



Neutral Citation Number: [2013] EWHC 2562 (Fam)

Case No: COP 12166222

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/08/2013

Before :

MRS. JUSTICE ELEANOR KING DBE

Between :

A NHS TRUST

Applicant

- and -

DE

1st Respondent

**(Appearing by his Litigation Friend the Official
Solicitor)**

- and -

FG and JK

2nd Respondents

- and -

C Local Authority

3rd Respondent

- and -

B Partnership Trust

4th Respondent

Miss Jane Tracey- Forster (instructed by Browne Jacobson) for the Claimant
Mr. Angus Moon QC (instructed by the Official Solicitor) appeared for the 1st Respondent
FG and JK (Not represented and appeared in person as the 2nd Respondents)
Mr. John McKendrick (instructed by Weightmans) appeared for the 3rd Respondent
Miss Victoria Butler-Cole (instructed by Bevan Britton) appeared for the 4th Respondent

Hearing dates: 29, 30, 31 July 2013 1, 2 August 2013

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.

.....

MRS. JUSTICE ELEANOR KING DBE

This judgment is being handed down on 16/8/13 It consists of 27 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

Mrs. Justice Eleanor King DBE :

This Judgment is subject to a Reporting Restrictions Order and this judgment is anonymised in compliance with that order.

Introduction

1. This is an application made by the NHS Foundation Trust in the Court of Protection for a raft of declarations in relation to a man, DE who is nearly 37.
2. DE suffers from a learning disability. He lives with his parents FG and JK. With the dedication of his parents and the support of his local disability services, DE has prospered and achieved far beyond what may have been expected given his level of disability. Prior to 2009, not only had he achieved a modest measure of autonomy in his day to day life, but he had a long standing and loving relationship with a woman, PQ, who is also learning disabled.
3. In 2009 PQ became pregnant and subsequently had a child XY. The consequences were profound for both families; legitimate concerns that DE may not have capacity to consent to sexual relations meant that protective measures had to be put in place to ensure that DE and PQ were not alone and DE became supervised at all times. DE was clear that he did not want any more children. His relationship nearly broke under the strain but remarkably it has weathered the storm
4. There is no question of DE having the capacity to make decisions as to use of contraception. FG and JK formed the view that the best way, in his interests, to achieve DE's wish not to have any more children and to restore as much independence as possible to him was by his having a vasectomy.
5. It is in this context that the court has come to consider the NHS Trust's applications for the following declarations:
 - a) DE does not have capacity to make a decision on whether or not to undergo a vasectomy and to consent to this procedure;
 - b) That it is lawful and in DE's best interests that he should undergo a vasectomy;
 - c) It is lawful for the NHS Trust to take any steps which are medically advised by the treating clinicians at the trust responsible for DE's care to undertake this procedure which may include the use of a general anaesthetic and all such steps as may be necessary to arrange and undertake the procedure including general anaesthesia.
6. The 2nd Respondents to the proceedings are DE's parents. The 3rd Respondent is the Local Authority within whose area DE lives and the 4th Respondent is the B Partnership Health Trust, the health care trust who has been responsible for carrying out substantial amounts of work with DE during the course of these proceedings.
7. Given DE's learning difficulties he has been deemed to lack capacity to act on his own behalf in these proceedings and on 18th June 2012 the Official Solicitor was invited to act as DE's litigation friend.

8. If the declarations sought are made it will, the court is told by the Official Solicitor, be the first time that a court in this jurisdiction has made orders permitting the sterilisation for non therapeutic reasons of a male unable to consent to such a procedure.

Background

9. DE suffers from life long learning disability, which is an impairment or disturbance of the functioning of his brain or mind. DE was tested using the Ammons Quick test of IQ by Dr. David Milnes, the independent Consultant in psychiatry of learning disabilities instructed to provide an opinion in this matter. This test suggested that DE has an IQ of 40. People with this level of IQ have an adult mental age of between 6 and 9 years, which gives an indication of the magnitude of DE's difficulties. In real terms it means that DE could not live on his own, he cannot use money, he has limited speech and is dependant on his parents to provide him with significant support both practical and emotional. The family have taken advantage of all the excellent services available to the learning disabled in their area with the result that DE has had an interesting and varied life with plenty of social contacts out side the family and as much independence as is possible.
10. JK has over 30 year's experience of caring for the learning disabled. She is part-owner and manages the day centre which DE attends each day. FG has retired but on a voluntary basis he regularly works with the learning disabled, including coaching at the swimming club which DE attends.
11. DE has been particularly fortunate in his parents. They have worked tirelessly to give him the best possible quality of life and in particular to ensure that he has as much independence and autonomy as can possibly be achieved. Although it took 15 years of patient work and support to get to that stage, by 2009 when PQ became pregnant, DE had learnt to travel to the day centre on the bus on his own (albeit with a telephone call to remind him to set off and a support worker knowing which bus to look out for when he arrived). In addition DE was able to walk through town to a leisure centre where he went to the gym with a friend and also to go to the local shops from his day centre without support. DE is a keen swimmer, going to training sessions for those without disabilities as well as the club at which his father coaches. He also loves football.
12. For over 10 years PQ had been DE's girlfriend. In addition to all the day to day support and provision of services outlined above, the Local Authority and DE & PQ's parents each supported their relationship. De and PQ saw each other alone in town, at evening clubs and social activities, their telephone calls were unsupervised and they spent time at each other's homes with limited supervision. DE's social worker, MB (who specialises in supporting disabled adults), told the court how very unusual it is to see such an enduring relationship between two significantly learning disabled people, it is she said remarkable and very *precious* and should be valued and protected in their interests.
13. That then in broad terms was DE's life prior to the birth of XY in June 2010. DNA testing confirmed that DE was XY's father. PQ's learning disabilities, although not as severe as DE's, nevertheless meant that she was unable to look after her baby herself and the local authority issued care proceedings in relation to XY. These were

resolved by agreement by the making of a Special Guardianship Order in favour of XY's maternal grandmother at whose home XY and PQ both live. PQ is unable to take XY out unaccompanied, requiring the assistance of a support worker. In this way she is able to go out and about with XY including to the social club she attends.

14. Prior to the pregnancy DE's parents and PQ's parents had routinely arranged for them to visit each other's houses and they saw each other regularly. I think it likely that DE's parents did not appreciate that the relationship was fully sexual. FG and JK undoubtedly had some reservations about the relationship; in court they were tactful and reluctant to articulate precisely what it was that made them less than happy about PQ. Reading between the lines I suspect that they felt that PQ was drawing DE into a relationship the nature of which he could not fully understand; indeed shortly after XY was born, when feelings were running very high, they suggested that DE had been sexually exploited by PQ. JK undoubtedly said some intemperate things at what was a very difficult time and the atmosphere, in what was usually a relaxed, happy household largely geared round ensuring DE's health, happiness and the maximising of his independence, became discordant and strained.
15. It is hardly surprising that the impact on the family was considerable; not only had DE and PQ had a child for which neither would be able to care, but the Local Authority issued care proceedings. If that were not enough to contend with, DE's life was turned upside down his routine rapidly had to be changed so as to ensure that he and PQ were not alone together. Visits to each other's home were stopped.
16. All agree that everything that occurred around this time caused DE considerable distress; he knew his parents were upset, which upset him, his tried and tested routines were interrupted and he no longer spent any time alone with PQ. DE struggled to understand what was going on and denied that XY was his baby. At that time he did not seem to comprehend that anything that he and PQ had done together had resulted in the birth of a child.
17. DE's parents were very concerned that no matter how hard they tried to supervise the relationship there was a possibility of another pregnancy. On 26th July 2010 GH discussed with the family's GP Dr. LM the possibility of DE undergoing a vasectomy. Dr. LM referred DE to the applicant NHS Trust by letter on 24th July 2011. Mr. XX, consultant urological surgeon at the NHS Trust, said that he could not see how it would be in DE's best interests to have a vasectomy. That remained his view when he gave evidence on 23rd April 2013, namely that "*my personal view is that a vasectomy is probably not in his best interest, but if the court thought it was the right thing I would be willing to carry out the procedure.*" It is accepted by all, including the NHS Trust for whom Dr XX works, that the views of other professionals who know DE better and have experience of learning disabled people, will be of more value to the court in assessing DE's best interests.
18. On 3rd June 2012 the applicant NHS Trust applied for declarations which would allow a vasectomy to take place. Permission was given to make the application and orders for directions were made on 3rd July 2012 and 17th October 2012 with reporting restrictions orders being made. Following on from JK's first approach to the general practitioner, work was carried out by ZZ a community learning disability nurse and CH, a clinical psychologist, to assess DE's understanding of the vasectomy procedure and capacity to consent to it.

19. I have considered how to describe ZZ's role; her contribution to DE's life, her skill and her professionalism can only be described as exceptional. Other than his parents, nobody knows DE better. ZZ worked with DE long before XY was actually born. In these early sessions DE consistently said he did not want any more babies. In ZZ's view he clearly did not have capacity at that time to consent to sexual relations.
20. The Official Solicitor instructed Dr. David Milnes to provide an independent psychiatric report. Dr. Milnes's 1st report dated 2nd November 2012 concluded that DE did not have capacity to consent to sexual relations or to contraception. At that time, based on information he had been given by XX that there was a not insignificant risk of long term chronic pain following a vasectomy procedure, Dr Milnes felt, on balance that a vasectomy would not be in DE's best interests.
21. Following the receipt of that report it was obvious to all that if DE did not have capacity to consent to sexual relations, then it would follow that it would be unlawful for anyone to have sexual intercourse with him. Serious sexual safeguarding issues therefore arose. In a report filed at that time ZZ made a plea for proportionality saying:

...given DE's historical and consistent expressed desire to have a relationship with PQ and the significant steps that he has achieved recently to attain a degree of independence, I would be keen to ensure that any protection plan was balanced and proportionate.....from a clinical perspective, my concern would be to ensure that the level of any restriction or supervision that is placed on DE (particularly with his contact with PQ) does not detract from the independence that he has attained or disrupt his social relationship with PQ in its entirety as my impression is that this relationship is very important to him.

22. At a hearing on 15 November 2012 in the light of Dr Milnes' report the court made by consent an interim declaration that DE did not have the capacity to consent to sexual relations. The Local Authority, quite properly and appropriately, thereafter held a Safeguarding Adults' Conference on 30 November 2012. A Protection Plan was put in place meaning that DE and PQ were not to be left alone without supervision. Inevitably this had a significant impact on all DE's activities, for example transport home being provided instead of DE getting the bus to avoid chance meetings with PQ. MB summarised the impact on DE as having *experienced the loss of:*

- a) Engaging without supervision/staff support, with the local community
- b) Walking through town from one venue to another with a friend
- c) Going to shops, making purchases, interacting with traders and passers by
- d) Using the local gym and facilities on the same terms as any other participant

and that is before one factors in the loss to DE of any form of privacy or time on his own with his long term girlfriend.

23. At about this time PQ ended the relationship with DE to his considerable distress. At the time it was not clear why PQ had decided to do this but, in due course, it was realised that she had wrongly believed that these proceedings in some way related to XY and she thought that if she stayed with DE she might lose her baby. In addition to this fear it had had to be explained to PQ that if she and DE had sexual intercourse she would be committing a criminal offence. It is hardly surprising that, frightened and with a limited ability wholly to understand what was happening, PQ completely withdrew from DE. DE therefore suffered a further loss, namely the loss of PQ between about November and June of 2013.
24. MB initially felt that DE coped well with the increased supervision and filed a statement to that effect but, as time went on it became clear to her that there was in fact a marked adverse impact upon DE. Gradually his ability to go out and to do things on his own was being lost and by April 2013 there were considerable concerns about DE's reduced level of independence. It has to be remembered that each achievement on DE's part takes months if not years to be gained and if not used and reinforced is quickly lost. FG told me that as winter approached last year DE stopped going to the day centre on the bus on his own, she said DE said that it was because it was cold, but Dr Milne felt it may well have been a loss of confidence and fear of doing wrong.
25. Due to the late, (but essential), entry of the local authority into the proceedings, what was intended to be a final hearing listed for 15th and 16th November 2012, was adjourned. XX provided a supplementary statement which significantly moderated what were the somewhat surprising views expressed in his first report in relation to "long term post operative"; problems. In the light of the significant diminution in perceived risks of chronic pain following a vasectomy, Dr Milnes produced a further report dated 17th February 2013 where he concluded that DE's best interests lay in a vasectomy being carried out.
26. The Official Solicitor obtained the views of an independent consultant urologist Mr. Jonathon Ramsey who in his report dated 4th April 2013 favoured XX's moderated opinion and expressed the view that the likelihood of severe scrotal pain following vasectomy is less than 0.5%.

The Trial

27. It had been hoped that the trial could proceed in April 2013. Evidence was heard from:
 - i) LM, DE's General Practitioner. With respect to LM his evidence given his very limited involvement with DE, took the matter no further.
 - ii) XX gave evidence that 0.5% was indeed a reasonable percentage reflecting the risk of chronic or severe scrotal pain. He himself had never had a patient come back with chronic scrotal pain. In answer to questions from the court XX said that he regarded a vasectomy as "*a routine safe form of long-term contraception for men*" and agreed that that view should be the starting point

for the court's consideration of the issues. XX said that he would use a procedure called the Li-no-scalpel technique which was the least invasive procedure and he himself would carry out the vasectomy.

- iii) YY, a consultant anaesthetist, also gave evidence; his view was that the operation could be carried out under local anaesthetic and the risks were "*one in a million*". Were it necessary to convert to a general anaesthetic the risk was one in 400,000, he regarded the procedure as "*very safe*"
 - iv) CH a Clinical psychologist who has done work with DE in the past and knows him well also gave evidence. It became clear during the course of her evidence that she considered that DE might be able to attain capacity to enter into sexual relations in time if the right sort of direct work was done with him. This suggestion clearly has a significant impact on the ultimate issue as to whether or not it is in DE's best interests to have a vasectomy. By agreement therefore the hearing was adjourned so that CH and ZZ could carry out further work with DE to assist him to acquire capacity to enter into sexual relations.
28. The matter was relisted for a further 5 days in July 2013. CH and ZZ have both produced witness statements setting out in detail the considerable amount of work (14 one hour sessions between April and July) done since the last hearing. The commitment shown not only by CH and ZZ but also JK cannot be overstated; DE has been reluctant but largely compliant and so roughly twice a week JK has had to coax DE to go and make arrangements to get him to and from the sessions. All the while JK has been working, running her own business and coping with the continuing anxiety about these proceedings.
29. By about March 2013 DE and PQ had resumed their relationship. PQ told her social worker that they kissed and cuddled but she understood that they could not be sexually intimate. Having spoken to DE and PQ, MB is clear that there is a sexual element to their relationship and that they would both like to engage in sexual relations in the future.
30. On 14 May 2013 a Safeguarding Review meeting was held by the Local Authority. At this meeting MB raised her concerns (shared by JK), about DE's loss of independence. A number of changes have been made following the meeting to enable DE to get out and about more whilst still supervising DE and PQ when they are together. By way of example DE now works weekly on a market stall run by his Day Service; staff are present but there is interaction with the public, he has time in the town centre and has a chance to visit other stalls. JK also told me in evidence that they have started the long, tortuous but hugely valuable process of DE being able to walk from his work base to a club in the company of a friend with whom he walked before PQ's pregnancy.
31. JK told the court:
- "I feel DE's world has been tipped upside down. We always encouraged him to do the best he could, go out and be as independent as he could, taking into account his learning disabilities and speech, like going on the bus to the next town. It took him 15 years to do that. Things don't come easily. Now I*

feel we've gone back a few steps. Even when the restrictions have been lifted, like walking from the base, he was very reluctant to do it. His confidence has been knocked back... I would like to get him back to where he was with his independence”.

32. By July at the completion of their work, CH and ZZ are both of the opinion that DE now has capacity to consent to sexual relations. Dr Milne, MB and the parents all agree.
33. Dr. Milnes produced a third report dated 21st July 2013 having seen DE on 12th July. Dr. Milnes also expressed the view that DE now has capacity to engage in sexual relations and that being so he concluded that a vasectomy is in his best interests.
34. The Official Solicitor has felt it necessary, notwithstanding the universal views now expressed by the witnesses, to explore the issue as to DE's capacity to enter into sexual relations. At the conclusion of the oral evidence in relation to this aspect of the case, the Official Solicitor now accepts that the court should proceed on the basis that DE has capacity to enter into sexual relations. Having read all the reports and heard the evidence I am satisfied that DE has capacity to enter into sexual relationships, although it will be necessary for him to have so called 'top-up' sessions to ensure that he remembers how to keep himself safe from sexually transmitted infections and diseases.
35. Whilst DE can consent to having a sexual relationship, it is accepted by all parties that he does not have capacity to consent to contraception and will not regain the necessary capacity. It is therefore remains for the court to determine whether or not it is in DE's best interests to have a vasectomy. In order to carry out the balancing exercise required in order for the court to reach a decision it is necessary for the court to consider in some detail certain aspects of DE's life and of his views in so far as they can be ascertained.

DE's personality

36. DE needs extensive support. He has very limited speech although with the benefit of the highly skilled work such as that carried out by CH and ZZ, “responds” well to visual aids. As these key people have got to know DE they have learnt to weave their way through his seeming inconsistencies until they are satisfied that they have a clear picture of DE's views or wishes.
37. The description of DE given by both JK in evidence and LM, Dr Milnes, ZZ and MB is in remarkable accord. He is described as a friendly, gentle person. He is cautious and by nature a man who will keep to the rules.
38. DE is well liked by his friends. He is not particularly assertive and if he is not unduly concerned about something he will simply go along with it, he is, I am satisfied persuadable to a certain degree. Those that know him best are clear that if he feels strongly about something he will find a way of doing what he wants notwithstanding that it does not accord with the wishes of someone close to him. It is important that it is borne in mind that as DE lacks a facility in language he will not express himself

orally but simply remove himself or just do what he wishes. There have been several examples given to the court:

- i) PQ wishes DE to go to their social club, it clashes with swimming - he goes swimming;
- ii) DE is very conscious that his parents have reservations about PQ separate from their anxiety about a further pregnancy. DE has resumed his relationship with PQ although he has tolerated, without objection, the restrictions imposed upon them.

39. The Official Solicitor has been exercised by the possibility that DE simply, as Mr Moon put it, *parrots* the views of his parents and that they have undue influence upon him. With respect to Mr Moon that in my judgment is too simplistic a way to think of it. It is agreed by all, including his parents, that FG and JK have considerable influence upon DE. I asked Mr Moon to withdraw the word 'undue' as I regard that as unfair and pejorative and Mr Moon is clear in his written submissions that he makes no criticism of the parents. It is inevitable in my judgment that DE will be heavily influenced by his parents; he looks to them for all his needs. As JK said in evidence *I keep him safe and he knows I make what he wants to happen happen for him.*
40. I have the utmost admiration for both of DE's parents. How easy would it have been for them to have been catastrophically over protective? To stifle him and to deny him any independence in an excess of caution. Far from that, JK has worked throughout to give DE as much independence as possible. The fact that DE's parents have encouraged him to go on his own to meet a friend for coffee and to go to the various clubs means that he is not wholly inward looking and dependant upon his parents for all social engagement. To their great credit he has a life separate from them which included PQ.
41. Whilst I complete accept that DE is significantly influenced by his parents, happily for DE, that influence loving and practical and has resulted in his having a quality of life which many with his difficulties could not hope to achieve. I am satisfied that he is capable of an independent view which can be ascertained by the likes of ZZ and more recently MB. Notwithstanding this I am equally satisfied that the notion of a vasectomy came from his parents and indeed this is borne out by Dr Milne who told the court that when he first saw DE, DE did not know what a vasectomy was.

DE's wishes and feelings

42. There are three areas in which it is relevant to consider DE's wishes and feelings:
- i) Where he wishes to live
 - ii) Does he wish to have any more children
 - iii) Does he wish to have a vasectomy
43. It is accepted by all that DE wishes to continue to live at home; his mother said in evidence that the only two things about which DE is consistent is that *he doesn't want to have a baby and he doesn't want to leave home.* I accept the submission of the

Local Authority that this is an important and significant factor when assessing his best interests as FG and JK will continue to care for DE indefinitely and it will be in that context that his life will continue to develop. It follows that as with all close families with or without disabilities, each persons comfort and happiness is, in part, dependant on and a reflection of, the comfort and happiness of the other family members.

DE's expressed desire to have no more children.

44. As will be clear from the paragraphs above, it is not straightforward to tease out DE's genuinely held wishes. I have been struck by the thoughtful, careful way in which all the witnesses have responded to Mr Moon's questions; on certain topics where appropriate they have expressed doubt, but the one matter in relation to which they have all been completely confident is that DE does not want more children.
45. It will be remembered that DE is not a youth; he is a man of 37 who has a child. Dr Milnes says that had DE not already had a child he would be more concerned about how he regarded DE's expressed view. DE has a far better understanding of matters when he has experienced an event and DE has experienced having a child. He said to Dr Milnes about a "*child I've got one*" that, Dr Milnes says, is a common and valid reason men give for not wanting another child. DE associates the time of XY's birth as a period of considerable distress and upset for all his family. DE Dr Milnes said personally suffered significant psychological distress. Mr Moon suggested to Dr Milnes that having been through it once, it would not be upsetting a second time. Dr Milnes disagreed believing that it may be worse for DE a second time.
46. Dr Milnes agreed with Mr Moon that on a simple level DE takes pride in XY. When he sees XY, (as he does with PQ for short periods of time), he has been seen to play with XY and call him '*my child my child*'. However when Dr Milnes showed DE photographs of men playing with children of various ages, (as opposed to caring for children), he said he did not want another child. When asked by Mr Moon if DE had gained a great deal by having a child Dr Milne replied *I don't know. He has experienced a great deal of distress and anxiety and some confusion.*
47. Mr Moon has sought to draw a distinction between parenting of a child and 'conceiving' or fathering a child. He has suggested that whilst DE may not want the responsibility, (even if he were able), to parent a child, a time may nevertheless come when he wished to 'father' another child; that is to say to conceive but not parent a baby. Thus says Mr Moon if DE has a vasectomy he is being deprived of his right to father a child.
48. Mr Moon is aware that in relation to DE I have found this distinction unhelpful. I find that DE is wholly unable to make any such a distinction himself; he has only ever had the briefest contact with XY fully supervised in public. He has never changed a nappy, fed XY or done any caring for his child at even a basic level and has never indicated any desire to do so. The unanimous evidence is that DE's views are more reliable in relation to matters of which he has experience and, so far as DE is concerned therefore, his only experience is as a 'father' as opposed to as a 'parent' and he is clear he does not want another child. When cross examined on this topic Dr Milne's evidence was that he believes DE does not want to either conceive or parent a child, even if that is an appropriate distinction to make.

49. The court must consider the possibility of DE changing his mind in the future. There is no evidence that suggests that that might be the case and DE has been clear throughout that he does not want another child. Whilst I bear the possibility in mind, I regard it as unlikely that DE will change his mind.
50. I am satisfied that DE does not want to have another child:
- i) The evidence of all those who know DE and have the skills to ascertain his wishes are clear that DE knows what it is to be a father and does not wish to have another child.
 - ii) DE has had the experience of having a child and is therefore able to bring to bear his own life experience, an important feature given his inability to think in abstract terms.
 - iii) DE is very well aware of the upset and distress which was the result of XY's birth; he would not wish to repeat it.
 - iv) I am satisfied that DE's own limitations render him childlike much of the time, and accept the evidence that it is highly unlikely that he would ever wish again to be in a situation where his own routine and life at home with his parents is so disrupted.
51. Dr Milnes regards being able to achieve this outcome for DE as the magnetic factor in favour of a vasectomy being carried out, with the stress and psychological upset likely to be caused to DE in the event of a further pregnancy as a further, although less, significant factor.

DE's wishes and feelings in relation to the proposed vasectomy

52. It is agreed that DE lacks the capacity to weigh up the competing arguments for and against having a vasectomy. That is not going to change no matter how dedicated and skilful the work carried out with DE may be. His wishes and feelings in relation to having a vasectomy have rightly been explored. He has been broadly in favour of the idea although in his most recent session with CH and ZZ on 23 July 2013 and with Dr Milnes, he expressed a view that he would prefer to use condoms. Neither CH nor Dr Milnes think these recent meetings are wholly to be relied upon. On 23 July, DE had just learnt that a very close friend had died and was deeply distressed, in addition, he had just had a session in which the issue of pain immediately following a vasectomy was discussed with DE. CH thought that this may have been the influencing factor. Dr Milnes' final view is that if it is explained to DE that a vasectomy is foolproof in relation to "*no more babies*", but that he might conceive with a condom *he would go for the vasectomy*.
53. I approach DE's wishes and feelings in relation to a vasectomy with the utmost caution. DE does not have the capacity to consent to a vasectomy and that must inevitably colour the court's approach. In my judgment the safer approach is to conclude:
- i) DE is clear and consistent that he does not wish to have another child

- ii) DE does not have the capacity to consent to contraception; it is therefore for the court to consider whether a vasectomy is or is not in his best interests having taken into account his wishes in respect of not having a baby.

54. In relation to the reported cases on consent to contraception there remains uncertainty as to whether a man needs to understand female contraception as well as male contraception before he is deemed to have capacity. In my judgment DE does not have the capacity to consent to contraception on any level. I therefore do not need to consider the issue and do not propose to comment on how a court, having heard full argument in a case where the issue is relevant, might decide.

Alternative contraception

55. The only two alternatives for contraception for DE are use of a condom or a vasectomy. In my judgment the court should not factor into account any contraceptive measure PQ may be taking for two reasons:

- i) The evidence is that PQ is unreliable in taking the contraceptive pill and has a phobia of needles so a Depo injection has been discounted.
- ii) In the event that the relationship breaks down, it is likely that he will form another relationship. In the group of learning disabled people who form DE's social circle, it is the norm for there to be relationships within the group; DE is popular and friendly and after 11 years with PQ accustomed to having a girlfriend. Even if PQ was wholly reliable in relation to her own contraceptive care, a future girlfriend may not be so assiduous.

56. A considerable amount of work has been done with DE since April to help DE learn to use a condom. Much progress has been made although there are defects in his technique. Dr Milnes believes there is further progress to be made but, says Dr Milnes, as the statistics show, using a condom is *quite difficult*. Dr Milnes told the court that if the user of the condom has *perfect technique and is very very careful* the risk of a pregnancy over a 12 month period is 2%. However in relation to the *typical, imperfect less than very very careful user* the incidence of pregnancy jumps to 18%.

57. These statistics do not relate to the learning disabled. It should be remembered, said Dr Milnes, that DE has had the equivalent of a full year's input and training in the space of 12 weeks and still he is not quite using a condom correctly; even though his technique would improve with more training, Dr Milnes was not to be moved from his opinion that that the best level of protection which could be achieved for DE using a condom would be at best an 18% failure rate and probably worse.

58. It goes without saying that the likelihood of pregnancy would be far greater in the event that DE failed to use a condom. Dr Milnes reluctantly conceded that, with regular clear instruction, DE would be as likely to use a condom as a person with capacity. Dr Milnes summed DE's position as follows: *vasectomy no babies; condom – might be babies*.

59. In my judgment there is a substantial risk of a further pregnancy. I cannot agree with Dr Milnes' reluctant concession to Mr Moon that with regular instruction, DE is as likely to use a condom as a man with capacity; it fails to take into account that until

now he has only practised on a false phallus, that he has expressed reluctance to use a condom and what has been called in this hearing the ‘*heat of the moment*’ factor. In my judgment it would be unrealistic to expect that DE’s use of a condom would be other than unreliable at best.

60. In my judgment when considering in DE’s best interests as to how his wish to avoid having further children is to be best achieved, the court would not be doing its duty when forming a view (effectively on DE’s behalf), as to the best form of contraception to understate the risk of a future pregnancy in the event taht condoms are to be relied on in the long term as DE’s contraceptive protection.
61. In weighing up the matters in favour and against the use of condoms versus a vasectomy, the court at no stage underestimates the seriousness of making an order which has the effect of taking away the fertility of a man. For the purposes of making the decision in this case I regard a vasectomy as permanently sterilising DE. I do not factor in favour of a vasectomy that there is a 44% chance that a vasectomy can be reversed, particularly as it is only in the most exceptional cases that such a procedure would be carried out by the National Health Service.
62. Dr Milne (in common with ZZ, MB CH and the parents) was clear that he believes it to be in DE’s best interests to have a vasectomy. He said in his report and confirmed in evidence that:

“It is clearly in DE’s best interest to have a vasectomy as the benefits of the procedure outweigh the principal cost which is a small risk of significant side effect namely long term testicular pain.

It is my opinion that the potential benefits of vasectomy clearly outweigh the costs. It is the most effective method of preventing him fathering another child, an outcome which he has clearly stated that he wishes to avoid.”

Consequences of a further pregnancy

63. In the event of a further pregnancy there would undoubtedly be further and probably more serious psychological distress and consequences for DE:
- i) Not only would DE be upset, as he does not want another child, but so too would be his parents, which has a direct and significant impact on DE’s well being and happiness. The court is not directly concerned with the interests of FG and JK, but it is concerned at how their levels of tension and distress impact on DE’s welfare and comfort and it is clear that that the impact is considerable.
 - ii) The court was told that in the event that PQ has another child, that baby would in all likelihood be taken into care and placed for adoption. When these proceedings were issued PQ broke off her relationship with DE as she wrongly believed them to be in someway connected with XY. There is no doubt that if

a baby was taken from PQ it would impact very significantly on DE and might well lead to the termination of this enduring relationship, a relationship which all the professionals involved regard as of great importance to him and which must be protected and nurtured in his best interests. DE was very upset when there was a three or four month hiatus in their relationship, I am satisfied that if the relationship foundered due to another pregnancy it would be a real and enduring loss to DE.

Impact on DE's life in the event that there is no vasectomy

64. If there is to be no vasectomy, I am satisfied that even though DE has the capacity to consent to sexual relations, there will continue to be a level of supervision which one would not wish in his interests to see. JK explained that she would not, for example, feel able to encourage DE to start travelling on the bus alone. The bus she explained goes past PQ's home and she would be worried that DE would get off and they may have unprotected sex or, given the high incidence of pregnancies with condoms, she may in any event become pregnant. If DE had a vasectomy she would feel able to encourage him to use the bus.
65. It is in DE's best interests for him to resume the life he had before PQ's pregnancy in so much as that can be achieved. It is no answer, as was suggested by Mr Moon, to say that because DE has not strained against the restrictions which have dramatically curtailed his independence, then it is not a significant feature. DE's independence was hard won and no one could fail to admire the efforts that JK and the workers are presently making to reintroduce DE to walking a 10 minute route with a friend without a support worker. Such advances take not weeks but months or, in the case of the bus, years to achieve and much of that progress has been lost. All those who care for DE (in every sense of the word), want to see his previous independence restored so that he can once again go to meet a friend for coffee or stroll in town with his friends.
66. DE's relationship with PQ is back on track. Dr Milnes said that the relationship is *very very important* to DE, *10 years plus for a relationship is, he said, unusual in any group*. Dr Milnes told the court that from DE's perspective this relationship is very important and must carry great weight in the balancing exercise to be carried out by the court.
67. Dr Milnes explained that DE needs total support from his parents in all aspects of his life, supervision is necessary for his protection and well being; who is to say that his mother would be wrong, and not acting in DE's best interests, if the level of independence she felt it wise to promote was less, and the supervision greater, in the event that the contraception used by DE was in the form of condoms.
68. DE has had to spend many hours with CH and XX over the last few months often twice a week. He has, not surprisingly, become "fed up" although given his amenable personality and desire to please, he has gone when asked to do so. Work will have to continue with DE in any event, but this will be at a low level reminding him periodically of the importance of using condoms as protection against STDs and STIs. Such work is different from expecting him to embark on further training in the use of condoms involving as it will practical work which he finds embarrassing. This is a small matter in the general scheme of things but is part of the overall picture which

overwhelmingly points to re-establishing as normal a life as possible as soon as possible for DE.

The Law

69. DE lacks capacity in relation to a number of important areas of his life namely:

- i) To litigate
- ii) To decide whether or not to consent to contraception
- iii) To decide/ consent to undergo a vasectomy procedure

DE does however have capacity to consent to sexual relations.

Where a person lacks capacity the Mental Capacity Act 2005 provides at *Section 1(5)* that:

“(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.”

70. Guidance is given in relation to the various factors which should be taken into account when a decision is made on behalf of a person lacking capacity. In so far as they apply to DE’s circumstances they are as follows:

4. Best Interests

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—

(a) the person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5)....

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a)...

(b) anyone engaged in caring for the person or interested in his welfare,

(c)....

(d).....

as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—

(a).....

(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

(9)....

(10)....

(11) "Relevant circumstances" are those—

(a) of which the person making the determination is aware, and

(b) which it would be reasonable to regard as relevant.

71. The court must consider all the *relevant circumstances (s4(2))* which are those of which the person making the determination is aware and which it would be reasonable to regard as relevant. *(s4(2))*.
72. The Human Rights Act 1998 incorporated into English law the European Convention of Human Rights. Any determination in relation to DE's welfare must therefore be considered against the backdrop of DE's rights as enshrined in the ECHR. Article 8 provides:

Right to respect for private and family life

1. Everyone has the right to respect for his private and family life

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the

protection of health or morals, or for the protection of the rights and freedoms of others.

73. Genetic parenthood without more is not sufficient to found a right to respect for family life under Art 8. In *Lebbink v Netherlands* 920050 40 EHRR 18, the court held:

“The Court does not agree with the applicant that a mere biological kinship without any further legal or factual elements indicating the existence of a close personal relationship, should be regarded as sufficient to attract the protection of Art 8”

74. It follows therefore that DE’s right to respect for family life under Art 8 is not violated by a decision that would reduce the likelihood of him becoming a genetic father in the future.

75. The question as to whether DE’s right to respect for *private life* is engaged is a different matter, encompassing as it does the right to personal autonomy and the right to conduct one’s life in a manner of one’s choosing; this includes respect for a person’s choices relating to their own body and control over their physical and psychological integrity. See *Pretty v United Kingdom* 920020 35 EHRR1 para [61]-[62].

76. Mr McKendrick on behalf of the Local Authority submits that the right to respect for *private life* guarantees respect for the right to choose whether or not to become a genetic parent. In particular he refers to two decisions:

- i) *Dickinson v UK* 920080 46 E.H.R.R. 41, a case concerning the refusal to grant artificial insemination facilities. It was held that Article 8 was engaged because the decision concerned the applicant’s private and family life *which notions incorporate the right to respect for their decision to become genetic parents*. The choice whether to become a genetic parent was described as *a particularly important facet of an individual’s existence or identity* [78]

- ii) *Evans v UK* 10 April 2007:

The Grand Chamber agrees with the Chamber that “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 worldincorporates the right to respect for both the decisions to become and not become a parent.

77. It follows therefore that the application of DE’s right to respect to private life involves competing rights which the court has to balance and consider:

- i) If DE undergoes a vasectomy the likelihood is that DE loses or has significantly reduced his ability to make the choice to become a genetic parent in the future;

On the other hand -

- ii) Under Art 8 DE has a right to respect for his autonomy which includes his decision not to have any more children and his wish to develop a sexual relationship with PQ which should be as anxiety free as possible.

78. Mr Moon in addition refers the court to Article 23 of the United Nations Convention on the rights of Persons with Disabilities (UNCRPD). The UNCRPD was ratified on 8 June 2009 but has not been incorporated into English law. Article 23 says:

1. State Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

(a)The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;

(b)The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;

(c)Persons with disabilities, including children, retain their fertility on an equal basis with others.

79. Mr Kendrick points out that, as with Article 8, potentially conflicting rights are also to be found within the UNCPD, for example Article 26 imposes upon the Government the obligation to:

“1.take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.”

80. Mr Moon suggests that in so much as it is appropriate to have a starting point when undertaking the task before the court it should be the rights enunciated in Article 8 and Article 23 which are such a starting point. I disagree and respectfully adopt the approach of Lord Justice Thorpe in *K v LBX* [2012] EWCA Civ 79 who said [32]

“There is in my judgment an artificiality in debates as to whether some proposition is a presumption, a starting point or a cross check”

81. Lady Justice Black went on to [53] speak of the risk that a prescribed starting point may deflect the decision-maker’s attention from one aspect of Article 8 to another and commented on the danger that, in its wider form, Article 8 carries with it *the danger that it contains within it an inherent conflict* (in that case between private and family life and in the present case, as identified above, different aspects of private life.)

82. Lord Justice Davies said: [62]

“Mr Armstrong has in effect wrongly conflated the approach that is called for when Article 8 is engaged in this context with the approach that is to be applied when making an overall determination under the 2005 Act. The general approach under the 2005 Act is laid down in section 4, with the principles set out in section 1 also applying. To add a further legal starting point to the act is not called for.”

83. I approach the decision to be made in this case as identified by Davies LJ namely that proper consideration can be given to any Article 8 (or Article 23 & 26) points which arise in the context of the section 4 Best Interests appraisal.

84. The courts have considered how s4 is to be applied in a number of reported cases. There is consensus that as matters stand the following should be borne in mind:

- i) The decision must be made in DE’s best interests not, in the interests of others although the interests of others may indirectly be a factor insofar as they relate to DE’s best interests. *Re Y (mental incapacity:bone marrow transplant* [2007] 2 FCR 172 and *Re A (Male Sterilisation)* [2000] 1 FLR 549.
- ii) The court is not tied to any clinical assessment of what is in DE’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.
- iii) Best Interests is an objective test *Burke v GMC* [2005] EWCA 1003.
- iv) 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*.
- v) There is no hierarchy in the list of factors in s4 and the weight to be attached to the various factors will depend upon the individual circumstances: *Re M.ITW and Z and Others* [2009] EWHC 252 Fam [32].
- vi) 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 252 Fam.

- vii) 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.
 - viii) The declaration should not be sought if vasectomy would be disproportionate and not the least restrictive step, risk management is better than invasive treatment *A Local Authority v K & Otrs* [2013] EWHC 242 [33].
 - ix) The decision is for the Judge not the expert. Their roles are distinct and it is for the Judge to make the final decision *A Local Authority v K.D and L* [2005] 1 FLR 851 [39] &[44].
85. An application was made for a declaration that a non-therapeutic male sterilisation was lawful in *Re A (Male Sterilisation)* [2000] 1 FLR 549. The application was refused at first instance and again on appeal. The application was predicated on the basis that a Down's Syndrome man *might have a sexual relationship in the future. The psychiatrist for the Official Solicitor judged the risk of sexual intercourse to be very small and Sumner J found that A was unlikely to enter into any casual sexual relationship with a woman.*
86. The President, Lady Justice Butler-Sloss held:
- i) *Best interests encompasses medical emotional and all other welfare issues [555E]*
 - ii) *The sterilisation of a man is not the equivalent of an application in respect of a woman. .. sexual intercourse for a woman carries the risk of pregnancy... there is no direct consequence for a man of sexual intercourse other than the possibility of sexually transmitted diseases.[557D]*
 - iii) *On the facts of the case the level of supervision does not depend upon his fertility and the operation would not free him to enjoy a more relaxed regime.*
 - iv) *If his quality of life were to be diminished, that would be a reason to seek at that time a hearing before a high court judge to grant a declaration that sterilisation would then be in A's best interest.*

Lord Justice Thorpe in his judgment said:

- v) *I share his view [A's psychiatrist], that A's fertility is of no advantage to him but a real disadvantage. In our society vasectomy has become the preferred method of contraception for many males who wish to separate their sexual and procreative functions. The obligation of society is to minimise the consequences of disability by vouchsafing for the disabled wherever possible the rights and freedoms vouchsafed to the majority who have been spared disability*
- vi) *In my judgment the crucial missing piece in the construction of the evidential jigsaw was evidence from A's mother and/or A's alternative carers that*

...supervision post vasectomy would be at a reduced level and opportunities for A to develop sexual experience and intimacy with a woman countenanced.[559H]

- vii) *The judge at first instance should draw up a balance sheet of factors of actual benefit and counterbalancing dis-benefits. Only if the account was in relatively significant credit should the judge conclude that the application was likely to advance the best interest of the claimant. [560G]*
- viii) *Although the appeal was dismissed Thorpe LJ concluded I would like to emphasise that its failure does not preclude a fresh application in future on fresh evidence.*
87. Mr McKendrick submits therefore that *Re B (a patient)* contains clear support for the proposition that a vasectomy may be in someone's best interests if it would improve the quality of the person's life and /or lead to lessened supervision. I accept, as submitted by Mr McKendrick that based upon my findings of fact there is in DE's case no *missing piece of the evidential jigsaw* and that the evidence unequivocally points to an improvement in the quality of DE's life in the event that he has a vasectomy.
88. In *ITW v Z* [2009] EWHC 2525 (Fam) Munby J as he then was set out his views on the question of the weight to be afforded to P's incapacitous wishes and feelings :

"I venture, however, to add the following observations:

i) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see Re MM; Local Authority X v MM (by the Official Solicitor) and KM [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at paras [121]-[124].

ii) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P's wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P's wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic. Just as the test of incapacity under the 2005 Act is, as under the common law, 'issue specific', so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.

iii) Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to all the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:

a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings: Re MM; Local Authority X v MM (by the Official Solicitor) and KM [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at para [124];

b) the strength and consistency of the views being expressed by P;

c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again Re MM; Local Authority X v MM (by the Official Solicitor) and KM [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at para [124];

d) 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

e) 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.

89. I have borne those views in mind in assessing how I should treat DE's wishes in relation to both having another child and to having a vasectomy.

The Balancing Exercise

90. At the conclusion of the hearing the position of the Local Authority, NHS Trust, B Partnership Trust and the parents was unchanged; neutral so far as the NHS Trust was concerned and supportive of a vasectomy in relation to the other parties.

91. The Official Solicitor on behalf of DE in his opening submissions opposed a vasectomy being carried out. He regarded the discomfort of the surgery and the small risk of long term pain as outweighing the benefits identified by the witnesses who addressed DE's best interests. In his closing submissions the Official Solicitor shifted his position to one which, in my judgment, was far more in touch with DE's 'real life' although was somewhat Delphic in the way it was expressed namely that the Official Solicitor *did not seek to submit that it would not be in DE's best interests to allow the vasectomy however he would not advance a positive case as to whether it is in DE's best interests to have a vasectomy.*

92. I therefore apply the findings to the s4 exercise:

- i) DE is 37. He will not regain capacity in the future. At every stage both his parents, ZZ and CH have done all that is reasonably practical to encourage DE to participate and to improve his ability to participate as fully as possible in the decision to be made. Not only have CH and ZZ by virtue of their skill and intimate knowledge of DE been able, (despite his considerable communication difficulties), to determine his true wishes and feelings but, have worked with him week after week to such good effect that during the course of the proceedings DE has gained the capacity to consent to sexual relations. (s4(1)(a), s4(3)(a) &(b), s4(4).
- ii) For the reasons set out in this judgment I am satisfied that DE has a genuine and settled desire not to have any more children: s4(6)(a).
- iii) Section 4(6)(c) requires the court to take into account other factors which DE would be likely to consider if he were able to go so; the so called “substituted judgment” test although it is but one factor with ‘best interests’ the final test. In this context the court must take into account the *Mental Capacity Act Code of Practice para 5.48* which allow actions that benefit other people, as long as they are in the best interests of the person who lacks capacity. DE is very close to his parents; he loves and relies upon them. If they are upset he is upset. The court can take into account the benefits to FG and JK of DE having a vasectomy if it is a factor DE would consider if he had capacity. It is likely that DE would consider the benefit to his parents of relieving them of the anxiety and strain that they have been suffering and of which he has been very conscious.

Such a benefit to the parents would be of significant benefit to DE, not only because he would benefit from them being happier and less anxious, but also because relieved of the anxiety of a second pregnancy, I am satisfied that JK would feel able significantly to relax the level of supervision she felt to be necessary and that, despite her general misgivings about PQ, would once again promote and support the relationship as she did prior to the pregnancy.
- iv) DE’s parents believe it is in DE’s best interests to have a vasectomy. Their absolute conviction that this is the right thing for their son has given them the stamina and courage to endure the tortuous litigation which they could never have foreseen when they went along to see the GP three years ago in July 2010: s4(7)(b).

Conclusion

93. In my judgment it is overwhelmingly in DE’s best interests to have a vasectomy. That being said the court does not make such an order lightly, conscious as it is that for the court to make an order permitting the lifelong removal of a person’s fertility for non-medical reasons requires strong justification.
94. In my judgment the following factors are in favour of DE having a vasectomy:
 - i) DE’s private life

- a) DE's relationship with PQ is enduring and loving. It is very important to DE and he was deeply distressed when there was a break at the beginning of the year. The relationship should be respected and supported in the way all other aspects of DE's life are respected and supported.
 - b) The relationship has been sexual in the past and DE (and PQ) would like to, and should be permitted, to resume their sexual relationship.
 - c) DE is unequivocal and consistent in expressing his wish not to have any more children.
 - d) The only way that this can be ensured is by DE having a vasectomy. There is a high (over 18%) chance of pregnancy using condoms; DE's technique is poor and he cannot be relied upon consistently to use them.
 - e) If another child was born not only would DE be deeply distressed but a removal of the child from PQ would be very likely to result in the breakdown of the relationship.
- ii) DE's relationship with his parents
- a) DE's only other consistently held and expressed view is that he wants to live at home with his parents. He is wholly dependant upon them for his physical and emotional welfare.
 - b) DE's parents were deeply distressed by PQ's pregnancy and the birth of XY. Although they are, JK says, *getting through it*, they have obviously been traumatised by all that has gone on since PQ's pregnancy was discovered in 2010. Those events remain raw and JK exhibited an almost tangible fear of the consequences of a second pregnancy. They know their anxiety has an impact upon DE, I am sure they do their best to protect DE from it but they are only human and inevitably DE is acutely aware of their distress; this has had a significant impact upon his own emotional comfort and well being. I have no doubt that a second pregnancy would have an even greater impact upon the family particularly as FG and JK would inevitably regard such a pregnancy as having been avoidable.
 - c) DE's parents support and protect DE, they organise every practical aspect of his life. It is not unreasonable to expect that if they do not have reassurance that DE has the benefit of effective contraception then the level of independence they will believe it is in his best interests for him to be afforded will be compromised.
- iii) DE's Independence
- a) PQ's pregnancy followed by the interim declaration that DE did not have the capacity to consent to sexual relations has had very serious consequences for DE, resulting in his losing, for a period, all autonomy

and his being supervised at all times. Whilst there has been some easing of supervision, his life is still very different from his life before XY was born and he is still never alone with PQ.

- b) The loss to DE has been compounded by the fact that due to his learning difficulties DE cannot ‘pick up where he left off’; skills which took years to acquire have, when not used, been lost, as has much of his confidence. The fact that DE has acquiesced as restrictions have been imposed upon him does not make the loss to him any less profound; it is both the entitlement and in the best interests of any person with significant disabilities, (whether learning or physical), that they be given such support as will enable them to be as much an integral part of society as can reasonably be achieved. It is simply stating the obvious to observe that DE’s quality of life is incomparably better when he can go and have a coffee in town with PQ or go to the local gym with his friend. As Mr McKendrick said *as a person with learning disabilities, his successes and failures in life are measured differently to the non learning disabled population.*

95. In my judgment DE’s hard earned achievements, whether learning to swim by imitation as he can’t process spoken instruction, or getting a bus on his own must be treasured, valued and measured in the same terms as the winning of an Iron Man or completing the Paris to Peking rally would be for a person without his disabilities.

96. Dr Milnes regarded the most magnetic factor in favour of a vasectomy as being DE’s desire not to have any more children. It is undoubtedly a magnetic factor carrying considerable weight, but in my judgment, allowing DE to resume his long term relationship with PQ and restoring to him his lost skills and independence are as important, if not more so, when determining his best interests.

97. The single factor against DE having a vasectomy identified by any party is:

i) The surgical procedure

a) The slender risk of DE suffering from long term scrotal pain and or discomfort, a risk further reduced by the fact that it is intended that the procedure would be carried out by a consultant urologist with a consultant anaesthetist. DE has tolerated local anaesthesia in the past and there is no reason to believe that he will not do so again. One or other of his parents will be with him throughout.

b) The procedure is non therapeutic.

c) The procedure does not protect against the transmission of STIs or STDs.

98. Every assessment of the best interests of a person under the Mental Capacity Act 2005 is by its very nature fact specific. I have reached the conclusion that a vasectomy is undoubtedly in DE’s best interests after having heard all the evidence and having taken into account all the circumstances before conducting the balancing exercise commended by Lord Justice Thorpe. In doing so I have been astute at all times to

keep to the forefront of my mind that the consequences of the proposed procedure for DE (ignoring the possibility of reversal), are to sterilise him and render him permanently infertile. The fact that the procedure to achieve this is routine, commonplace and safe should not ever be allowed to mask or minimise that bald fact when a court is considering such an application.

99. I will make appropriate orders and declarations which shall include that it is lawful and in DE's best interests to undergo a vasectomy; that it is lawful and in DE's best interests for the applicant, its employees and/or agents to take any reasonable and proportionate steps which are medically advised by DE's treating clinicians in order to perform a vasectomy, which may include sedation, local anaesthesia and/or general anaesthesia; and that any vasectomy performed upon DE shall be carried out at the hospital by a consultant urological surgeon and the necessary sedation and/or anaesthesia shall be administered by a consultant anaesthetist.