Neutral Citation Number: [2019] EWCOP 26

Case No: 1348552

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/06/2019

Before :

Mrs Justice Lieven

- -

Between :

AN NHS FOUNDATION TRUST **Applicant**

- and -

1. AB

(By her litigation friend, the Official Solicitor)

2. CD

3. A LOCAL AUTHORITY

Respondents

- -
- -

Ms Fiona Paterson (instructed by NHS Trust) for the **Applicant**
Ms Susanna Rickard (instructed by the Official Solicitor) for the **First Respondent**
Mr John McKendrick QC (instructed by Bindmans LLP) for the **Second Respondent**
Mr Jack Anderson (instructed by the Local Authority) for the **Third Respondent**

Hearing dates: Thursday 20th June 2019 & Friday 21st 2019

- -

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 LIEVEN DBE

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Lieven:

1. This is an application by the NHS Trust for an order in respect of a 24 year old woman AB who is 22 weeks pregnant and, who the Trust say lacks capacity and in whose best interests it is said to have a termination of pregnancy. The hearing was conducted in open court, but subject to a transparency order to ensure that AB could not be identified.

2. The Trust was represented by Ms Paterson, the Official Solicitor by Ms Rickard, CD by Mr McKendrick QC and the local authority by Mr Anderson. I am grateful to all of them for their assistance.
3. Given the urgency of this matter I gave an ex tempore judgment. That necessarily means that there is not as detailed analysis of the caselaw as I would have liked.

4. I have had witness statements from Dr N (perinatal psychiatrist); Ms T (consultant obstetrician); Professor X (consultant psychiatrist) and Ms S (SA's social worker) and from CD (AB's mother). I heard oral evidence from these witnesses.

5. Before turning to the substance of this matter I would like to record my unhappiness about the lateness of this application. AB is now estimated to be 22 weeks pregnant and therefore the cut-off date under the Abortion Act 1967 of 24 weeks is imminent. The fact of AB's pregnancy first came to the attention of the Trust in mid-April 2019. I appreciate this is not at all, a straightforward case but it would have been in everyone's interests, and most importantly AB's if this application had been made sooner.

6. AB is a 24-year-old woman with a diagnosis of moderate learning disability and challenging behaviour. AB was born in Nigeria and came to the UK in around 2007. She was adopted at a very early age (a few days) by CD and has considered her to be her mother throughout her life. I believe she lived with her mother and her grandmother for some time, and then with her grandmother and her mother close by, but came to live with her mother (CD) in 2017 after her grandmother died. She was evidently very close to her grandmother, and was very upset and confused when she died. AB attended special schools throughout her childhood in England, and has undertaken some courses at a local college

7. She has been diagnosed by Professor X as having moderate intellectual disability ICD10. As such characteristics include an approximate IQ of 35-49 and someone who functions at a level roughly equivalent of a 6-9-year-old. The cause of her disability is not known, and therefore it is not known whether it has a genetic cause. It is also not known whether any members of her birth family have any psychotic condition, which is relevant for the assessment of risk in proceeding with the pregnancy. There is no suggestion that there is any fluctuation in her condition such as would lead to fluctuating capacity.

8. AB speaks both English and Igbo, but her English can evidently be difficult to understand. The Trust has gone to considerable efforts to ensure that they can fully understand her and explain matters to her in an appropriate way. I have not met AB or heard her speak, but it is clear from the notes of her conversation with the Official Solicitor's agent, which I will refer to below, that her language and communication abilities are significantly impaired.

9. In addition, AB has a history of behavioural difficulties. She is currently prescribed Risperidone and sertraline to manage her mood and behaviour. When she does not receive

these her behaviour deteriorates. Dr N explained that the fact that AB responds to risperidone suggests that she may suffer from some form of psychosis, and this becomes relevant when I come to the risks related to her giving birth. These behavioural problems date back to when she was a teenager and have varied over the years. Her behaviour on occasions can be very difficult to control and there have been incidents of her smashing a TV and breaking other things, this seems to happen when she does not get her own way and is upset. The particular incidents occurred after the death of her grandmother. There is also evidence that she finds it very difficult to sit still, although the reporting on this is inconsistent.

10. AB's behavioural problems are highly relevant to my decision, because they go to the question of what would happen to AB and the baby, if the termination did not happen. CD says that the Trust has overestimated AB's difficulties and that she is more capable, and less of a risk to the baby than the Dr N and the Trust think. However, there is an email in the papers from CD to Ms S at the local authority in February 2018, i.e. well before the pregnancy, in which CD is asking for more support for AB. In this she describes AB as follows;

> "AB likes going out but unfortunately there is a limit to the episodes of outing that her care package and my circumstance can contain. As a result, the exit house key has to be hidden. At the least opportunity, AB would leave the home. At one instance, in X Road, AB left home on her own and I had to search for AB for one hour and found her in R market area. The reason being that I came back from night duty, and she let herself out when I was asleep. As AB grows older, she gets more assertive about wanting to go out and not stay indoors. AB has a history of self-harm, hence all knives including table knives are locked up to reduce her risk. She has in the past used a sharp knife to smash our glass top of our electric cooker because she was upset. So, the reality about AB is that she needs a 24/7 supervision and needs more care input as opposed to her current care plan."

11. I take into account the fact that this email was written to support an attempt to get more resources for AB. However, CD was a professional midwife for many years and I have no

doubt that this email was an accurate statement of her view on AB's functioning, risks and needs at that time.

12. The risperidone was stopped when it became known she was pregnant. CD reports that she became "more active" and more volatile. At the capacity assessment Professor X noted that she behaved inappropriately at times being overly friendly and familiar. The risperidone was restarted because of these behavioural issues, and her behaviour seems to have become more appropriate.

13. AB has been known to the local Adolescent Mental health team since 2011. She has received support from the local authority for many years.

14. In late 2018 AB travelled to Nigeria with her mother, and stayed there with family whilst CD returned to England. When she returned to the UK in April 2019 it became apparent that she was pregnant. The circumstances of her becoming pregnant are unknown, but there is no doubt that she did not have the capacity to consent. Although I am not going to make any formal declaration of capacity to sexual relations at this hearing. I understand the police are carrying out a safeguarding investigation. Although I do not wish to pre-empt the police investigation or any formal decision made by the local authority, I have no doubt having heard her that CD has nothing but AB's best interests at heart and is devastated by the fact that she has become pregnant.

15. It is clear from the chronology and the notes that the issue of a possible termination was raised almost immediately she was known to be pregnant. Capacity assessments have been carried out on 2 and 16 May the first by Dr N, a consultant in perinatal psychiatry and a

group of professionals. The second was with the additional assistance of the Speech and Language service at the NHS hospital, to ensure that the best means possible were used to communicate with AB. Professor X was also involved in the capacity assessments. He has expertise as the Chair of Intellectual Disability at the relevant hospital. The assessments covered capacity to litigate; to consent to sexual relationships; capacity to make decisions about psychiatric assessments; and capacity to decide whether to terminate the pregnancy.

16. On both occasions the professionals concluded that she lacked capacity in all relevant respects. All parties in these proceedings accept that AB does not have capacity in relation to any of the issues before me, and no one was asserting a case that she did have capacity to consent to sexual relations. It necessarily follows that the pregnancy was as a result of rape and that has some relevance when it comes to best interests.

17. The assessors asked her whether she understood that she had a baby "in her tummy". She seemed to have very little understanding of the process of birth, and probably even less of the meaning of having a termination or of the baby "going away". Dr N said that she was unable to answer questions in any detail, and she found it very difficult to sit still through the interview. She pointed to a doll and said that was her baby.

18. The sense I have from the evidence, including that of CD and Ms R, is that as the pregnancy has developed AB has more understanding that she is pregnant, and that means she has a baby inside her, and that it will be born. This is unsurprising as she sees her stomach grow and begins to feel the baby. I will return to the evidence about AB's wishes and feelings below.

19. AB has some self-care skills, largely being able to dress herself. However, Dr N's evidence was also that on one of the afternoons AB was left in the team's care and was unable to feed herself. This may have been partly because of being in unfamiliar surroundings. She seems to be more independent in her current care home, although there is no suggestion that she can look after herself, or go out on her own.

20. CD is a devout Roman Catholic of Nigerian (Igbo) heritage. She is strongly opposed to abortion and said that within the community it is never spoken about, and there is a real stigma to having a termination. CD said that she was always opposed to AB having a termination, although there is some suggestion that at first, she accepted that it would be in AB's best interests. However, when it became apparent that the Trust was contemplating AB's having a termination, CD made clear that she was strongly opposed and that if AB did have a termination CD said would not be able to support her through that. On 16 May AB was accompanied by her aunt to the hospital with suitcases, and has been living in a care home since then. My understanding of CD's position is that if AB did have a termination, she would have AB back home. CD's evidence was strongly focused on AB's interests, and CD's concern that AB would be very upset by having a termination and not know what had happened to the baby.

21. A good deal of the Trust evidence focused on the purely medical situation. Given that I do not think that this is the critical issue in the ultimate balance I will not rehearse that evidence in great detail. If AB has the termination it will be undertaken under general anaesthetic and will involve a two-stage process. There will be some pain and discomfort but this will be manageable. There is no reason to believe there would be any complications.

22. It is very difficult to assess how AB will respond to the termination. All three Trust witnesses thought that the termination would be less traumatic for her than the baby being taken away. I note the particular expertise in this regard of Professor Z and Dr N, but take into account the fact that her mother is plainly the person who knows her best. Her mother thought she would be potentially very upset about the loss of the baby. This is one of the real unknowns in the case.

23. If she did have the baby then the likelihood would be it would be by caesarean section. Ms T was concerned about ante natal treatment for AB given her behavioural problems. Although I am sure that this would be very professionally managed, and would almost certainly be manageable, I was struck by Ms T evidence that she had never managed a pregnancy with someone with as severe learning difficulties as AB. This was equally the case for Professor X and Dr N. Ms T was concerned about how AB would cope after the caesarean given that it is major abdominal surgery. It seems to me that this adds to the risk of AB suffering a very traumatic experience after the birth, but if other factors led to a conclusion that she should have the baby would not be an insuperable issue.

24. Dr N gave evidence about the risk of postpartum psychosis. This is a very serious psychotic condition which would need to be treated with anti-psychotic medication and almost certainly in-patient treatment in a psychiatric unit. The impact of having such an episode should not be underestimated. The very experience can leave lifelong effects on patients and the impact of being admitted as an in-patient to a psychiatric hospital suffering a psychotic episode would be extremely traumatic for AB. The difficulty is that it is almost impossible to assess the likelihood of this happening. However, I did feel that both the Official Solicitor, and Mr McKendrick on behalf of CD, although less in his closing, underplayed the consequences for AB of taking the risk of AB's mental illness being

exacerbated by giving birth and the baby being taken away. This is an issue where the lack of capacity is very important. In expressing her wishes and feelings AB has no understanding of the risk she would be taking with her mental health if she proceeded with the pregnancy. I am the person who has to put myself into her position, to try to determine what she would decide, see the Aintree case to which I refer below.

25. CD's wishes and feelings are not straightforward. The evidence from the Trust witnesses is that she does not really understand the fact of the pregnancy or the consequences. Ms T was an excellent and very empathetic witness (that is not to say the others were not but I felt Ms T had formed a bond with AB). She felt that AB only had a passing understanding of what having a baby meant, even though at any one time she might say she wanted to have the baby. She referred to AB thinking the doll was her baby, and then after a few minutes throwing the doll away.

26. CD says that she speaks to AB regularly and that she wants the baby. Ms S agrees.

27. The Official Solicitor's agent visited AB on 14 June and I have read a long and detailed attendance note. I will read one extract, but there is much more. Mr McKendrick relied heavily on this. He referred me to parts where AB spoke on a number of occasions about wanting the baby and wanting to live with the baby, of the baby needing pampers, of it having milk and of her having some understanding that she would need help with the baby. I think it does show that SA has some understanding of a baby's needs and probably of her inability to meet those needs, but not very much more than that.

"AB: C

LD: If you lived at C Road, would you need someone to help you

AB: My mum. My aunty, my mum, my baby. My mum and I can keep my baby.

LD: What would they do?

AB: Carry her. Carry her, the baby. I give it to my mum, my baby. My mum and I can keep my baby.

LD: You would give your baby to your mum?

AB: Yes, my aunty give it to her, my baby. My mummy wants it.

LD: Your mum wants it?

AB: Yeah, my own baby.

LD: How would you feel AB if your baby went away?

AB: Good. Baby is happy.

LD: The doctors have said they could take your baby out of your tummy.

AB: No.

LD: How would you feel if they did that?

AB: Save it Save it, the baby.

LD: How would you feel if there was no more baby?

AB: No more baby.

LD: How would you feel if there was no more baby?

AB: Good. Baby like it.

LD: How would AB feel?

AB: Feeling better.

LD: AB, if the doctors took the baby out of your tummy…

AB: Yeah.

LD: And took it away…

AB: Yeah.

> LD: So there was no more baby, how would you feel?
>
> AB: Happy.
>
> LD: What about if you didn't see the baby because it went away?
>
> AB: Push the baby out.
>
> LD: If they took the baby away…
>
> AB: Yeah.
>
> AB: So you couldn't see the baby…
>
> AB: My mum. My mum needs it, the baby
>
> LD: Your mum takes the baby?
>
> AB: No. My mum listen to it, the baby…"

28. This extract gives a flavour both of AB's wishes and of her level of understanding. What I glean from this is that AB is happy that she is pregnant and likes the idea of having a baby. I think that it shows that if she was making the choice, at this moment she would not want a termination. But the very nature of her lack of capacity is that she does not have a full (or actually on the evidence very much) understanding of the nature of the decision. Ms S's evidence was that her attitude to the baby fluctuates. From the Official Solicitor's agent's attendance note, she has no understanding, either of the birth process or more importantly what happens next. She has no idea that the baby is unlikely to be able to live with her, the consequences for her relationship with her mother, the potential mental health impact, or the emotional and psychological issues that arise. Her perception of the situation seems to be of the baby as an object, like a nice doll.

29. In this regard CD's evidence that AB has experience of cousins' babies in Nigeria and England may well be relevant, but not in the way the Official Solicitor relies upon it. Holding a baby for a few minutes and enjoying being with it may well have been a highly pleasurable

experience for AB, as it is for many people, but it gives her absolutely no insight into what will happen to her life if this baby is born or the realities of living 24/7 with a small baby, or a toddler growing up.

30. There are two issues under the Mental Capacity Act that I have to consider; whether AB has capacity; and if she does not have capacity whether it is in her best interests to have the termination.

The law

31. Under the Abortion Act 1967 a termination can be performed under the 24th week under s.1(1)(a);

> *"(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—*
>
> *(a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family;"*

32. Ms T gave evidence that in her view the terms of s.1 were met. The appropriate forms have not yet been completed, but I have no reason to believe that they will not be lawfully completed. It was agreed by all counsel that the fact that the s.1 test is met does not alter the analysis I have to carry out under the MCA.

33. On the first question, that of capacity, the law is as follows. Section 1 of the Mental Capacity Act 2005 provides, insofar as relevant:

"(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

Section 2 of the Act provides, insofar as relevant, as follows:

"(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

(2) It does not matter whether the impairment or disturbance is permanent or temporary.

(3) A lack of capacity cannot be established merely by reference to (a) a 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 his capacity."

Section 3 provides, insofar as relevant,

"(1) For the purposes of section 2 , a person is unable to make a decision for himself if he is unable

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means)."

Section 4(3) of the Act, in the provisions as to best interest to which I shall turn later, provides that a decision-maker deciding what should be done in the best interests, "must consider whether it is likely that the person will at some time have capacity in relation to the matter in question and, if it appears likely that he will, when that is likely to be."

17. The central principles relating to capacity were summarised by Baker J (as he then was) in , *CC v KK [2012] EWHC 2136 (COP)* at paras. 18 to 25. I do not think it is necessary to set out the entirety of this passage, particularly as it records very well-known and uncontentious propositions, but the key parts are as follows;

> *"18. First, a person must be assumed to have capacity unless it is established that she lacks capacity: s. 1(2) . The burden of proof therefore lies on the party asserting that P does not have capacity…. The standard of proof is the balance of probabilities: s. 2(4) .*
>
> *19. Secondly, the Act provides that a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain: s. 2(1) . Thus the test for capacity involves two stages. The first stage, sometimes called the 'diagnostic test', is whether the person has such an impairment or disturbance. The second stage, sometimes known as the 'functional test', is whether the impairment or disturbance renders the person unable to make the decision. S. 3(1) provides that, for the purposes of s. 2 , a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision; (b) to retain that information; (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means. Important guidance as to the assessment of capacity generally, and the interpretation and application of the four components of the functional test in particular, is set out in Chapter 4 of the Mental Capacity Act 2005 Code of Practice.*
>
> *20. Third, capacity is both issue-specific and time specific. A person may have capacity in respect of certain matters but not in relation to other matters. Equally, a person may have capacity at one time and not at another….*
>
> *21. Fourthly, a person is not to be treated as unable to make a decision unless all practicable steps to help her to do so have*

> *been taken without success: s.1(3) . The Code of Practice stresses that 'it is important not to assess someone's understanding before they have been given relevant information about a decision' (para 4.16). Relevant information is said in paragraph 4.19 to include 'what the likely consequences of a decision would be (the possible effects of deciding one way or another) – and also the likely consequences of making no decision at all'. Paragraph 4.46 of the Code of Practice adds that 'it is important to assess people when they are in the best state to make the decision, if possible'.*
>
> *22. Fifth, I bear in mind and adopt the important observations of Macur J in LBL v RYJ [2010] EWHC 2664 (Fam) (at para.24), that 'it is not necessary for the person to comprehend every detail of the issue … it is not always necessary for a person to comprehend all peripheral detail …' …*
>
> *23. Sixth, a person is not to be treated as unable to make a decision merely because she makes an unwise decision: s. 1(4) . …*
>
> *24. Finally, in assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in addition the court in these cases will invariably have evidence from other clinicians and professionals who have experience of treating and working with P, the subject of the proceedings. Often there will be evidence from family and friends of P. …*

34. The approach to a best interest's assessment under the MCA was considered by the Supreme court in *Aintree University Hospitals v* Bland and at para 24 the Court said;

> *"The advantage of a best interests' test was that it focused on the patient as an individual, rather than the conduct of the doctor, and took all the circumstances, both medical and non-medical, into account: paras 3.26, 3.27. But the best interests test should also contain "a strong element of 'substituted judgment'" (para 3.25), taking into account both the past and present wishes and feelings of the patient as an individual, and also the factors which he would consider if able to do so: para 3.28. This might include "altruistic sentiments and concern for others": para 3.31. The Act has helpfully added a reference to the beliefs and values which would be likely to influence his decision if he had capacity. Both provide for consultation with carers and others interested in the patient's welfare as to what*

> *would be in his best interests and in particular what his own views would have been."*

35. I have also had regard to the judgment of Munby LJ when President in *X (A child)* , a case which concerned a termination of pregnancy for a 14 year old girl. At para 9 the President said;

> *"I leave on one side cases where the mother has for whatever reason so little appreciation of what is going on as not to be able to express any wishes and feelings. This, I emphasise, is not such a case. The point is very simple and profoundly important. This court in exercise of its inherent jurisdiction in relation to children undoubtedly has power to authorise the use of restraint and physical force to compel a child to submit to a surgical procedure: see Re C (Detention: Medical Treatment) [1997] 2 FLR 180 and Re PS (Incapacitated or Vulnerable Adult) [2007] EWHC 623 (Fam), [2007] 2 FLR 1083 . I say nothing about how this power should appropriately be exercised in the case of other forms of medical or surgical intervention. In the case of the proposed termination of a pregnancy, however, the point surely is this. Only the most compelling arguments could possibly justify compelling a mother who wished to carry her child to term to submit to an unwanted termination. It would be unwise to be too prescriptive, for every case must be judged on its own unique facts, but I find it hard to conceive of any case where such a drastic form of order – such an immensely invasive procedure – could be appropriate in the case of a mother who does not want a termination, unless there was powerful evidence that allowing the pregnancy to continue would put the mother's life or long-term health at very grave risk. Conversely, it would be a very strong thing indeed, if the mother wants a termination, to require her to continue with an unwanted pregnancy even though the conditions in section 1 of the 1967 Act are satisfied."*

36. I wholly accept the thrust of this passage. I do not accept however Mr McKendrick's submission that there is a test of grave risk to life or long-term health. The caselaw on the MCA makes clear that each case is intensely fact specific, and in balancing P's wishes with judgements as to her interests, much will turn on the nature of her understanding.

37. At para 17 the President said;

> *"One factor which it did seem important to take into account was the likelihood or otherwise of X being able to keep her baby if there was no termination. This required me, necessarily on the basis of incomplete information, to predict the outcome, not merely of the care proceedings already on foot in relation to X but also of the care proceedings in relation to her child which almost inevitably would be commenced after the birth. The need for a judicial view on a point which might be seen to be pre-judging the care proceedings was, in my judgment, inescapable. My view, which I expressed at the hearing and which was embodied in my order (see below) was that there was "very little chance" that X would be able to keep her baby if it was born. Having done so, however, it seemed to me that I should not be further involved in the care proceedings, so I recused myself."*

38. Mr McKendrick submitted that these comments were fact specific, which of course is true. But it is clear that in an appropriate case the Judge will have to consider what will happen if the baby is born, including the risk of it being taken into care. I have no doubt here that is a factor that I have to consider in order to assess AB's best interests.

Position of the parties

39. All parties agree AB does not have capacity.

40. The Trust considers it is in her best interests to have the termination. They are concerned that it will be very difficult to manage her pregnancy and the subsequent caesarean; that she will suffer greater psychological and emotional harm from having the baby and then having it removed than having a termination; that she will probably effectively move on from the termination quite rapidly; and that there is a real though unquantifiable risk of serious harm to her mental health if she gives birth.

41. CD is opposed to her having a termination. CD made clear that terminations are not considered acceptable in her community, and are never carried out openly. She feels AB

would be very upset by the termination. She accepts that AB could not care for the baby alone, but wants the baby and AB to live with her. She thinks that this could happen.

42. Mr McKendrick in closing emphasised that AB's wishes and feelings, so far as they can be ascertained – she wants the baby, she has some understanding of its needs, she appreciates that she will need help with it. He also says the evidence shows that she was very upset by the grandmother's death and there is a significant risk that she would have a similar response to a termination. She may derive pleasure from having mothered a baby and although she may view it as distressing to have it taken away overall, she might find the experience of having had the baby immensely rewarding. He said the team at the Trust would have time to prepare her for giving birth, including for the possibility of the child being removed. He described her as being non-compliant with any termination. And rightly emphasised the draconian nature of the state ordering a termination on a woman who is not compliant.

43. The local authority is neutral. Ms S thought in her oral evidence that it was in AB's best interests to have the baby, but Mr Anderson made clear that his client was neutral, and Ms S was clear that she was not speaking on behalf of the local authority in that view. The local authority sent the Trust an email setting out the position if the baby was born, that says

> *"In regards to the below question, we are planning to have our Legal Planning Meeting pending the outcome of the court hearing on 20th June 2019. If the Court approves the termination, our role will end. However, if the court does not grant termination the assessment will go ahead. We would not consider Child Protection Conference due to AS cognitive impairment. We will apply to the court for a Care Order prior to birth.*
>
> *We may consider if there are any protective family members who could care for the baby. We will consider parenting assessment, psychological assessment and Family Group Conference for any potential family members who puts their selves forward to be assessed. If the outcome of this assessment*

> *is not positive the Local Authority will place the child in care. After all family findings is complemented and there are no one who can care for the baby, the LA may consider Adoption."*

44. The Official Solicitor is opposed to the termination. He says that the Trust has focused too much on the medical issues; that the evidence suggests AB wants to continue with the pregnancy; and that the evidence suggests that the baby could be cared for within the wider community. The latter is a factor that Ms Rickards placed considerable weight on in her closing although there was very little evidence on the potential for wider family members caring for the baby and whether or not AB would have contact with the baby in those circumstances.

Conclusions

Capacity

45. The conclusion on capacity in this case appears to me to be quite clear. The diagnostic test is plainly met. The evidence shows that she struggles to understand that she is pregnant or indeed what that means. She certainly cannot process the information about either the pregnancy, or giving birth, or the consequences of having a baby, whatever those might be. She cannot understand or process and weigh up the information she is given. Therefore, she falls within s.2(1)(a) and (c). This finding applies to all the relevant capacity questions.

Best interests

46. The significantly more difficult question in this case is what is in AB'S best interests. I am acutely conscious of the fact that for the state to order someone to have a termination,

where it appears that they do not want it, is immensely intrusive and certainly interferes with her Article 8 rights. However, the very nature of the MCA is that the court is given the duty of deciding enormously difficult decisions which the individual may well not agree with, for the very reason that the individual does not fully understand the decision to be made. This is very much the case here where the decision either way could have lifelong consequences.

47. The following matters are relevant: medical risks; psychiatric risks; emotional/psychological risks from termination; emotional/psychological risks from having the baby; AB's wishes and feelings.

48. There is some medical risk from any general anaesthetic, but AB is young and physically healthy. There is a greater risk from giving birth under a general anaesthetic than the termination, but the difference on the facts of this case is minor. A caesarean section is a significant operation with physical consequences, but again that is not a determinative factor in this case. I do take into account Ms T's evidence of the problems of managing AB's pregnancy and birth and I do give this some weight but do not consider it determinative.

49. I am concerned about Dr N's evidence about risk of postpartum psychosis. There is a risk of this happening, but how great a risk is not possible to assess. However, it would be a tragedy for AB to give birth, have the baby taken away (to which I return) and suffer lifelong consequences on her mental health by reason of exacerbating her psychosis.

50. It is very difficult to predict the emotional/psychological risks to AB from the termination. She undoubtedly knows she is pregnant and understands that she will give birth to a baby. I

suspect she will grieve the loss of the baby. She may forget quickly, as Professor X thought might happen, she may not. But for AB the impact of having a termination under a general anaesthetic would be the same as a miscarriage, that might be very upsetting, but she will not go through the emotional, philosophical and moral dilemmas of a termination as might some women who were making a "choice". There is a real danger in this case of everyone imposing their own moral or philosophical views on termination onto a woman who operates with a mental age of about a 6-9-year-old. Concepts of choice, guilt, and cultural norms are not ones which I suspect mean anything to AB.

51. I have to focus on AB as an individual and her best interests, not societal views on termination, the rights of disabled people in general (including as set out in the UNCRDP), or some concept of the benefits of having a genetic child and being biological mother; in circumstances where AB is unable to comprehend these concepts.

52. Therefore, I accept that she probably will suffer some trauma or upset from the termination but for the reasons I am about to explain I think that will be a lesser impact than having the baby.

53. If AB has the baby then all parties accept that she will not be able to care for it alone. In those circumstances there is no doubt that the local authority will step in and seek (and in all probability, obtain) some form of protective orders. What happens next is necessarily speculative, but it is speculation which I have to enter into to try to decide what is in AB's best interests. I also think that there is a very real risk, if not probability that the view of the local authority, supported by the Court, will be that AB cannot live with the baby. Dr N gave evidence that if asked for advice by the local authority, and she and her team would be so

asked, she would advise that AB should not live with the baby because of the risks to the baby and should not have unsupervised contact with the child.

54. In this regard, I am afraid I think CD's position is wholly unrealistic, and indeed so is that of the Official Solicitor. CD accepts AB cannot be left alone, and could not be left alone with the baby. It was CD who raised the risks that AB posed to herself in the email in 2018. There is a world of difference between liking babies when they belong to someone else and live somewhere else and when they are living with you 24/7. I think it unlikely that the local authority would be able to tolerate the risk to the baby of living with AB. Therefore, if CD seeks care of the baby the consequence is likely to be that AB could no longer live with her mother.

55. In that scenario AB suffers the real trauma of having the baby taken away and not being able to live at her home or with her mother.

56. This is the point where I do not accept Mr McKendrick's submissions. In terms of predictability of impact I think it is likely that AB would suffer great trauma from the baby being removed, that is the known experience of most women. It will be a real baby which she will probably have met and touched, and it will go. In contrast the pregnancy although real to her, does not have a baby physically before her, and the impact is in my view likely to be. As Ms Paterson puts it the baby is not a physical presence. The psychiatric evidence is that AB thinks in immediate and concrete terms. This also means that I reject Mr McKendrick's suggestion that the team at the Hospital will have plenty of time to prepare AB for the potential removal of the baby. It does not seem likely to me that AB would

understand such an idea in the abstract, and the removal of the baby would be deeply traumatic for her.

57. I accept that AB's family may find her having the baby and it being removed more acceptable than termination, and therefore might be able to support her more if the baby was removed. However, I think hearing CD's evidence she will support her daughter either way, and wider familial acceptance and support is too nebulous for me to put weight on.

58. There is the possibility that the baby would be placed with another family member, perhaps in England perhaps in Nigeria. Family adoptions are common in the West African community. The Official Solicitor placed considerable reliance on this in his closing submissions. However, firstly, AB would still have the trauma of the baby taken away from her, within hours or perhaps a day or two in hospital. For most mothers this process is highly upsetting. Secondly, this might allow her to maintain contact and stay with CD, but this is highly speculative. It is equally likely the child would be placed for adoption and AB would have no, or only the most limited contact. Thirdly, the risk of psychiatric impact remains.

59. The Official Solicitor argues that allowing the pregnancy to continue and AB to have the child, would allow her to have the child born alive and then potentially to maintain contact with it. I accept that this might be a vindication of AB's right to have a child, but I wonder the degree to which the Official Solicitor is imposing a philosophical judgement in the abstract of a person's rights, in circumstances where the focus must under the law be on a real individual and a real set of risks and benefits. It is also effectively unknowable, whether in

the scenario the Official Solicitor posits, AB would even know the child was hers if she met it again after it was removed.

60. AB's wishes and feelings are plainly a relevant consideration. There are cases where wishes and feelings would be determinative, even where the person had no capacity. If AB's wishes and feelings were clearly expressed and I felt she had any understanding (albeit non-capacious ones) of the consequences of giving birth, I would give them a great deal of weight. However, AB's wishes are not clear. She likes being pregnant, she would probably like to have a baby, but she has no sense of what this means. As I have said I think she would like to have a baby in the same way she would like to have a nice doll. I just do not feel I can give very much weight to those expressions of wishes and feelings. I also take into account that she has no idea of the risks with her mental health that she would be taking by continuing with the pregnancy.

61. I have had regard to potential stigma from the community, here and in Nigeria. As far as England is concerned CD was clear that few people know she is pregnant, although I do take into account that AB herself may tell people. In any event, I would hope and expect that both communities would understand that this was not a decision of either CD or AB, but one that was ordered by the court.

62. Focusing on AB and her own facts, the risks of allowing her to give birth are in no particular order: Increased psychotic illness; trauma from the caesarean section; trauma and upset of the baby being removed and the risk of the baby being placed with CD and AB losing her home with her mother as well as the baby. The benefits are that of her having a child born

alive and the possibility of some, albeit limited future contact. She may take joy from this, it is not possible to know.

63. In my view the balance in terms of AB's best interests lies in her having the termination. I should make clear that I do not underestimate the harm from this course, but I think that is clearly outweighed by the harm from continuing the pregnancy.