pursuant to *rule 92(2) Court of Protection Rules 2007*) on 2 September 2014 and this remains in force.

The Applicants and their duties towards DD

20. 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, undertake the proposed sterilisation procedure for DD (it having previously been responsible for all aspects of her obstetric and gynaecological care in her last pregnancy), and the Third Applicant is the relevant local authority charged with safeguarding responsibilities for DD. As I had cause to mention in my previous judgments, once again, these three public bodies have worked closely and collaboratively in seeking to resolve the difficult issues in this case.

21. My previous judgments have been predicated upon an acknowledgement of the duties owed by the Applicants towards a pregnant woman in their area who was believed to lack capacity, and who was at considerable risk of harm. The current situation, in which DD does not obviously or immediately demand medical treatment, caused me to raise with counsel at the hearing how the duties towards DD arise in the instant case. Mr. McKendrick provided further helpful submissions in this regard after the hearing, with which Mr. Horne agreed, and which I have considered with care.

22. I am satisfied that the duty to act to protect DD falls primarily on the Third Applicant (the safeguarding department of The Council) which has a duty to safeguard DD, and to protect her from harm. A separate duty probably falls on the First Applicant (the Mental Health Trust) which provides health, including mental health services, to patients in a non-hospital setting, in the community and are aware of DD's apparent lack of capacity in respect of mode and delivery of pregnancy and contraceptive decisions; they consider themselves under a duty to monitor her need for health services, given she appears to be incapable to access services herself.

23. The specific articulation of the duties on the Applicants is regrettably less than clear. As the authors of *Community Care and the Law*, (Clements and Thompson, Legal Action Group, 4th Ed.) put it at paragraph 25.1:

> *"The law regulating the protection from abuse of vulnerable adults in England and Wales derives from a complex mishmash of legislation, guidance and ad hoc court interventions."*

24. I am bound to agree. At present, there appears to be no one piece of legislation which requires local authorities, in particular, to take steps to prevent abuse or harm of vulnerable adults; this will change to some extent if or when *section 1* of the *Care Act 2014* (which appears to consolidate some of the existing statutory duties and create a duty to promote an individual's well-being, including their physical and mental health) is brought into force. At present, the duties arise, it seems to me, from a combination of:

    i) 'Community care' statutes including, but not limited to, *National Assistance Act 1948* (local authorities under a duty to "*make arrangements for promoting the welfare of persons*": *section 29*), the *Chronically Sick and Disabled Persons Act 1970* (*section 2*), *Care Standards Act 2000*, *Safeguarding Vulnerable Groups Act 2006*, *Disabled Persons (Services, Consultation and Representation) Act 1986*, and importantly *section 47* of the *NHS and Community Care Act 1990*;

    ii) The common law (see *Re Z (Local Authority Duty)* [2004] EWHC 2817 (Fam), [2005] 1 FLR 740 at [19]) (see [25] below);

    iii) The *Human Rights Act 1998*, and

    iv) The *2005 Act*.

25. Munby LJ (as he then was) in *A Local Authority v A* [2010] EWHC 978 (Fam) at paragraphs 64 to 69 more fully discussed the "*five main sources of local authority competence*" in this area; it is unnecessary for me to reproduce this helpful summary in this judgment, but I have had regard to it. In turn, he cited with approval Hedley J's analysis of local authority duties in *Re Z (Local Authority: Duty)* [2004] EWHC 2817 (Fam), [2005] 1 FLR 740, at para [19] (a case very different on its facts from the instant case), where the issue arose as to the duty owed by a local authority when the welfare of a vulnerable person in their area is threatened by the criminal (or other wrongful) act of another. In that case, Hedley J found that duties were owed under a range of legislative provisions (encompassed within Munby LJ's 'five main sources' referred to above) and concluded:

> "*In my judgment in a case such as this the local authority incurred the following duties:*
>
> i) *To investigate the position of a vulnerable adult to consider what was her true position and intention;*
>
> ii) *To consider whether she was legally competent to make and carry out her decision and intention;*
>
> iii) *To consider whether any other (and if so, what) influence may be operating on her position and intention and to ensure that she has all relevant information and knows all available options;*
>
> iv) *To consider whether she was legally competent to make and carry out her decision and intention;*

> v) *To consider whether to invoke the inherent jurisdiction of the High Court so that the question of competence could be judicially investigated and determined;*
>
> vi) *In the event of the adult not being competent, to provide all such assistance as may be reasonably required both to determine and give effect to her best interests;*
>
> vii) *In the event of the adult being competent to allow her in any lawful way to give effect to her decision although that should not preclude the giving of advice or assistance in accordance with what are perceived to be her best interests;*
>
> viii) *Where there are reasonable grounds to suspect that the commission of a criminal offence may be involved, to draw that to the attention of the police;*
>
> ix) *In very exceptional circumstances, to invoke the jurisdiction of the court under Section 222 of the [Local Government Act] 1972 …*"

26. This list, in my judgment, continues to provide a reliable summary of the duties, and a minimum standard, for authorities, with one particular addition – plainly (v) (above) should now be supplemented by reference to an application under the *2005 Act* (which was not in force at the time of *Re Z*). On the instant facts, (viii) and (ix) (above) are not relevant; save for that, the list fairly reflects the approach taken of the Applicant authorities towards DD in this case.

27. Mr. McKendrick relies on the Department of Health Circular "*No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*" which has force as statutory guidance under *Section 7* of the *Local Authority Social Services Act 1970*, which Munby LJ identified as one of his 'five main sources' of the duties on an authority (his third). Mr. McKendrick maintains that the guidance applies to DD given that she is a person:

> "*who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm…*" (para.2.3)

The Guidance, it seems to me, is targeted at protecting vulnerable people from '*abuse*', even if that arises from an act of neglect or an omission to act, and from which the authority has a duty to protect the vulnerable person. Although the definition of abuse by neglect may be said to cover DD's situation (viz:

> *"Neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate*

> *health, social care or educational services, the withholding of the necessities of life, such as medication , adequate nutrition and heating*" (para.2.7)),

this does not arise, in the instant case, as a result of abuse by a third party.

28. Therefore, while I am not convinced that the Guidance does apply to DD (she is not obviously a victim of abuse), this is immaterial as I am satisfied that duties lie elsewhere within the statutes and common law. Moreover, as Munby LJ further observed in *A Local Authority v A* (above), if a local authority seeks to control an incapacitated or vulnerable adult it is under a duty to enlist the assistance of either the Court of Protection or the High Court*:* see *Re BJ (Incapacitated Adult)* [2009] EWHC 3310 (Fam), [2010] 1 FLR 1373, at paras [21]-[22], and see again *Re Z (Local Authority: Duty)* (citation above – again at para [19]), and *Re E (by her litigation friend the Official Solicitor) v Channel Four; News International Ltd and St Helens Borough Council* [2005] EWHC 1144 (Fam), [2005] 2 FLR 913 , at paras [2], [69]. This is precisely what these authorities have commendably done in the instant case.

29. There was further discussion at the hearing as to the whether the Applicants owe a duty to DD under *Article 2 ECHR*. The relevant part of *Article 2* provides that "*Everyone's right to life shall be protected by law*".

30. The Official Solicitor does not specifically argue that the Applicants owe a positive, operational duty under *Article 2* to protect DD's life, nor do the Applicants concede such a duty. The European Court of Human Rights have interpreted the key words of *Article 2* (set out above) as imposing three distinct duties – one of which is a positive duty to protect life in certain circumstances, of which an aspect is an 'operational' duty (see *Osman v UK* (2000) 29 EHRR 245 at [115]). In this respect, both counsel helpfully drew my attention to *Rabone v Pennine Care Foundation Trust* [2012] UKSC 2, in which it was held (per Lord Dyson, borrowing the language from *Osman*) at [21]:

> "*… that the existence of a "real and immediate risk" to life is a necessary but not sufficient condition for the existence of the duty*".

The Supreme Court in that case discussed the 'operational duty' under *Article 2* existing in the following circumstances:

i) Where there has been an assumption of responsibility by the state for the individual's welfare and safety (including by the exercise of control) (i.e. in prison, in a psychiatric hospital, in an immigration detention centre or otherwise) (*Rabone* [22]);

ii) In circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the operational duty even where there has been no assumption of control by the state, such as where a local authority fails to exercise its powers to protect a child who to its knowledge is at risk of abuse as in *Z v United Kingdom* Application No 29392/95, [2001] ECHR 333 (10 May 2001) (*Rabone* [23]);

iii) Where an 'exceptional' risk arises, not an "ordinary" risk of the kind that individuals in the relevant category should reasonably be expected to take (in which no *article* 2 duty arises) (*Rabone* [24]).

31. Lord Dyson added in *Rabone* at [25] that:

> "*The jurisprudence of the operational duty is young. Its boundaries are still being explored by the ECtHR as new circumstances are presented to it for consideration. But it seems to me that the court has been tending to expand the categories of circumstances in which the operational duty will be found to exist*."

32. It is, for reasons set out above, unnecessary for me to decide whether *Article 2* is actually engaged here at all, or at this time. I recognise that DD's situation may well develop (or have developed) in such a way as to give rise to an operational duty, for instance, if she did become pregnant, and particularly if she took steps to conceal it. It may well be that as the jurisprudence further develops beyond *Rabone*, DD's current situation would be considered to give rise to an operational duty. But my view, on these facts and at this time, is that the risk to DD's life is not so 'immediate' as to impose on the Applicants a positive operational duty to act under *Article 2*, separate from its statutory and common law obligations.

Dramatis Personae

33. For ease of reference I have prepared a schedule of some of the relevant medical and other professional personnel involved in this case, which is attached to this judgment as a schedule.

Background obstetric and contraceptive history

34. I set out much of DD's relevant background obstetric history in my first judgment at [2014] EWCOP 11 at [20-44], and do not propose to rehearse it here. In that judgment, I described the circumstances in which DD's six children were born, four by caesarean section. Two children were born at her home, described as unhygienic and overrun by pets; one delivery was apparently achieved by dangerously unorthodox means (there was evidence, although it was denied, that BC used Bar-B-Q tongs as forceps); DD and BC's limited opportunity to care for these two babies at home (before the authorities intervened) was observed to be significantly harmful to the infants.

35. In my second judgment (at [2014] EWCOP 13 [11]) I set out what was then known of DD's contraceptive history. Given the particular significance of this history to the issues engaged at this hearing, I reproduce the relevant passage here:

> "*DD's medical notes (more fully available since the last hearing, and discussed by both Dr. F and Dr. Rowlands) reveal that during her childhood and adult life she has periodically received advice about contraception, and has been prescribed, and has used, different forms of contraception. The evidence appears to show that the*

> *contraceptive pill was first prescribed for DD when she was 12 years old. Her first Depo-Provera injection was in March 2000 but she was unwilling to use it again after 2 injections because of heavy bleeding, and in September 2000 she requested to go back on the oral contraceptive pill. There is a note of a discussion between DD and her GP in March 2002 at which DD requested contraception – the GP discussed a range of contraceptives including the pill, coil and implants, and DD agreed to an implant. The GP inserted the implant later that month although it was in place only briefly as, in fact at that time it transpired, DD was pregnant with Child 1; accordingly, the implant was removed. Following Child 1's birth, a further implant was inserted. In September 2003, the family planning clinic prescribed the oral contraceptive pill in addition to the existing implant. In December 2003, DD attended her GP requesting sterilisation (this was not the first time she had made this request). A specific referral for sterilisation was made in January 2005. When seen in hospital two months later, that request was refused as her motives were felt to be inconsistent and therefore unreliable. In October 2005, DD attended the family planning clinic and underwent the re-insertion of a contraceptive implant. This was removed in 2008, and at that time she indicated that she and her partner would use condoms. Later in 2008 she sought advice on becoming pregnant.*"

36. The Official Solicitor's more detailed review of DD's extensive medical records since that hearing have revealed a number of additional important points:

i) When DD was seen in 2002, she expressed the view that she did not want to be fitted with an intra-uterine device (IUD/IUS), although no reasons were recorded for that view;

ii) On 18 February 2003, at a GP appointment, DD expressed the wish to be sterilised;

iii) On 3 September 2003, at a follow-up appointment, DD repeated her wish to be sterilised, although her partner did not agree;

iv) On 2 December 2003, at a further follow-up appointment, DD again expressed a wish to be sterilised;

v) On 18 May 2004, DD re-attended the clinic. Again she expressed her wish to be sterilised, stating that she and her partner were determined not to have any more children; she was referred for a consultation, although it was noted that she was then only 26 years old;

vi) On 13 January 2005, DD was reviewed in clinic; she expressed the view that she did not want an IUD/IUS;

vii) On 24 January 2005, she was seen by a Consultant Gynaecologist (on the referral relating to sterilisation); the consultant rejected her request for sterilisation on the basis of inconsistency in her reasoning;

viii) By 2008, DD indicated to the clinic that she was no longer proposing to use contraception as she wished to conceive; she was then in a new relationship with BC;

ix) There is little indication from the notes that DD has used contraception at any stage during her relationship with BC.

37. The medical records do not suggest that any clinician felt that DD lacked the capacity to make decisions in relation to contraception, although it appears that the gynaecologist who rejected DD's request for sterilisation on 24 January 2005 (see [36(vii) above) plainly had concerns over the rationale for her request. The review of the notes reveals that even when DD has been willing to use contraception, she has always rejected an intra-uterine device (IUD or IUS).

38. Relevant to the current application, the Official Solicitor also rightly reminds me (these are facts I alluded to in my previous judgment) that during the most recent pregnancy:

i) Twenty-five unannounced visits by a range of personnel from social services were made to DD's home, none of which resulted in DD or BC allowing access to their property or engaging with statutory services in a meaningful way. As a result, the Applicants were unable to confirm the position in relation to any pregnancy;

ii) The Applicants then made a number of visits to DD's property attempting to engage her in midwifery care, all without success. For instance, DD did not allow access on 16 April, 15 May, or 22 May. In addition, she failed to attend antenatal appointments booked at the hospital on 23 April and 21 May 2014.

Recent history since [2014] EWCOP 13

39. On 17 July 2014, a sixth child (Child 6) was delivered to DD by caesarean section. DD was generally co-operative with all of the medical procedures once in the hospital, she settled into her hospital stay, and enjoyed the care and attention; the operation was a success. Mr. A (Consultant Obstetrician and Gynaecologist) who performed the operation reported as follows:

> "*During [DD]'s caesarean section it was noted that the lower part of her uterus, below the previous caesarean incisions, was very thin. So much so it looked like paper, with her baby's head visible through the thin muscle layer which is usually much thicker.*

40. An emergency protection order under *section 44* of the *Children Act 1989* was applied for, and Child 6 was placed in interim foster care. Although DD and BC saw Child 6 daily on the ward (and were observed to show "*warmth and affection towards the baby*" [Dr. F]), they did not take up the opportunity of any further contact after Child

6 had left hospital. In proceedings concerning Child 6 brought under *Part IV* of the *Children Act 1989*, DD was represented by the Official Solicitor but she did not engage or participate in any meaningful way with those proceedings. Final care and placement orders have now been made in relation to Child 6, who has been placed for adoption with one of her older siblings.

41. On 11 August 2014, DD attended an initial appointment to discuss contraception with her GP.

42. On 13 August 2014 the Applicants' team attended at DD's home to convey DD to a local health centre for contraceptive education and a capacity assessment; the level of anger and frustration displayed by both BC and DD at the Applicants' actions was significant and at a higher emotional level than at any other visit (I discuss this at [135(v)] below). The assessment did not happen.

43. On 18 September 2014, DD made an appointment for Depo-Provera injection.

44. On 17 November 2014, DD attended her GP surgery for an unrelated medical complaint. She was reminded of the forthcoming scheduled repeat Depo-Provera injection (11 December 2014), but replied "*I am not coming in for that.*"

45. The next administration of Depo-Provera was scheduled to take place on 11 December 2014; a reminder was sent by text. DD failed to attend. A letter was delivered to her home, asking her to attend the following day. DD then attended the surgery, shouting and indicating that she was "*not going to come in for any appointments for these injections* … [she] *just wants to be left alone*". She did not attend the appointment on 12 December.

46. On 14 December the Applicants attended DD's property, forcibly entered and administered the injection there. This was extremely distressing for DD.

47. On 5 January 2015, DD attended at her GP surgery; she was "*very upset about the injection*" which had been administered on 14 December 2014 (see [135(vi)] below).

Capacity: section 1, 2 and 3 MCA 2005

48. **General comments**: In making my determination of capacity, I start with the statutory assumption that DD has capacity to make decisions with regard to the relevant issues; only if it is established that she lacks capacity (see *section 1(2)* of the *2005 Act*) can the court possibly intervene. 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 *2005 Act*.

49. I remind myself that just because DD has an Autistic Spectrum Disorder and mild/borderline learning disability does not of itself establish lack of capacity, that her impairment can be permanent or temporary (*section 2(2)*). The issue of capacity is to be decided on the balance of probabilities (*section 2(4)*).

50. The critical phrase in *section 2(1)*, defining the 'diagnostic' element of the test – "*impairment of, or a disturbance in the functioning of her mind*" - is not defined in

the *2005 Act* itself. I am nonetheless guided by paragraph 4.12 of the Code of Practice which includes "*significant learning disabilities*" as an example of a condition meeting the 'diagnostic test'. The Official Solicitor has raised a caution in this case about how to treat the causal link between the diagnostic and functional tests where some but not all of her conditions meet the diagnostic criteria (i.e. he accepts that Autistic Spectrum Disorder unequivocally does, but DD's learning disabilities and/or psychological disorder do not). I do not consider it necessary to determine that particular issue, which will not influence my conclusion on capacity.

51. In making the assessment of capacity, I have gone on to apply the provisions of *section 3* of the *2005 Act*, 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.

52. I previously set out the legal framework for a determination of capacity in my earlier judgments in relation to DD at [2014] EWCOP 11 [55-63] and at [2014] EWCOP 13 [15]. In reaching my conclusions on this application, I have conscientiously adopted the principles which I set out in paragraphs [48]-[51] above, and in my early judgments, and wish to emphasise (particularly given that this is in some respects an exercise which I have repeated four times already in the last seven months in this case) that I well recognise that:

    i) It is necessary to proceed to determine capacity on the evidence as it presents at this stage, in respect of this current decision: see, *inter alia* [4.4] *Mental Capacity Act Code of Practice*;

    ii) Assessment of capacity is a decision-specific determination: *York City Council v C* [2013] EWCA Civ 478; [2014] Fam 10

53. **Diagnostic test**: In order to determine issues of capacity relevant to the specific decisions arising now, I have received and read a number of updated reports including those from Dr. F and Dr. Latham. This assists me in an understanding of DD's "*impairment of, or disturbance in the functioning of, the mind or brain*" (per *section 2(1)* of the *2005 Act*). Summaries of these experts' earlier evidence can be found at [2014] EWCOP 11 [46-54], and [70-78]); their evidence at earlier hearings (influenced as it was by a 2003 report of Dr. Lindsey, see in particular my judgment at [49-51] where I set out Dr. Lindsey's helpful assessment of DD) was that:

    i) DD has mild to borderline learning difficulties; she has a full scale IQ between 67 and 75;

    ii) DD has an Autistic Spectrum Disorder

> "*… 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)…*
>
> "*[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.*" – per Dr. F (see [2014] EWCOP 11 [52]);

Insofar as their opinions differed at all, I preferred the evidence of Dr. F (see [2014] EWCOP 11 [78]

54. I was satisfied at that time of my first ruling that DD's decision making:

> "*…lacks the essential characteristic of discrimination which only comes when the relevant information is evaluated, and weighed*" (see [2014] EWCOP 11 [86]).

55. Dr. F has had the chance to assess DD on three separate occasions since I delivered that judgment on 4 July 2014. His further assessments (report 15 August 2014 and 6 January 2015) have yielded a number of additional insights, namely that DD displays poor reciprocal social interventions, "*poor insight into her social difficulties*"; "*stereotyped idiosyncratic us of words and phrases*" with "*clear abnormalities in two way conversations*…."; he concludes:

> "*DD demonstrates marked black or white thinking regarding the different types of contraception available. She is unable to hold both positive and negative aspects of each type of contraception in mind, which is an essential component of weighing information to reach decisions*".

He goes on to opine that this is caused by her Autistic Spectrum Disorder, a condition which is characterised in DD by an extremely rigid style of thinking with difficulty in cognitive flexibility, repetitive and stereotyped style of speech, abnormalities with non-verbal communication (eye contacts and facial expressions), difficulties in social interactions and forming relationships, and a restrictive interest pattern. It is accepted

that the quality and intensity of some of these features will be more apparent on clinical examination than they will to experts considering matters only on the papers.

56. Clinical Psychologist L agrees with Dr. F that "*[DD]'s presentation was strikingly consistent with a person with an Autistic Spectrum condition*". She comments that DD's working memory is an area of relative weakness. It gives an indication that her abilities to take in, hold, process and use information with which she is presented are within the Extremely Low range. Dr. L considers that DD's verbal ability has led people to overestimate her cognitive functioning in the past.

57. Dr Denman considers that DD has a psychological disorder which is a legacy of her early upbringing, and which significantly contributes to her inability to understand and process the relevant information (but which may not of itself satisfy the 'diagnostic' element of the capacity test), and contributes to her "*marked narrative incoherence*". Dr. Denman does not materially demur from the view of Dr. F respecting that Dr. F had undertaken a "*longitudinal*" review of DD's functioning over a period of time. Dr. Denman considers that DD's learning disability has materially contributed to her capacity to "*understand and decide about the possible option of sterilisation in her case*". All experts consider that the Autistic Spectrum Disorder is the most prominent active "*impairment of, or disturbance in the functioning of, the mind or brain*".

58. In summary, while the experts were divided (at least as to emphasis) as to the significance of the learning disability and/or psychological disturbance in the assessment of impairment or disturbance of the mind, they were of one view that this was undoubtedly caused by her Autistic Spectrum Disorder. This conclusion leads me to deal with 'functionality' under each of the specific decisions under consideration.

Capacity to litigate:

59. Specific considerations are relevant to a determination of capacity to litigate; I discussed these at [2014] EWCOP 11 [64-68], and again apply those legal principles to a determination of DD's current capacity to litigate.

60. Dr F has taken the view for some time, supported by others, that DD was unlikely to be able to understand the complex matters that relate to her case due to her Autistic Spectrum Disorder and borderline leading disabilities. He assessed that the highly rigid style of thinking which related to DD's Autism Spectrum Disorder, made it unlikely that she would be able to use or weigh legal advice to reach decisions within the litigation.

61. There is nothing in the evidence before me now which indicates that the position has changed; indeed, this reasoning can be transposed with greater force into this stage of the proceedings. This is the combined view of the experts whose evidence I have studied at this hearing.

62. DD refuses to acknowledge that this litigation is occurring, to engage with the issues involved, and to accept the power of the Court to make determinations in relation to contraception/sterilisation.

63. On the limited but nonetheless overwhelming evidence on this aspect, I am satisfied that DD lacks capacity to litigate, and accordingly make the declaration to that effect under *section 15* of the *2005 Act*.

Capacity to make decisions in relation to contraception and sterilisation.

64. **Relevant Information on which to make a decision**: In *A Local Authority v Mrs A (by the OS) and Mr A* [2010] EWHC 1549 (Fam)) at [64] Bodey J set out a list of the 'Relevant Information' which a person would be expected to take into account in making a decision on contraception, limiting that information to the reasonably foreseeable consequences of deciding one way or another in relation to contraception (in principle and type) – the proximate medical issue. I set these out at [2014] EWCOP 13 at [16].

65. Bodey J's list includes "*(ii) the types [of contraceptive] available and how each is used*". In this case, the following methods have been identified as available and potentially clinically appropriate for DD:

    i) Progesterone pill;

    ii) Condom (male and female);

    iii) Depo-Provera injection;

    iv) Sub-dermal implant;

    v) Intra-uterine (hormonal) coil;

    vi) Non-hormonal (copper) coil;

    vii) Sterilisation.

66. At the earlier hearing I considered what specific factors would be 'reasonably foreseeable consequences' of, or 'proximate' to, the relevant decision about contraception for DD; I set out a list of those which would be specific and germane to her at [2014] EWCOP 13 [17]. Before turning to consider the relevant statutory 'functionality' criteria as they apply to this decision, I reproduce that list, updated to take account of new information. Thus, in deciding on contraception, type of contraception and/or sterilisation, DD would in my judgment be expected to have regard to the following 'relevant information' specific to her:

    i) the risk of a thrombo-embolic disease during any future pregnancy (as mentioned above, DD suffered a thrombotic embolism during her fourth pregnancy);

    ii) the risk of delivering a pre-term infant (her fourth child was born at 29 weeks and suffered breathing difficulties);

    iii) the impact on DD's mental and emotional health of any further pregnancy (DD has suffered from a delusional disorder following her second and third pregnancies);

iv) the additional risks of a home birth for DD (which would always be likely to be her preferred mode of delivery);

v) the risk of placenta accreta; as mentioned above ([9](ii)), given that DD has undergone four caesarean sections, this would be particularly dangerous for DD, given the significant risk of extensive haemorrhaging at the point of removal; if bleeding cannot be stemmed DD faces the prospect of hysterectomy;

vi) that she faces considerable (and, with each pregnancy, increasing) risks to her life through the delivery of any child. Vaginal birth after caesarean carries considerable risks associated with rupture of the uterus; this is particularly acute given that the uterine wall is now seen to be 'tissue thin'; caesarean section carries risk of operative failure, adhesions or bowel or bladder injury, and the general risks associated with general anaesthetic.

67. **Section 3(1)(a): 'unable to understand'?**: The evidence, taken as a whole, reveals that DD is likely to have an understanding (even if rudimentary) of the reproductive process, notwithstanding that in the recent capacity assessments, DD's stated beliefs about the circumstances in which she has become pregnant were recorded:

> "*[DD] expressed the belief that there was no father to her baby … she stated that she took a tablet from a health food shop which had affected her hormones and this had led to her pregnancy*" (Dr. F)

68. I am satisfied, on the evidence, that DD has a basic understanding of the purpose of contraception. What is equally clear, and is of concern, is that DD does *not* understand the importance of her not becoming pregnant again, for her own sake. Dr Denman, instructed on behalf of the Official Solicitor, concluded that:

> "*What [DD] is unable to consider is the possibility that there is an overriding medical reason for contraception in terms of her own physical health. In her interviews she either simply denies this is a possibility or behaves in ways that make it at best unclear whether she understands that there could be severe consequences for her health. Overall, therefore I do not believe that [DD] has the capacity to understand or to weigh the relevant information that would allow her to decide on the need for contraception in her case*."

69. The other experts concur that only in limited respects does DD appear to understand that a further pregnancy may cause damage to her (specifically to her uterine wall); her basic and limited understanding of this is not consistently maintained, or retained. Dr. Latham was less sure that DD could not understand the relevant information, but the significant preponderance of the expert evidence leads to me to conclude that DD does not have sufficient understanding, by reason of her condition, to make the relevant decision about contraception or sterilisation, or make a choice between those options.

70. **Section 3(1)(c): 'unable to use or weigh…'?**: In 2003, when assessing DD in the context of *Part IV Children Act 1989* proceedings, Dr Lindsey found that DD had difficulty with problem-solving: she was unable to imagine the consequences of various courses of action in weighing up the "pros and cons" in order to make a decision about the best course.

71. In a meeting with Dr. F, Dr. L, and Nurse I more recently, on 16 July 2014 (just before Child 6's birth), DD's initial stance was to reject the fact that any of the risks described as associated with pregnancy (catastrophic bleeding, uterine scar rupture, the danger associated with birth at home, stroke) could apply to her. Dr F formed the view that this was consistent with her rigidity of thinking: she tended to see things in black or white, rather than in the round, and once she had decided something or formed a particular view, it was very difficult for her to change that view or to see matters from an alternative perspective. By the time of a further meeting on the 18 July 2014, she had been told of Mr. A's finding (from the caesarean procedure) of the finding of the 'tissue-thin' wall of her uterus. The fact that Mr. A had been able to see her uterine wall and describe it to her helped DD to accept that this was a real and identifiable risk. Ultimately, DD required considerable prompting to recognise the implications of this condition, i.e. that she could bleed to death if a rupture occurred. Dr. L remained unpersuaded that DD understood the risk of death, given that DD was unable to expand on it or to incorporate it into her discussion.

72. In the more distant past (see [35] and [36] above) DD showed a keenness for sterilisation; when she was referred for the procedure, the consultant was not satisfied that she had any consistency of reasoning (see [36(vii)] above). DD's more recent views about sterilisation have shown any greater reliability, oscillating between being vehemently opposed to it, to requesting it immediately (and being distressed when this could not be arranged), before reverting to opposition. Dr. F is of the view that her oscillation is illustrative of her rigid 'black and white' thinking, and reveals an inability to weigh up the benefits and disbenefits of the procedure.

73. DD has been clear throughout all discussions recently and historically that she does not wish for an IUD/IUS to be fitted, stating that she does not "*want something inside*" or "*up*" her; she would not consider any of the benefits or otherwise of the IUD/IUS, and in recent discussions has demonstrated no ability to 'weigh' the relevant information concerning it. She has stated that she does not want to be fitted with a contraceptive implant as (among other adverse side-effects about which she complained) she believed that it had given her a "*slipped disc*" (the suggested causative link is not possible). She could see no positive benefits of the implant (even though she had one in place herself in the past). DD has been opposed to any hormonal based contraceptive in the past (including the Depo-Provera injection).

74. Dr. F concludes his August 2014 report with this significant opinion relevant to this aspect of the 'functionality' assessment:

> "*[DD] has demonstrated an inability to weigh information regarding all forms of contraception. In relation to sterilisation, she demonstrates black and white thinking and jumped from one extreme position to another without weighing the relevant information. She is unable to view the various forms of contraception 'in the round' being unable to*

> *acknowledge and weigh positive and negative aspects of the various choices. She was also unable to weigh information regarding future risks of stroke and the risk of premature births. [DD]'s black or white thinking is caused by her ASD and her rigid thinking relating to risks in future pregnancies is also caused by the rigid thinking caused by her ASD*"

And later

> "*[DD] is unable to hold both positive and negative aspects of each contraception in mind, which is an essential component of weighing information to reach decisions.*"

Dr. F confirmed in his most recent (January 2015) report that he remains of the same opinion.

75. No other expert who has opined on this, including Dr. Latham and Dr. L, expresses any contrary view, Dr. Latham specifically finding that "[DD]'s *incapacity is based on her inability to weigh information rather than any other aspect of the test"*, and that Autistic Spectrum Disorder is a significant factor in that inability; Dr. Denman agrees. The evidence overwhelmingly demonstrates this lack of ability to weigh the relevant information.

76. **Section 1(3): have all *"practicable steps"* been taken to help**? I read *section 1(3)* together with *section 4(3)* of the *2005 Act*, considering whether "*all practicable steps to help [her] to [make a decision] have been taken without success*" together with "*whether it is likely that the person will at some time have capacity in relation to the matter in question.*" I am satisfied, from all of the evidence which I have received, both orally and in writing over the last seven months, that considerable efforts have indeed been made to assist DD to make relevant decisions. Against a backdrop of repeated failure to engage with professionals involved from the three Applicant authorities (to which I made reference in my earlier judgments), a number of discussions have been attempted with DD around the time of, and since, the birth of Child 6, notably on 16 July, 18 July (twice), 22 July, 29 July and on the 13 August. These discussions have been held against a background of DD being "*very resistant*" to engaging in any form of education session, or being provided with information about education in a formal way. Moreover, various methods have been deployed to engage her, including the use of visual aids.

77. Significant among the strategies to assist DD to understand the issues was the inspired use of a 'social story', which was specifically developed by Dr. F and Dr. L, and which used writing, with photographs, diagrams, and pictures. The 'social story' involved a character called 'Helen' – a woman who has had six babies and for whom being pregnant "*would be bad for her health*". In the story, Helen is being asked to make a contraception choice, between the IUD and sterilisation; DD was taken through the story and was asked to help Helen decide. Dr. F describes the session thus:

> "*[DD] engaged well with the social story although asked afterwards if it was a real person. She chose the sterilisation option for Helen giving the following reasons: only one*

> *operation would be needed for the sterilisation versus repeat procedures for the coil; she believed that it would be 'discomforting' to have something inside her. She did not question the risks which Helen faced from future pregnancies…*"

I discuss this 'social story' again below, relevant to DD's wishes and feelings (see [120(ii)] below).

78. **Section 4(3): Likelihood of regaining capacity**: While this subsection (which requires the court "*to consider whether it is likely that the person will at some time have the capacity in relation to the matter in question*") strictly falls to be considered as a 'best interests' factor, it is practical to deal with it here (as I indicate above it is not unhelpful to look at *section 1(3)* and *section 4(3)* together). In this respect, Dr Latham expressed the view (on behalf of the Official Solicitor) that it is unlikely that DD will acquire capacity, unless DD is able to develop a personal or professional relationship where she can be supported in making such decisions; the current indicators are that this is vanishingly unlikely for the foreseeable future. Dr. Denman considered it "*very unlikely*" that DD would develop capacity in relation to decision-making relevant to contraception/sterilisation; the Applicants support those views, and having looked at the evidence as a whole, I readily accept them.

79. **Conclusion on capacity to make decisions in relation to contraception and sterilisation**: The expert opinion is unanimous that by virtue of her Autistic Spectrum Disorder, DD lacks capacity to make the critical decision about contraception and sterilisation. The views of the Applicants' treating clinicians in this regard have been buttressed by the expertise marshalled by the Official Solicitor (specifically Dr. Latham and Dr. Denman). The evidence strongly indicates that DD is unable to retain much, if any, information relevant to this critical decision. However, I am wholly satisfied that she is unable to understand, and more specifically to weigh, the relevant information.

80. Therefore, for the reasons which I have set out above, I accept that expert view, and declare that DD lacks capacity to make decisions in relation to contraception and sterilisation, and accordingly make the declaration to that effect under *section 15* of the *2005 Act*.

Best interests: section 1(5) MCA 2005

General legal principles:

81. In reaching a decision on this critical issue, in DD's best interests I have applied faithfully the provisions of *section 4* of the *2005 Act*, and considered "*all the relevant circumstances*" of this particular case (*section 4(2)*). Some of the wider legal principles relevant to medical treatment cases are discussed in *Aintree University Hospital NHS Foundation Trust v James* [2013] 3 WLR 1299 (reproduced in part in *Sheffield Teaching Hospital NHS Foundation Trust v TH and Another* [2014] EWCOP 4 at [36], [55] and [56]), which I referenced at paragraph [90] of my first judgment ([2014] EWCOP 11).

82. As outlined in the summary above, DD's human rights considerations are inextricably bound up in the best interests' determination here. There can be no question but that the relief sought here directly interferes with the *Article 8* rights of DD and her partner BC ("*the right to respect for his private and family life, his home …*"). Even though parenthood on its own is not sufficient to found a right to respect for *family* life under *Article 8* (see *Lebbink v Netherlands* 40 EHRR 18), nonetheless the relevance of a right to a *private* life under *Article* 8 is clearly established by *Dickson v UK* (2008) 46 E.H.R.R. 41 (see [65/66]), and by *Evans v UK* [2006] All ER D 82 (Mar); in *Evans*, the Court noted the scope of *Article 8* at paragraph 57 stating (emphasis added):

> "*[The Grand Chamber] agrees [with the Chamber] since 'private life', which is a broad term, encompassing, inter alia, aspects of an individual's physical and social identity including the right to personal autonomy, personal development and to establish and develop relationships with other human being and the outside world (Pretty v UK [2002] ECHR 2346/02 at [61]) incorporates the right to respect for both the decisions to become and not to become a parent.*"

83. It follows that I can and should only interfere with the rights if I am satisfied that this is necessary and in accordance with the law for the protection of DD's health (*Article 8(2) ECHR*).

84. I had cause specifically to consider the issue of sterilisation of a vulnerable and incapacitous woman in *A Local Authority v K* [2013] EWCOP 242. I summarised the relevant test at [26], thus:

> *"Any decision made or endorsed by the Court in a case such as this must, by statute, be taken in the best interests of K (section 1(5) MCA 2005), with regard to the fact that the decision should be the "least restrictive" of K's rights and freedom of action (section 1(6)). In reaching a conclusion on her best interests, I have had regard to the provisions of section 4 MCA 2005, and to "all the relevant circumstances" (section 4(2)). Those circumstances include all "medical, emotional and all other welfare issues" concerning K (borrowing the language of the pre-MCA 2005 Court of Appeal decisions of Re MB (Medical Treatment) [1997] 2 FLR 426 at 429, and R-B v Official Solicitor: Re A (Medical Sterilisation) (1999) 53 BMLR 66). In this respect, I have of course had regard to the method of achieving the sterilisation (involving the necessary hospitalisation of K), the likely permanence of the procedure, and the interference with K's physical integrity".*

85. In the more recent decision of *A Health Authority v DE* [2013] EWHC 2562 (Fam), [2013] F.C.R. 343 ("*DE*") Eleanor King J. (as she then was), at [84] specifically drew together a number of important principles from the authorities, some of which have particular significance here, including:

i) The court is not tied to any clinical assessment of what is in P's best interests and should reach its own conclusion on the evidence before it *Trust A and Trust B v H (An Adult Patient)* [2006] EWHC 1230. Hence, in the instant case, although there is broad consensus between the represented parties as to the orders I should make, I have considered it appropriate to review and discuss the evidence in this full judgment;

ii) The weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar case, carry much less, or even very little, weight. *Re M. ITW and Z and Others* [2009] EWHC 2525 (Fam); this is of particular relevance in the instant case, as the risks to DD's life and well-being are specific and highly unusual;

iii) There may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "*magnetic importance*" in influencing or even determining the outcome: *Re M. ITW and Z and Others* [2009] EWHC 2525 (Fam);

iv) Any benefit of treatment has to be balanced and considered in the light of any additional suffering or detriment the treatment option would entail *Re A (Male Sterilisation)* [2000] 1 FLR 549 at 560.

86. I separately referred in [2014] EWCOP 11 [97(i)] to the fact that "'*best interests' are not limited to best <u>medical</u> interests, but the wider best interests of DD*" (emphasis added). In *Re MB* [1997] EWCA Civ 3093 [35] (a passage not in fact quoted in my earlier judgments) Butler Sloss P said:

> "*In considering the scope of best interests, it seems to us that they have to be treated on similar principles to the welfare of a child since the court and the doctors are concerned with a person unable to make the necessary decision for himself, see Re F (Mental Patient: Sterilisation) [1990] 2 AC 1. In coming to such a decision relevant information about the patient`s circumstances and background should where possible and if time permits be made available to the judge*". [36]

<u>The risks of future pregnancies</u>.

87. The Official Solicitor submits that the history between 2008 and 2014 shows that, irrespective of DD's wishes in this regard, she will continue to have sexual relations with BC and is likely to fall pregnant absent contraceptive treatment. There is obvious force in that submission, which I accept, and I proceed to determine this application on that basis.

88. As I outlined in the summary above ([9(i)/(ii)]), there are two particular identified life-threatening medical risks of a further pregnancy for DD:

i) Uterine rupture;

and

ii) Placenta accreta, or Placenta praevia;

There is additionally, the risk of:

iii) Thrombotic event in pregnancy.

89. **Uterine rupture**: Mr. A, who performed the caesarean section, commented as follows (in the original this passage directly follows that at [39] above):

> *"In future pregnancies this [i.e. the thinness of the lower part of her uterus, below the previous caesarean incisions] is likely to get worse with a significant chance of scar or lower uterine segment giving way either during the pregnancy or particularly at the time of labour/delivery. Uterine contractions would stretch this area further with the high risk of it coming apart. This would result in her baby going into her abdomen and dying and then there would be significant intra-abdominal bleeding which would be life threatening for [DD]. If she had another concealed pregnancy and this happened at home the result would most likely be the death of [DD]. It is difficult to quantify this risk; however, my clinical view is that if she went into labour, there would be a 50% risk of her uterus rupturing."* (emphasis by underlining added).

Mr. Griffiths puts the risk of this at "*at least 10-20%, quite possibly much higher*".

90. As Mr. A comments (in the passage above), the risk of uterine rupture arises during pregnancy prior to delivery, as well as at the point of delivery. DD would be increasingly exposed to this life-threatening risk the bigger her foetus grew, but would present enormous challenges in monitoring given her wholesale disengagement from services and her denial of the applicability of any risks to her health of pregnancy. It is agreed by all of the experts that the risk of uterine rupture:

i) is not predictable;

and

ii) would be life-threatening it were to occur; it would almost certainly be fatal for DD and the infant if a vaginal birth were attempted unsupervised outside of a maternity unit.

91. **Placenta accreta or placenta praevia**: I outlined the basic risk of these conditions in my summary above (see [9(ii)]). Mr Griffiths, consultant obstetrician and gynaecologist, drawing from a recent paper by Cook JR at al - *Multiple Repeat Caesarean Section in the UK: incidence and consequences to mother and child. A national, prospective, cohort study. BJOG: Int J Obstet Gynaecol 2013;120:85–91* discussed these conditions (and the risk of uterine rupture) more fully. In summary,

he was of the view that the risks of these conditions are all now higher for DD than they were before her last caesarean section, opining that:

> "*Accordingly the risks (with an attempted vaginal birth unless there had been appropriate antenatal care) of either placenta accreta, placenta praevia or uterine rupture in labour and the consequences therefore would be <u>at least</u> 30%.*." (emphasis in the original).

Mr Griffiths explained that the 30% risk was the sum of 18.5% (representing the number of cases from the 'Cook' study where there was a finding of placenta accreta/praevia/both) and 10% (being Mr. Griffiths' lowest "*crude*" estimate of the risk of uterine rupture: as he put it: "*Crudely … I would suggest the risk of uterine rupture would be at least 10-20%, quite possibly much higher.*"). He added, significantly:

> "*The occurrence of either of these* [placenta accreta, praevia, or uterine rupture] *in an unsupervised birth would almost certainly be fatal to the mother*".

92. DD would either have placenta praevia/accreta or not. If she did not, her risk of haemorrhage as a result of abnormal placental anatomy would not be particularly raised. By contrast if she was unfortunate enough to suffer these complications, she would be certain to suffer the haemorrhage. Placental localisation scanning (as occurred during the pregnancy with Child 6) would determine which of these scenarios DD faces. Without such scanning (which was only achieved in the last pregnancy following court intervention and forced entry to her home, and which would be the position in a concealed pregnancy), all that can be said is that she would face the epidemiological risk.

93. If DD had either a placenta accreta or praevia, and delivered at home, even if BC were to summon immediate medical assistance (which in my judgment is doubtful given his failure to do so in 2011, and his general attitude to professional support), such medical assistance would be unlikely to arrive in sufficient time to prevent DD dying as a result of blood loss, according to Mr. Griffiths.

94. The Official Solicitor tentatively submitted that the percentage risks could be calculated so as to yield an overall risk to DD of a significant life-threatening event of c.70%; this was achieved by adding 18.5% from the 'Cook' study (placenta accreta/praevia) to the figure proposed by Mr. A of 50% (uterine rupture) (see [88] above). I am not comfortable with this approach, which was in any event not supported by the Applicants (specifically Mr. A). It matters not. The simple fact, it seems to me, is that if DD should successfully conceal her pregnancy, or (even assuming the pregnancy went to full-term) attempt another home delivery, the clinical risk of a fatal outcome from either of these medical conditions, measured at "*at least*" 30% or 50%, is dangerously and unacceptably high.

95. **A repeat of an intra-cerebral embolism**: DD would face the risk of a further thrombotic event (as occurred during her pregnancy in 2011); that risk does not appear to be markedly different from that which any woman would face with an

unsupervised home delivery. It is nonetheless significant, and proved compromising to DD's health and well-being in the past.

Less restrictive options: section 1(6) MCA 2005

96. In considering what is in DD's best interests, I must have "*regard*" to "*whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action*." (*section 1(6)* of the *2005 Act*).

97. *Section 1(6)* does not require me necessarily to choose the less restrictive option where a choice exists. I am obliged to have "*regard*" to the principle of less intervention, but can plainly opt for the intervention which is not the least restrictive if it is in the best interests of the individual involved: see *C v A Local Authority* [2011] EWHC 1539 (Admin) per Ryder J, at [61].

98. It is accepted by counsel, unsurprisingly, that sterilisation is *not* the 'less restrictive' *medical* option in terms of irreversible (or largely irreversible) treatment to bring an effective end to child-bearing opportunities for DD; it is indeed the more, or most, restrictive. However, that is not the whole picture. DD's "*rights and freedoms*" must be viewed in a wider context than just the medical procedure itself; her 'rights and freedoms' include the clear right to respect for her privacy. Sterilisation is in this context, in fact, much more likely to free her from further intrusion of her 'private life' from professionals, whereas the insertion of a coil (carrying with it a greater need for monitoring and in due course replacement/removal) would not. In this wider sense, sterilisation is in my judgment the less restrictive of the two principal options under consideration.

Are separate Article 12 ECHR rights engaged in this case?

99. *Article 12 ECHR* provides that "*Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right*".

100. Although *Article 12* reflects an absolute right, its limits remain poorly defined. Both counsel submit that *Article 12 ECHR* does not contain a free standing right to found a family in the absence of marriage; they submit that this is one 'conjunctive' right, not two 'disjunctive' rights. In my view the words "*this right*" in the *Article* strongly suggests that these two apparently separate rights, which are capable of operating independently of each other (i.e. "*to marry*" and "*to found a family*"), are in fact to be treated as linked, indeed effectively as one single right, and therefore is of no immediate application here.

101. It seems to me, in any event, that even if "*the right… to found a family*" were to be viewed independently of the "*right to marry*" it would offer little more protection to the individual (DD) than the provisions of *Article 8*. I would further have had little trouble in concluding that the sterilisation procedure proposed is neither an arbitrary nor disproportionate interference with any *Article 12* right to found a family (if it were indeed found to exist separate from marriage). As I have heard no detailed contrary argument beyond that reflected in this judgment, it is not appropriate, or necessary, for me to make further comment.

102. I have been addressed briefly by counsel on the potential import of the *United Nations Convention on the Rights of Persons with Disabilities* (UNCRPD), ratified by the UK in 2009 although not yet incorporated into English law. In my judgment, no discrete argument under the UNCRPD arises in this case. In any event, as an undomesticated international instrument, the Convention has no direct effect (see Lord Bingham in *A v Secretary of State for the Home Department* [2005] UKHL 71; [2006] 2 AC 221 at [27]) and I do not consider it necessary to address its potential relevance further.

Sterilisation and contraception options: the 'Balance Sheet'

103. Although female fertility declines from the mid-30s onwards, Mr. A expresses the concern (echoed by others) that it is very likely that DD will fall pregnant again, without contraception; history would support this opinion (see [87] in 'The risks of future pregnancies' above). Dr Rowlands, sexual and reproductive health specialist, in his report, dated 16 January 2015, explains the duration of fertility for the average woman, and advises that the mean age of menopause to be 51 (although pregnancy beyond the age of 50 is rare). It appears therefore that DD is at risk (albeit a diminishing one) of future pregnancy for around 15 more years.

104. The contraceptive options have been set out at [65] above, and I have considered their efficacy in DD's case. I, like the experts advising me, have effectively excluded from consideration the use either of progesterone pill or barrier methods (condoms or cap), requiring (in each respect) a high level of personal compliance by DD or BC, which is far from assured; indeed DD has expressly, adamantly and consistently refused to take the progesterone pill. It is no longer feasible, in my judgment, to continue to provide DD with a contraceptive Depo-Provera injection every three months. This would involve a long-term expectation on DD to comply with the regime, against a background of low level compliance in the recent short term. Were DD to withdraw her co-operation, the reactivation of court process, and short-term emergency measures (including possible forcible entry into her home and restraint) to secure contraception while further court decisions are taken would be a disproportionate (and as it is, an avoidable) interference in DD's private life. My conclusion in this respect is reinforced by her GP who reported, following DD's visit to the surgery a few weeks ago, that DD "… *seems to be coming more 'anti' the injections to me rather than accepting them.*"

105. The insertion of a sub-dermal implant is not indicated on the instant facts:

i) For DD, it would require insertion under local anaesthetic, which she would be likely to resist;

ii) The previous insertion of a sub-dermal implant caused DD unacceptably high levels of bleeding and mood swings, which she found difficult; both of these are likely to occur;

iii) The implant would require to be medically checked at regular intervals (there is a real risk which DD would resist co-operation with check-ups);

iv) The implant is removable; DD is said to have high pain thresholds, and would be capable of removing it herself (without medical supervision) or having it

removed; DD would be unlikely to report its removal, exposing the risk of future pregnancy.

106. Realistically, therefore the choice is between IUD/IUS contraception, and therapeutic sterilisation.

107. In this case, I have been greatly helped by the Applicants to consider the actual benefits and counterbalancing disbenefits of these particular options, by reference to their balance sheet of factors. In the paragraphs which follow I identify what seem to me to be the most important considerations.

108. Featuring prominently in favour of IUD/IUS contraception is:

i) IUD is effective immediately; IUS effective within 7 days;

ii) That this form of contraception is less restrictive than sterilisation, in the sense that it is more easily reversible, and once removed normal fertility resumes immediately;

iii) The failure rate at 5 years for a copper IUD is less than 2%, and of a IUS Mirena less than 1%;

iv) A woman's menstrual cycle is not affected (this is likely to be re-assuring to DD);

v) Once fitted, it does not require DD's ongoing co-operation/reliability;

vi) An IUD (as opposed to IUS) does not contain hormones, therefore DD would not experience any of the hormonal side effects which have caused her distress in the past.

109. Against IUD/IUS contraception, the following factors are relevant:

i) It is invasive;

ii) There would be likely to be short term distress at being removed from her home, possibly forcibly, for the procedure under general anaesthetic; (this arises in relation to sterilisation too, see below);

iii) There may be long term distress at her loss of child-bearing capacity;

iv) A further procedure will be a required in 5 (IUS) or 10 (IUD) years time to replace the coil; this would require further general anaesthetic; a yet further procedure would probably be required when the coil is no longer required, in order to avoid the risk of infection;

v) There is a risk that an IUD/IUS would be removed (either by herself or at a clinic which does not know her background history);

vi) There is a risk that the IUD/IUS could be spontaneously expelled; the guidelines produced by the National Collaborating Centre for Women's and Children's Health (Long-acting reversible contraception: NICE guideline.

London: RCOG. 2005), estimate that risk is about 5% over 5 years; the evidence of the experts before me suggest a higher figure of 7-8%. Dr Rowlands reports that expulsion is most common in the first year of use, particularly within the first 3 months. The risk of expulsion is highly significant in my judgment; unlike a compliant woman who wants to use the coil, DD is most unlikely to report expulsion;

vii) IUDs and an IUSs have a range of side-effects. Women may suffer from pain and unacceptable bleeding (heavy menstruation with an IUD, or absent bleeding for the IUS);

viii) With the IUS, it is possible to suffer some hormonal side effects from systemic absorption of progestogen such as breast tenderness, mood changes, acne and hair loss, but these diminish over time. More rarely, women develop ovarian cysts which can cause abdominal pain;

ix) Any alternative (reversible) forms of contraception would be markedly less reliable than sterilisation in preventing further pregnancy;

x) Dr Denman considers that the insertion of an IUD/IUS is more likely to cause DD distress because one of her psychological processes involves a visceral appreciation of her body contents. She considers that it is *"fairly likely"* that DD will imagine the intra-uterine device as a massive foreign body inside herself, worry that it is moving inside her or attribute any pain or symptom to its presence;

xi) Dr. Denman is concerned about potential longer-term psychological implications of insertion of a coil – she further considers (against the background of her alleged history of abuse by her father/brother and her perception of the intrusion by statutory services in her life) that DD will suffer an exacerbation of feelings of being violated, controlled and intruded on. She considers that these feelings will be stronger than with sterilisation because of the sexual symbolism of the act of inserting the intra-uterine device, but also more simply because the device can be removed by those who control her, but they refuse to do so.

xii) DD has throughout articulated her firm opposition to being fitted with a coil and the thought of something inside her ("*I don't want something up me*"); this elevates the risk in my judgment that she would take steps to remove it or have it removed;

xiii) Dr. F considers it likely that DD will remain distressed until she finds a method of removing the IUD/IUS.

110. Featuring prominently in favour of laparoscopic sterilisation is:

i) This is the outcome with the greatest prospect of preventing further pregnancy; DD's fertility carries significantly more disbenefits to her than benefits;

ii) It is a single, relatively simple, and definitive surgical procedure;

iii) No medical follow-up would be required (either in the short-term or long-term). This most fully gives effect to DD's long held, and consistent, wish and feeling to be treated as normal as possible and to be left alone without interferences in her private life. She finds the involvement of agencies intolerable. Mr A said: "*Following a sterilisation procedure, [DD] would not need ongoing contraceptive appointments or reviews, nor would be monitored in respect of future pregnancies; she would return to a much more independent lifestyle*";

iv) There is a *"considerable"* risk that even if DD were to become pregnant again, an elective caesarean section would necessitate emergency hysterectomy to save her life; this would have the effect of removing her fertility at that stage in any event.

v) Menstrual periods are unaffected by the sterilisation procedure;

vi) Dr. Griffiths' view that "*[i]f anything, sterilisation has a positive effect on female sexual function*";

vii) There failure of a sterilisation procedure is estimated to be 2-3 in 1,000; this risk includes surgeon error in failing to occlude the tubes effectively.

111. The factors weighing against laparoscopic sterilisation, on the evidence, are:

i) It is invasive;

ii) There would be likely to be short term distress at being removed from her home, possibly forcibly, for the procedure under general anaesthetic; (this arises in relation to insertion of coil too, see above);

iii) There may be long term distress at her loss of child-bearing capacity;

iv) Dr. Denman is concerned about potential longer-term psychological implications of sterilisation – that DD may also experience the ligation of her fallopian tubes as creating a blockage, imagine babies or eggs trying to get out or worry that more has been cut out of her than people are being honest about. Dr. Denman and Dr. L are concerned that sterilisation might force DD to grieve for the losses of her children which she has perhaps been avoiding by becoming pregnant;

v) There are potential complications of laparoscopic clip sterilisation; these are identified in the recent publication *Clinical Effectiveness Unit. Male and female sterilisation. London: Faculty of Sexual and Reproductive Healthcare; 2014*. They include damage to bowel, bladder or blood vessels which would necessitate opening the abdomen (laparotomy). These complications occur at a rate of about 2 in 1000; the risk of death associated with laparoscopy is about 1 in 12,000. Mr A and Mr Griffiths do not give precise figures for the complications. Mr Griffiths describes these risks as "*minimal*"; these risks are mitigated if the procedure is undertaken by an experienced clinician, which Mr. A undoubtedly is;

vi) Sterilisation brings with it a risk of long-term chronic pain of around 1:1,000;

vii) Some post-operative pain and discomfort is possible; long term pain is said to be "*very rare*" (Mr. A).

112. While I have adopted the 'balance sheet' approach (explained by Thorpe LJ in *Re A (Male sterilisation)* [2000] 1 FLR 549 at 560) and consider it helpful, it does not of itself resolve the issues; my final determination is ultimately informed by the *weight* put upon the various factors in favour of or against the proposed course of action that are identified therein.

113. In my view, the factors in favour of sterilisation (and against IUD/IUS) considerably outweigh those in favour of the insertion of an IUD/IUS. There are, furthermore, two factors of 'magnetic' importance (see [85(iii)] above) which weigh most heavily in the overall evaluation, pointing towards laparoscopic clip sterilisation as the outcome which clearly corresponds with DD's best interests:

i) Future pregnancy poses such a high risk to DD's life that the option which most effectively reduces the prospects of this should be preferred; this is one of those exceptional cases where medical necessity justifies the considerable interference;

ii) Sterilisation is the treatment which most closely coincides with DD's dominant wishes and feelings to be left alone to enjoy a 'normal' life free from intrusion by health and social services.

114. Significantly, I do not find that DD's fertility is a 'magnetic' factor in the best interests' assessment on the other side. As I have earlier said (see [9] above), while this case is not about eugenics, it is clear that her fertility brings no realistic prospect of parenting a child. Rather than being a benefit, it is a burden to her, bringing with it the prospect of ongoing long-term intrusion by health and social services into her life.

DD's wishes and feelings: *section 4(6) MCA 2005*

115. An important check on the invasion of DD's personal autonomy, and a statutory requirement in any event, is the obligation on me to have regard to DD's wishes and feelings. *Section 4(6)(a)* of the *2005 Act* requires me to consider the "*past and present*" 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).

116. DD has had, it appears, experience of many forms of contraception over her adult life. There is some evidence that her views about future contraception have been fashioned by experience; in recent discussions, she has recalled some of the unpleasant side-effects of hormonal contraception. Moreover, I am satisfied that she has been entirely consistent throughout her adult life in her resistance to the IUD/IUS; nowhere in the records of discussions with DD is there any indication that she would be prepared to countenance it. She is resistant to having anything 'put up inside her', and expert opinion (Dr. Denman and Dr. F) suggests (no higher) that she connects this bodily violation with some traumatic (probably sexual) abusive experience in her past.

117. While she has at times said that she would prefer to remain on Depo-Provera, recent history shows that she is inconsistent in accepting this form of contraception; while she was compliant with the administration of Depo-Provera on 18 September, she failed to attend her relevant appointment for, and declared her opposition to, this treatment in December 2014. She has in the more distant past requested sterilisation and co-operated with an appointment with a specialist obstetrician in this regard.

118. DD has not articulated her reasons for rejecting or supporting contraceptive treatment in any consistent manner. However, she has been consistent in maintaining a wish to be left alone, and to assert her personal autonomy in relation to her body; in the discussion on 16 July she is reported to have said that *"if I cannot work my body and be who I am there is no point in being on this planet. …"*. As her recent letter to Ms Y makes clear (see [17] above), "*my body is mine*", and she asserts "*human rights*" in relation to it. She abhors social work or other professional involvement in her life, and wants to be treated as 'normal'.

119. I note that at times she has said that she believes that her family is complete, and that she does not want more children; at other times she has said that she intends to go to Australia to have more children. DD's continual discussion of Child 1 indicates that pregnancy serves a function of allowing her to hope that she may be able to "replace" him, and prove that she is fit to parent. That said, I cannot reach any clear conclusion about her aspirations for more children.

120. In the context of this specific application, a number of attempts were made to educate and consult with DD about the merits, and various forms, of contraception; I summarise the most material exchanges with professionals as follows:

    i) 16 July 2014: (in hospital, the day before Child 6's birth) she said that she had never asked for sterilisation in the past (this is factually inaccurate) and did not want sterilisation now. She said that sterilisation would leave her feeling "*empty and unhappy*" … "*I want all my organs inside me*". It was explained to her that no organs would be removed. She was apparently opposed to this procedure, but showed some interest in the diagrams in the leaflets explaining it;

    ii) 18 July 2014 (first meeting: 13:00hs): at this meeting it was apparent that she thought that sterilisation involved the removal of organs; she seemed to be able to understand that sterilisation involved applying clips to the fallopian

tubes which apparently "*made her feel 'urgh'*"; she nonetheless engaged with the 'social story' involving 'Helen' (see [77]) and chose sterilisation as the best option for her.

I am struck by DD's response to the social story exercise in which DD chose sterilisation for Helen on facts which, of course, related to her situation. However, I am not able to conclude on the balance of probabilities that this demonstrates a clear and determinative wish for sterilisation over and above any other form of birth-control;

iii) 18 July 2014 (second meeting: 15:50hs): at this meeting DD requested to be sterilised, and immediately so. She became tearful when she was told that this could not happen straight away (the marked change in approach since the meeting on the 16 July was consistent with her 'black and white' thinking referred to at [74] above and does not in the view of Dr. F demonstrate adequate weighing of the relevant information); she told BC in this meeting that she was only agreeing sterilisation "*to get the idiots off my back*"

iv) 22 July: DD requested sterilisation when she met with Midwife C at a home visit;

v) 23 July: DD refused to discuss sterilisation at an unannounced home visit with Nurse I;

vi) 27 July: DD was expressing a preference for a Depo-Provera injection instead of sterilisation. She telephoned the obstetric unit at the clinic and left a message for Midwife C to that effect;

vii) 29 July: DD changed her mind when she met with Midwife C again: because "*…said she had had enough of all the letters and knocking on the door as it was "doing her head in" and she had decide to have the Depo-Provera injection*";

viii) 30 July: DD registered with the GP surgery, and requested a Depo-Provera injection that day;

ix) As discussed elsewhere in this judgment, although DD was physically compliant with the Depo-Provera injection on 18 September 2014, she evidenced a clear intention from 17 November 2014 that she did not want another injection, a view which culminated in the need to forcibly administer the last injection on 14 December. At a visit to the GP in early January 2015 she indicated that she did not want any further injections.

121. Dr. F concluded:

> "*Her wishes regarding contraception have changed dramatically, initially refusing to consider any form of contraception (16 July) to pleading for an immediate sterilisation and being strongly against hormonal contraceptives (18th July) to the current position. Her current wishes do not appear to be deeply held preferences. I am*

> *concerned that once she feels people are no longer closely monitoring her, she will disengage and stop having the 12 weekly injections"*

122. I have had further regard to the comments of Munby J (as he then was) in *ITW v Z* [2009] EWHC 2525. First, that P's wishes and feelings will always be a significant factor to which the court must pay close regard. Second, that the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. Third, that when considering the weight and importance to be attached to P's wishes and feelings, the court must have regard to all the relevant circumstances. They will include, but not be limited to, such matters as the degree of the P's incapacity; the strength and consistency of the views being expressed by P; the possible impact upon P of knowledge that her wishes and feelings are not being given effect to; the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and, crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests.

BC's wishes and feelings: *section 4(7) MCA 2005*

123. There has been no assessment of BC within these proceedings, but I am required under *section 4(7)* of the *2005 Act* to consider BC's wishes and feelings. I piece these together from a range of sources.

124. I am drawn first back to a 2009 psychological assessment of BC, which was undertaken in the context of *Part IV Children Act 1989* proceedings. Making allowances for the historic nature of that evidence, it reveals the following information about BC:

i) Psychometric (Wechsler Adult Intelligence Scale 3rd Edition [WAIS III]) demonstrated that BC had a slightly higher Performance IQ (i.e. ability to understand, reason with and use non-verbal information) of 70, compared with his verbal IQ (his understanding and use of verbal information). His full scale IQ was 62 points. This fell within the 'Significantly Impaired' Range;

ii) BC's Working Memory impairments were such that when there were competing demands he would struggle with memory more than other people;

iii) Some aspects of BC's communication style were consistent with an autistic spectrum disorder;

iv) Medical and other records have suggested that BC has Asperger's Syndrome.

125. Some assessment was undertaken of DD and BC's relationship. In a further psychological report (also from 2009) a further clinical psychologist had observed that:

> *"Indeed, both [BC] and [DD] appear to feed into each others personality features, and exacerbate, for example, beliefs in the need to defend themselves from the 'attacks' from others, and to a degree they boost each others beliefs*

> *that they do not need support. … The complex dynamics of their relationship are such that at times they will be both seek to retain control, inevitably leading one to feel that they are being 'abused' and overwhelmed, leading to the triggering of their own defensive attachment responses"*

126. More recent assessment has not been possible; the dynamics of DD's and BC's relationship is poorly understood, but observations of them together suggest that they have a co-dependent or mutually dependent relationship. Although Dr. L considers that BC controls DD to some extent, there is, in my judgment, ample evidence of the dynamic described in the paragraph above in play in the recent exchanges with professionals.

127. There is no good evidence relating to BC's view on fathering further children. At a meeting with Mr. A on 16 July, BC initially said that he would 'take care' of future contraception. On further questioning, he admitted that he had not used condoms for the last five years, and was adamant that he would not consider a vasectomy; DD, present for this conversation, told Mr. A that BC was "*sterile … and so no contraception was needed and that this pregnancy 'just happened'"*. On a visit to the couple's home on 12 January 2015, Ms Y reported that she asked BC whether she wanted DD to be sterilised:

> "*He said: 'No! It is her decision. Leave us alone'. I explained that if she was sterilised then they wouldn't be able to have any more children. He said he didn't care and again, they didn't want any more children.*"

128. What is abundantly clear from this exchange, and from the multiple contacts between BC and professional services in the distant and more recent past, is that he does not want professionals involved in his (and DD's) life, and wants "*to be left alone*". Although these views have been expressed vociferously at times of high stress and anxiety, they have also been expressed when BC has been more calmly engaging with those trying to assist the couple. Nothing in what I have read or heard leads me to conclude that he would do otherwise than oppose any planned procedure for DD, whether contraceptive or sterilisation.

Conclusion on best interests:

129. The opening 'Summary' section of this judgment draws together the key threads of the evidence and the law, which I have discussed more fully in this judgment.

130. In reaching my ultimate conclusion, I have weighed carefully the identified factors which fall on both sides of the balance (see particularly [108-111] above), and the views of DD and BC; I have had regard to the less restrictive option in its widest application, and have of course maintained focus upon the basic human rights of the protagonists. Having conducted this detailed exercise, I have reached the clear conclusion that laporoscopic sterilisation is in DD's best interests, and I shall authorise the Applicants to undertake this procedure.

131. The sterilisation treatment proposed here, and authorised by me, has one predominant purpose, and that is to preserve DD's life.

Giving effect to the order: *section 16(5) MCA 2005*: If necessary, forcible entry into the home

132. On the day of the planned procedure, medical and other professionals will attend at DD and BC's home and DD will be invited, indeed encouraged, voluntarily to attend the relevant ward of the local hospital for the procedure. The plan is that she will be admitted as a day patient and the planned sterilisation will be carried out under general anaesthetic. In view of past history, a contingency plan has been formulated to deal with any lack of co-operation. A detailed care plan has been presented to the court, which has been considered and approved by the Official Solicitor.

133. As I have commented in my earlier judgments, *section 16(5)* of the *2005 Act* gives me authority to "*make such further orders or give such directions … as* [I] *think*[s] *necessary or expedient for giving effect to, or otherwise in connection with, an order*…". This statutory provision endows the court with a wide jurisdiction, limited essentially by what is lawful, necessary and proportionate, to support its essential orders. This approach is consistent with the approach of the court in pre-2005 Act cases discussed by Munby J (as he then was) in *A Local Authority v MA & SA* [2005] EWHC 2942 (Fam), and see also *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)* [2002] EWHC 2278 (Fam), [2003] 1 FLR 292, at para [50], and *In re S (Hospital Patient: Court's Jurisdiction)* [1995] Fam 26 at page 36.

134. As I have previously concluded (see for instance [2014] EWCOP 44 [16]), this section can be used to authorise (albeit at the most extreme end of this ancillary jurisdiction) entry by force into a vulnerable person's home, and (in accordance with the deprivation of liberty requirements established by statute - *section 4A* and *section 16* of the *2005 Act* – the Mental Capacity Code and good practice guidance, discussed in the Supreme Court decision in *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor* [2014] UKSC 19), the ability to restrain the person as is necessary and proportionate.

135. The Applicants seek an order permitting forcible entry to DD's home, to permit them to remove her to a clinic where the procedure can take place, restraining DD as a 'day patient' for this purpose. I have reflected carefully on the necessity, and proportionality, of this significant intrusion into DD's home, and have concluded that – unpalatable as it undoubtedly is – there is no real alternative. In reaching this conclusion I have carefully reviewed previous such authorisations:

    i) On 8th April 2014, a warrant was executed under *section 135* of the *Mental Health Act 1983,* pursuant to which DD's home was forcibly entered; she was taken to a psychiatric unit for the purposes of an assessment of her mental disorder, and for an important placental location scan. She was assessed by two consultant psychiatrists who concluded that she has a mental disorder namely Childhood Autism and borderline Learning Disability; it was reported that "*after an initial period of emotional distress, DD became calm. She recognises the police, said Midwife C, as the local beat officers. The police presence offered reassurance and had a calming effect upon both DD and BC*" (see [2014] EWCOP 8 [30]);

    ii) Pursuant to Pauffley J's order of 18 June 2014, DD's home was further forcibly entered (on the following day) for the purposes of conveying her to a

clinic for an ante-natal scan, so that the well-being of the baby, and of DD herself, could be checked. As to this, I recorded that:

> "*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)…. 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*." (see [2014] EWCOP 11 at [41]);

iii) The Applicants then made application for further forcible entry *prior to the impending delivery of her sixth child* in order to remove DD to take her to a unit for the purposes of receiving contraception education (see [2014] EWCOP 11 [19(vii) and [145-160]); I refused this application as I was troubled about the increasing distress being displayed by DD and BC, and was keen to ensure that the removal of DD from her home for the purposes of the caesarean section was achieved with as minimal distress as possible. I said then, specifically [159(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.*"

iv) Pursuant to my order of 4 July 2014, the home was, however, forcibly entered on 16 July 2014 in order to convey DD to the hospital for the purposes of the caesarean section. In my judgment ([2014] EWCOP 11 [93]) I described the plan thus:

> "*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*"

When the team visited the home, they could not obtain an answer to their knocking. They gained entry to the home, where DD and BC became for a short time distressed. DD was helped to leave the flat, and by that time was calm, entering the ambulance independently and without restraint; she was calm on the ambulance journey, and exited the ambulance independently. As Dr. F summarised the situation:

> "*Although initially distressed, [DD] had calmed quite quickly upon getting into the private ambulance and settling in to her private room.*"

v) I made an order of the 15 July 2014, following a separate hearing, authorising forcible entry into DD's home for a time *after the impending delivery of her sixth child* to convey her to a community health service resource for the purposes of facilitating education for DD in relation to contraception, assessment of her capacity to make decisions in relation to contraception (at that hearing I also authorised the administration of a short-term contraception (Depo-Provera) by way of injection). After attempts to encourage co-operation, the Applicants entered by force on 13 August 2014; DD was so distressed by the events that it was not possible to engage her in the relevant education and, although she conveyed to a clinic for the purposes of meeting with the staff, she was quickly returned home. I referred to this incident at [2014] EWCOP 44 at [8] by highlighting my anxiety about the effect on DD of repeated forced entries to DD's home:

> "*[T]he removal of DD from her home on 13th August was considerably more difficult than that on 16th July. It was precisely the repetition of that sort of incident which had caused me to refuse the Applicant's application for the earlier proposed forced removal from the home on 7th July, prior to the caesarean section. As Mr McKendrick has pointed out, and Mr Horne agrees (and I concur), the scope for repeating this sort of procedure hereafter is now very considerably limited*".

vi) On 14 December, it was necessary to attend and forcibly gain entry to DD's home to administer the Depo-Provera injection. Social Worker D reports that DD and BC were angry at the intrusion; Positive Behaviour Specialist J was able to speak with DD. BC threatened Mr. D. It appears that the professionals had to use full seat restraint during which she had understandably become angry, upset and aggressive towards staff. It was said that:

> "*The level of distress however was of a greater level than any other previous visit … I can only assume that any future visits like this are going to increase her resentment towards*

> *professional interference in her life and she is going to become more obstructive towards the professionals involved, both verbally and physically*."

136. Thus it can be seen that each forced entry to the home has been (understandably) followed by escalating levels of distress experienced and displayed on the part of DD and BC. This is of real concern to me. I repeat what I said prior to the third such forced entry which I authorised in my 4 July 2014 judgment ([2014] EWCOP 11 [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"*

137. The same principles apply now. I would like to comment on the following aspects of the care plan:

i) It is imperative, in my judgment, that Ms J (a Positive Behaviour Specialist) is present on this occasion; she has been successful in engaging with DD and calming her on previous occasions;

ii) I accept that the presence of the police is on the whole beneficial. As I indicated in [2014] EWCOP 11 [132]

> "*The presence of the police has not aggravated the situation; on the contrary, I was advised by [social worker] 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.*"

In relation to the 14 December 2014 visit, Mr. D commented:

> "*I believe that the police officers were required to attend [DD]'s house on the day and I think that it did assist in preventing any potential breach of the peace or assaults.*"

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 sterilisation procedure. While I am satisfied that it would only be right to advise a capacitious person of the projected date for a surgical procedure (most fully in accordance with their *Article 6* and *Article 8 ECHR* rights), so that the person concerned (and those who support them) can properly prepare for this, there are obvious risks of doing so in this case. They are:

    i) Advance notice of the projected date would be likely to raise DD's and BC's stress and anxiety levels, which is likely to have an adverse effect on DD's (and possibly BC's) mental health;

    ii) That they may seek to leave their home, and/or disappear. This course has been hinted at by DD in her recent letter to Ms Y. If they were to leave the area, and move to a location where they are not known to medical or mental health services, the very risks which the professionals are here attempting to forestall are more than likely to come to pass, with dire consequences.

139. For the reasons set out above, I have concluded that it is necessary for the Applicants to withhold from DD and BC the relevant information concerning the date of the procedure.

Orders

140. For the reasons set out above, I propose to declare:

    i) pursuant to *section 15* of the *2005 Act* that DD lacks capacity to litigate in relation to the relevant issues;

    ii) pursuant to *section 15* of the *2005 Act* that DD lacks capacity to make decisions in respect of contraception;

    iii) pursuant to *section 15* of the *2005 Act* that it is lawful and in DD's best interests to undergo a therapeutic sterilisation and authorise the applicants' staff to do so, together with the provision of all ancillary care and treatment;

    Further,

    iv) subject to certain safeguards (more fully set out in the care plan and reflected in the proposed draft order) being required, I propose to authorise the applicants to remove DD from her home and take steps to convey her to hospital for the purposes of the sterilisation procedure, and authorise the use of reasonable and proportionate measures to ensure that she is able to receive the said treatment even if any deprivation of liberty is caused by the same;

v) I authorise the applicants to take such necessary and proportionate steps to give effect to the best interests declarations above to include, forced entry and necessary restraint, and authorise that any interferences with DD's rights under *Article 8* of the *ECHR* as being in her best interests.

141. I have had the opportunity to review a more detailed and comprehensive draft order which has been agreed between counsel. I approve that draft.

142. That is my judgment.

Schedule to Judgment

Dramatis Personae:

Clinical Practitioner	**Discipline**
Consultant Obstetrician A (Mr. A)	Consultant Obstetrician & Gynaecologist, Applicant Acute Trust
Consultant Anaesthetist B	Consultant Anaesthetist, Applicant Acute Trust
Midwife C	Midwife, Applicant Acute Trust
Social Worker D (Mr. D)	Mental Health Practitioner, Applicant Council
Consultant Psychiatrist E	Consultant Psychiatrist, Applicant Mental Health Trust
Consultant Psychiatrist F (Dr. F)	Consultant Psychiatrist in Learning Disability, Applicant Mental Health Trust
Safeguarding Chair G	Chair Joint Commissioning & Adult Social Care, Applicant Council
Social Worker H	Senior Social Worker, Applicant Council
Nurse I	Nurse Consultant, Community Contraception and Sexual Health, Applicant Mental Health Trust
Positive Behaviour Specialist J (Ms J)	Deputy Ward Manager, Applicant Mental Health Trust
Nurse K	Learning Disability Liaison Nurse, Applicant Mental Health Trust
Clinical Psychologist L (Dr. L)	Clinical Psychologist specialising in working with adults with learning disabilities, Applicant Mental Health Trust
Nurse M	Primary Care Liaison Nurse, Applicant Mental Health Trust
Nurse N	Community Psychiatric Nurse, Applicant Mental Health Trust
Consultant Neonatologist O	Consultant Neonatologist, Applicant Acute Trust
Speech & Language Therapist P	Speech & Language Therapist, Applicant Mental Health Trust
Speech & Language Therapist Q	Speech & Language Therapist, Applicant Mental Health Trust
Service Manager R	Service Manager Community Learning Disabilities Team, Applicant Mental Health Trust
Registered Manager S	Registered Manager of Placement, Applicant Council
Manager T	Adult Social Care General Manager, Applicant Council
Assistant Manager U	Assistant Manager of Placement
Assistant Manager V	Assistant Manager of Placement
Ms Y	Solicitor agent instructed on behalf of the Official Solicitor
GP 1	General Practitioner, Applicant's Surgery
GP 2	General Practitioner, Applicant's Surgery
GP Practice Manager	Practice Manager, Applicant's Surgery
Nurse GP Practice	Any Nurse, Applicant's Surgery

Instructed by the Official Solicitor:	
Dr. Francesca Denman	Consultant Psychiatrist in Psychotherapy
Dr. Sam Rowlands	Consultant in Sexual and Reproductive Health
Mr. Malcolm Griffiths	Consultant Obstetrician & Gynaecologist
Dr. Richard Latham	Consultant Forensic Psychiatrist
Previously instructed (in Children Act 1989 proceedings concerning DD's children) [2003]/[2009]	
Dr. Lindsey	Consultant Psychiatrist [2003]