This judgment was delivered in public and the proceedings are subject to the Transparency Orders dated 16 October and 23 October 2023. The anonymity of the first respondent, her family and her treating clinicians must be strictly preserved and nothing must be published that would identify the first respondent or her treating clinicians, either directly or indirectly. 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.

Neutral Citation [2023] EWCOP 183

IN THE COURT OF PROTECTION **Case No 14158438**

Royal Courts of Justice
Strand
London WC2A 2LL

24 October 2023

Before

JOHN MCKENDRICK KC
(Sitting as a Tier 3 Judge of the Court)
SITTING IN PUBLIC

Between:

(1) NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST
(2) PENNINE CARE NHS FOUNDATION TRUST

Applicants

AND

(1) Ms H (By her litigation friend, the Official Solicitor)
(2) Mr FS
(3) Mrs MH

Re H (An Adult; Termination)

Respondents

Ms Katie Scott (on 16 October 2023) instructed by Hill Dickinson and Hempsons respectively for the first and second applicants
Mr James Berry (on 23 October 2023) instructed by Hill Dickinson for the first applicant
Mr Vikram Sachdeva KC instructed by Hempsons for the second applicant (on 23 October 2023)

Mr Conrad Hallin (on 16 October 2023) and **Ms Jenni Richards KC** (on 23 October 2023) instructed by the Official Solicitor for the first respondent
The second respondent appeared in person
The third respondent appeared in person (on 23 October 2023)

HEARING DATES: 16 AND 23 OCTOBER 2023

APPROVED JUDGMENT

This judgment was handed down remotely at 14.30am on 24.10.23 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

John McKendrick KC:

Introduction

1. These proceedings concern the health and welfare of the first respondent and in particular focus on: i. whether she has capacity to make a decision to consent to terminate her pregnancy; ii. if she lacks capacity in respect of this matter, whether a termination is in her best interests or not; and iii. if a termination is in her best interests, whether this should be carried out by a medical or surgical procedure. She is a party to this application and the Official Solicitor acts as her litigation friend. The first respondent is anonymised in this judgment as Ms H.

2. The first and second applicants issued an application on 12 October 2023 for relief pursuant to the Mental Capacity Act 2005 (hereafter "the 2005 Act") seeking orders in respect of Ms H's healthcare and in particular seeking declarations she lacks capacity to conduct the proceedings and to make a decision to terminate her pregnancy. They seek an order that a medical termination is in her best interests. The first applicant is responsible for Ms H's obstetric care. The second applicant is responsible for the care of her mental health.

3. The second respondent is Ms H's father, anonymised as Mr FS. He appeared, in person, at the hearing on 16 October 2023 and asked to be joined as a party. I granted that application. He attended again remotely on 23 October 2023.

4. The third respondent is Ms H's mother, anonymised as Mrs MH. She was served with the application but did not attend the hearing on 16 October 2023 and did not apply to

be a party at that stage. On 18 October 2023 I received an application for her to be joined as a party which I granted on the same date, although this order was not received by the parties. Mrs MH did not know she was joined as a party until the morning of 23 October 2023. I adjourned the start of the hearing for around an hour to permit her to read some of the evidence filed and asked that the solicitors identify the salient evidence for her. I considered, although no application was made, whether to adjourn the hearing to allow Mrs MH more time. I considered the over-riding objective found in the COP Rules and the need for justice having regard to the principles of the 2005 Act. I was concerned the application had been adjourned once already and that an urgent decision was required to be made for Ms H. I was re-assured that the Official Solicitor wished to test the evidence and that Ms Richards was prepared to cross-examine the Trusts' witnesses. On balance, I considered a further adjournment was not necessary and that it was not unjust to proceed. Mrs MH had been involved in the decision making process and had attended a best interest meeting. She was able to question all witnesses and make articulate submissions.

5. On 13 October 2023 Theis J, the Vice President of the Court of Protection, made urgent case management directions which included: granting permission to the applicants; inviting the Official Solicitor to act as litigation friend to Ms H; ensuring service of the application on Mrs MH and Mr FS; providing for disclosure of records to the Official Solicitor and listing the matter for a hearing at 14.00 16 October 2023 with any further evidence to be filed and served by 12.00 13 October 2023 and directing that position statements be filed and served by 12.00 16 October 2023.

6. At the outset of the hearing on 16 October 2023, whilst sitting in public, I made a reporting restriction order prohibiting the reporting of the identify of Ms H and her family members. I was also persuaded, balancing Articles 8 and 10 ECHR, that it was necessary to prohibit the identification of the treating clinicians. Termination of pregnancy arises strong feelings in some. There is (currently) no public interest in the naming of the particular clinicians. They are entitled to protection to carry out their clinical functions without fearing being named. I made clear this was a determination which could be revisited and made the order until the conclusion of the proceedings. I amended the reporting restriction order at the outset of the hearing on 23 October 2023 to prohibit the identification of several more clinicians.

7. After having read the evidence and having heard oral evidence on 16 October 2023, it was clear at the conclusion of that hearing (around 19:00) that an adjournment of the hearing was necessary and no determination could be made. I made directions for further psychiatric evidence in respect of the balance of harm to Ms H's psychiatric health of: i. continuing the pregnancy; ii. medical termination; and iii. surgical termination. I made a direction that evidence from two registered medical practitioners in respect of the section 1 Abortion Act 1967 test (hereafter "the 1967 Act") be filed and served. I granted the Official Solicitor permission to instruct two expert witnesses (although such instructions were not possible in the timescales demanded by the hearings).

8. At the hearing on 23 October 2023 I was in receipt of the evidence directed. After hearing further evidence and submissions, at the conclusion of the hearing (around 18:00) I made declarations that Ms H lacks capacity to conduct these proceedings and to make a decision whether to terminate her pregnancy or as to the method of termination. I made an order that a medical termination is in her best interests. I authorised the use of covert medication and in one limited exception, the use of restraint. I endeavour to set out below my reasons for arriving at these principal conclusions on Ms H's behalf.

9. Ms H is a woman of twenty six years of age. She is diagnosed with Schizoaffective disorder and has been and remains detained pursuant to section 3 of the Mental Health Act 1983 (hereafter "the 1983 Act"). Her pregnancy came to light in July 2023 when she was detained in hospital. With one exception she has been consistent in her wish to have a termination of her pregnancy.

10. This leads the applicants to seek the following relief from the court:

> "[Ms H] lacks capacity to make decisions about terminating her pregnancy and conducting this litigation.
>
> It is lawful for [Ms H] to undergo a medical termination of her foetus in accordance with the applicants care plan dated 11 October 2023.
>
> It is lawful for the applicants to use reasonable and proportionate measures, including the use of physical and chemical restraint, to provide the termination of

[Ms H]'s foetus in accordance with the care plan provided they are the least restrictive measures practicable, and provided always that:

i. Any chemical and physical restraint used is the minimum necessary and proportionate to the likelihood of [Ms H] suffering harm, and the seriousness of that harm, if that restraint were not to be used.
ii. All reasonable steps are taken to minimise distress to [Ms H] and to preserve her dignity."

11. The summary of the evidence below sets out the background to the difficult issues which give rise to the application before the court.

Remote Judicial Visit With Ms H

12. At the outset of the hearing on 16 October 2023 I was informed by Mr Hallin that Ms H wished to meet with the judge who was making the decision. I consulted the Practice Note on Judicial Visits found at [2022] EWCOP 5, dated 10 February 2022. I endeavoured to follow this guidance. I consulted with the parties regarding the purpose of the meeting and the practicalities. I agreed to meet with Ms H by way of Microsoft Teams with her solicitor, Ms O'Connell, present. Ms O'Connell took a note of our meeting which I approved the following day which was then circulated to all parties. When I met with Ms H she was in a room at the hospital where she is detained. She was initially present with her two support workers and Ms G (the family liaison officer). As she is a witness, I asked Ms G to leave, which she agreed to. I spoke with Ms H for around ten minutes in the presence of her two support workers. She was agitated. She told me she was wanted a termination and when I asked her whether she would want a medical or surgical termination she clearly chose a medical termination.

13. The purpose of my visit was largely to comply with Ms H's wish to meet with the judge. Given the terms of section 4 (4) of the 2005 Act, there is a duty on the court "*so far as reasonably practicable,* [to] *permit and encourage* [Ms H] *to participate, or to improve her ability to participate, as fully as possible in any act done for her and any decision affecting her*." I did not require to see Ms H to ascertain her wishes and feelings. These had been comprehensively set out in a most helpful attendance note exhibited to a witness statement (see below).

14. A decision to terminate a pregnancy is a profoundly personal one. It would have been inconsistent with the duty on the court to both promote Ms H's autonomy, and to respect

her dignity, for the judge not to have met with her, at her request. It was a privilege to meet with Ms H.

The Evidence Presented on 16 October 2023

Mr K Consultant Psychiatrist

15. Dr K is a consultant psychiatrist employed by the second applicant. He specialises in general psychiatry and perinatal psychiatry. He provided a witness statement dated 11 October 2023. He does not have a regular role in Ms H's care but was asked to provide his opinion. He met her on 9 October 2023 in the company of a ward sister. The meeting took place a few days after a meeting with midwives and a scan which confirmed the foetus is alive and growing in utero. His evidence was that Ms H's consultant obstetrician has concluded that Ms H lacks the capacity to make a decision whether to have a termination and his "own conclusion from meeting [Ms H] would support that assessment".

16. His evidence is succinct:

> "Whilst [Ms H] can certainly understand certain relevant information such as the need to take tablets to carry out the termination and the need to move to the labour ward to do so, she spoke inconsistently about the pregnancy and the baby. She presented with symptoms of mania and psychosis during our meeting. She spoke of being in line to the throne of India and a successful singing career. She continues to refer to twins and that certain anti-psychotic medications were connected with her being gang raped. She stated that she wanted to have a termination as the foetus is a result of rape, she also said she was not ready to have child. On the other hand, she stated that she wants to have a child with her boyfriend as soon as she had terminated the pregnancy.
>
> It is clear that her delusions are impacting on her being able to understand information about the baby and weigh that information as part of the decision-making process."

17. His written evidence did not consider the psychiatric/psychological and wider mental health risks to Ms H of: i. continuing the pregnancy; and ii. the issue of a medical termination versus a surgical termination.

18. In answer to questions put to him by Mr Hallin he gave evidence that Ms H had been clear in her meeting with him that she wanted a termination. Her psychotic state however affected her ability to weigh up the 'pros and cons' to make a decision. Her thinking was delusional, evidenced by the fact she variously thought she was the 'on the throne of India', had a successful singing career, was raped and had carried twins. His evidence did not go into detail in respect of her decision-making ability in respect of medical verses surgical termination. Dr K told me he had not seen Dr D's witness statement for the purposes of these proceedings. He said it was difficult to predict with any certainty whether Ms H would take the necessary medication for a medical termination, but as a judgement call he thought it more likely she would, however, he was concerned that it was difficult to predict her behaviour given her mental health, in circumstances where she would be on a labour ward with a considerable amount of blood and pain brought on by the termination. He described this as "difficult" particularly given the necessary window of 24-48 hours for the treatment. He said it was possible she could withstand it and could be given sedation to help. His evidence was that vaginal examinations were a risk and she was likely to be distressed because of her belief she had been raped. The birth of a live foetus, if that took place, would be distressing and could make her psychiatric condition worse. He said that it was 'logical' that a surgical termination would be short, with less pain and it seemed to him to be 'less traumatic'. He said that, on balance, it would be better as it would expose Ms H to less pain, less bleeding, and avoid the risk of her seeing the foetus with signs of life. He pointed out however that she might wonder what had happened during the procedure because she would be unconscious. He told me he had not expressed his views on the less risky surgical termination before. He told me there were multiple risks of continuing the pregnancy which included: the damage to her mental health from continuing an unwanted pregnancy, post-natal psychosis and post-natal depression both of which were significantly higher given her mania and psychosis. When asked by me directly whether the termination or continuing the pregnancy presented higher risks he said: "I have thought about this for some time. It is very difficult. The risks are almost equal in both directions". It is my impression that Ms Scott was surprised by this

evidence and in re-examination sought clarification. Dr K agreed that a growing abdomen and lactating would be distressing for Ms H but Dr K was less clear that Ms H had provided a consistently negative view of her pregnancy.

Mr G, Nurse/Responsible Clinician

19. Mr G is a consultant nurse with the second applicant. He is a registered mental health nurse. He is Ms H's responsible clinician for the purposes of the Mental Health Act 1983 (hereafter "the 1983 Act"). He has provided a witness statement dated 10 October 2023. He first met her in June 2022 when she had a short inpatient admission. Ms H is currently detained pursuant to section 3 of the 1983 Act. She has been known to community mental health service in her local area since 2015 when she was diagnosed with Schizoaffective disorder. There is no evidence of intellectual impairments. Mr G's evidence is that when unwell Ms H has elated mood, pressured speech, grandiose ideas and persecutory beliefs particularly around being poisoned and sexually assaulted. She is vulnerable and at risk of physical, psychological and sexual harm. She has misused drugs. She has limited insight which he describes as "partial". He describes her as "chaotic, elusive and difficult to engage".

20. Ms H was detained pursuant to section 2 of the 1983 Act on 19 July 2023. This was converted to section 3 on 14 August 2023. Prior to her admission there is a chronology of bizarre behaviour including section 136 1983 Act interventions. Drug testing around this time was positive for cannabis and cocaine. His witness statement charts the period of her detention and her behaviour. On 22 July 2023 routine urine testing detected she was pregnant, which was confirmed by blood tests. She was described as "happy" about this news.

21. On 25 July 2023 she was seen by a doctor and a mental health midwife. It is reported she stated she was no longer pregnant as "she had spat it out". She was abusive and threatening and required rapid tranquilization. On 28 July 2023 she informed nursing staff that she knew the identity of the father and that "he does not want the child and he will kill her if she doesn't get rid of it". She reiterated however she was no longer pregnant as she had "coughed it up".

22. He explains that it has been necessary to nurse her in seclusion, that she was supported by a ratio of 3:1 for some time which is now reduced to 2:1. He says that the prescription of Lorazepam was taking place almost daily but has now reduced to around twice a week. He states that it had been hoped that she would be well enough to make her own decisions about the pregnancy/termination but whilst she has been very unwell and is going in the right direction, she still has a high level of need and "continues to dispute her pregnancy and continues to lack insight into her medical disorder".

23. He states that the proposed treatment is for Ms H to have a termination. He states that "all recent" discussions support Ms H wishing to have a termination and she wishes for this to take place by taking medication. He sets out options should she be 'non-compliant'. He states that Ms H will not currently speak with him and therefore he has not discussed her pregnancy. Notwithstanding this he opines that it is "very unlikely" Ms H would be able to understand and weigh the necessary information about the termination.

24. He sets out in detail excerpts of Ms H's recorded views about her pregnancy. Having been initially happy (on one occasion) she has often denied she is pregnant and only three days after being informed of her pregnancy she is reported to have said she was no longer pregnant because she had spat it out. She has repeatedly said she has miscarried and is no longer pregnant. She has denied the pregnancy and reported that the foetus is dead. She also said she does not want the baby as she believes it is dying. She often states the pregnancy was brought about by her being raped by a medical professional. There are many reports of her asking for an abortion.

25. He states that Ms H has a good relationship with her mother. Her mother is reported to support the termination. He reports it is not clear who the father of the foetus is. He states he is confident, contrary to Ms H's disclosures, that the father is not a member of the hospital staff. He concludes that the termination is in her best interests and should be done as soon as possible. He leaves the question of how it should take place to obstetric clinical colleagues.

26. He exhibits his 2 August 2023 report to the First-tier Tribunal. He also exhibits an entry into the medical records from a consultant psychiatrist, Dr A. That records that Ms H suffers from a mental disorder characterised by persecutory delusions which is having

a ‘huge impact’ on her ability to relate to others and tolerate their views. Dr A concludes Ms H has not been given sufficient information to make a decision about her pregnancy and she requires the opportunity to be given the correct information and every practical step should be taken to support her. Also exhibited are seclusion records.

27. In cross-examination Mr G disagreed with Dr K and stated that it was not evenly balanced whether it was “more harmful, psychologically, to continue with the pregnancy”. He said the only positive comment Ms H had made about her pregnancy was at the very beginning in July 2023. He agreed Ms H had agreed to have a medical termination. He did not believe there would be an improvement in her delusional beliefs during her pregnancy.

Dr D, Consultant Obstetrician and Gynaecologist

28. Dr D is a consultant obstetrician and gynaecologist employed by the first applicant. She has been a consultant since 2016. She recounts a history of the midwife involvement, I assume from records. On 4 October 2023 she met with Ms H on the mental health ward. Dr D records the following from this assessment:

> [Ms H] had pressure of speech and lost focus during the discussion regarding the termination of pregnancy and repeatedly:
>
> - Discussed her sister’s education stating that she was 1 year and 15 days younger than [Ms H]
> - Alleged that she had been sexually assaulted several times whilst an inpatient on A ward and the 136 suite
> - Stated that she had 3 deceased foetuses inside her which she wanted to get out
> - Stated she has 3 hearts
> - Said she wants to see her family
> - Said she has been an inpatient for 17 weeks (this is not correct)
> - Stated that A ward staff have confiscated her phone
> - Stated she has lost an excessive amount of weight due to being neglected/ starved in the 136 suite

- Said she had a twin pregnancy but she was given an injection which killed them, and that she has buried them in the hospital grounds and planted a rose tree
- Said that she is a 26 year old woman and it's her prerogative to have a termination of pregnancy
- Stated that her mother supports her decision to have a termination of pregnancy.

29. Dr D's written evidence on capacity is:

> "She informed us that she had a surgical termination before, and we informed her that we could only provide her with a medical one. She confirmed that she would take tablets instead of going for a Surgical Termination.
> She appeared very unwell mentally, but confirmed she wanted to go ahead with the termination. She remained under the delusional belief that she is only 6 weeks pregnant, and the foetus has already died."

30. Dr D explains that her service does not provide surgical terminations. Medical termination involves the patient being given a tablet called mifepristone (200 mg) orally. One tablet will be given, then 24 to 48 hrs later the patient needs to be given a regime of misoprostol tablets depending on the gestation of pregnancy but it is estimated for Ms H around five tablets should be administered. The misoprostol tablets can be given orally or vaginally. This can be provided "up to 21+5 weeks". If the pregnancy exceeds "21+6" Ms H medical termination would need to take place at a different hospital with the administration of Feticide. Dr D states: "Generally, there are no side effects after taking Mifepristone, and commonly women go home after taking this tablet."

31. Dr D explains that Ms H had an ultrasound on 5 October 2024 which confirmed she was then 15 weeks pregnant. She will not need another, she writes. Dr D notes that Ms H has been compliant with ultrasounds for her pregnancy.

32. The treating team are concerned that Ms H may not cooperate with the termination procedure, Dr D states that Ms H will need:

"to be provided with the regime of misoprostol. The dosage will depend on the gestation of pregnancy. [Ms H] is now coming up to being 15 weeks pregnant, so if this were to take place in say a week, the regime would be misoprostol 400 microgram 3 hourly for 5 doses. If [Ms H] vomits up her oral medication, misoprostol can be given vaginally, but this may cause distress to [Ms H]. This could be tried if she were to agree/comply to it. If she did not agree, we would not administer the tablets vaginally by force as this is likely to be extremely distressing for her. The procedure would need to be abandoned and her wishes about a termination would need to be revisited once she was back on [A] Ward. We could only wait up to 24 hours to see if [Ms H] would carry on with the next dose.

If [Ms H] accepted the first/second dose and then did not comply further, there is the risk that the foetus can carry on developing or it could die in the uterus. Therefore, there would be no guarantee that the termination would have been completed.

A cannula to be inserted and bloods taken for Full blood count and Group and Save. She has agreed to this. It is anticipated therefore that she will comply with this part of the procedure. However, A Ward staff will be contacted to establish if confirmation of her blood group is known to them. If she does not comply then restraint would be required for the above procedure."

33. Dr D sets out the risks to Ms H, given she was at fifteen weeks gestation:

"If the medical termination is performed early in the pregnancy (by which I mean before 13 weeks), it's more likely to be a quick procedure with less chances of bleeding and less chance of needing to go to theatre. As [Ms H] is now in her 15th week, the risks are increased. These risks are:

a. In some terminations, only the foetus is passed, but the placenta is retained. We would assess whether this has happened by vaginal examination. This occurs in 13 women out of every 100. If this does occur, she may need to go to theatre for the placenta to be removed.

b. She may also need to go to theatre if she starts bleeding heavily. This occurs in 1.4 women out of every 100.
c. If [Ms H] was to bleed heavily or the placenta did not pass, then she would need to go to theatre. The Labour Ward has 2 theatres and [Ms H] would be a priority. If the medical emergency occurred in the evening, there is the likelihood that we would need to wait for the relevant staff to be called in. However, it must be emphasised from a medical science stance, that you cannot rule out the above risks."

34. Dr D then sets out the risks to Ms H if she is required to go to theatre for placenta removal. This may take place with a local anaesthetic placed into the spine. If that is not possible then a general anaesthesia would be needed. Suction evacuation of the placenta would take place. If this is not possible Ms H may need a hysterectomy. Dr D gives evidence she would only remove the womb as a last resort to save life and the risk of a hysterectomy is less than 1 %. When discussing these issues with Ms H, Dr D states:

> "I discussed the risk of not passing the placenta during the termination with her on 4 October 2023. She acknowledged that she may need to go to theatre."

35. Dr D sets out the statistical risks to the medical termination:

> "13 women in every 100 will require surgery to evacuate retained products of conception.
> 1.4 women in every 100 will have heavy bleeding requiring transfusion.
> 4 women in every 100 will have an infection.
> Less than 1 woman in 100 (for women with previous Caesarean section) will have uterine rupture."

36. Dr D continues in her evidence to state:

> "There is the further concern that if the termination procedure is conducted after 16 weeks of pregnancy, there will be a likelihood that the foetus when expelled,

will show signs of life. This could include spontaneous breathing, spontaneous heartbeat, pulsation of the umbilical cord or definite movement of voluntary muscles. As the foetus/baby will not be resuscitated, the baby will be treated with dignity and care. In addition, a coroner's referral would need to be made at this stage. Furthermore, because [Ms H] will be past 15 weeks pregnant, her breasts will start to produce milk and she will therefore be provided with Cabergoline tablet (1 mg as a single dose) to suppress milk production."

37. Dr D's evidence continues to set out the benefits and burdens of: i. medical termination; ii. surgical termination; iii. no termination. She concludes that a medical termination is in Ms H's best interests and urges the court to hear the application as soon as possible given the damaging effect to Ms H of prolonging the pregnancy.

38. Dr D was questioned first by Ms Scott to deal with gaps in the evidence. She was asked whether the section 1, 1967 Act test was met. She said yes. She identified a colleague who agreed. She did not (at first) identify which of the section 1 1967 Act sub-tests were met or the grounds upon which she and her obstetric colleagues agreed the tests was met such that a lawful termination could take place. In answer to my question she then said the sub-section 1 (1) (a) test was met because of the psychiatric harm that would be caused if the pregnancy continued. When I raised with her the view of Dr K of the termination and pregnancy being finely balanced, she said she could not give evidence of psychiatric risks but raised her concern in respect of the risks of raised blood pressure. She made reference to another psychiatrist who had spoken in a meeting, but could not recall the name of the psychiatrist or identify notes from that meeting. She then said both mental health and physical health risks were higher if the pregnancy continued. She gave evidence that her unit did not carry out surgical terminations and the only provider that did have the ability to provide a termination was in London but it was "too far". She clarified in her evidence that misoprostol would require five doses orally or vaginally and that there would likely need to be vaginal examination over the 24-48 hour period. She told me that Ms H had not had a vaginal examination. She explained that it was accepted that restraint could not be used to administer the oral or vaginal medication or carry out the vaginal examinations, in the event that Ms H was non-compliant. If she was resistant they would need to abandon the medical termination. She accepted there was a risk of sepsis and of heavy bleeding.

39. In answer to questions from Mr Hallin, she accepted Dr K's psychiatric evidence, accepting he "is the psychiatrist". She accepted a surgical termination had advantages in as much as did not involve repeated vaginal examinations and did not take 24-48 hours. She accepted that if the medical termination begins but Ms H becomes distressed and is not compliant then there was a risk Ms H would have to go to term with a damaged foetus. In answer to a question from me she gave evidence there was still a window for a surgical termination because Ms H was at 16 weeks. She noted earlier in her evidence "every day counts."

Ms G, Family Liaison Officer

40. Ms G is a family liaison officer and a registered nursing associate in the employ of the second applicant. She has provided a witness statement dated 10 October 2023. She relays Ms H's mother's views, who she has spoken to via telephone on Zoom on one occasion. Ms H's mother says that Ms H "told her that she would not want to have a baby to look after at this stage in her life because she could only just look after herself and would not cope looking after a baby as well." Ms H has said that she :does want to be a mother in the future" but was still too young for motherhood now. Ms G reports that Ms H's mother's view is that Ms H's true wish would be for the termination. It is reported by Ms G that Ms H's mother was able to reflect on Ms H's views in respect of a termination it is said took place when she was seventeen. Ms H's mother, Mrs MH, indicates Ms H was in a relationship with a man for 2 ½ months between April and July 2023. She had never met him. It is said the relationship end was a catalyst for Ms H to take cocaine. Ms H's mother is very concerned the pregnancy has run this far and the "last thing she wants for" Ms H is for her to give birth to a baby. She was of the view a surgical termination was preferable over a medical termination. Ms G says that at a Zoom call between her and Ms H and her mother, Ms H said she definitely wanted termination of the "rape baby". The only time she contradicted this view was that she would have the baby if it was "Z's". It is not clear who Z is.

41. Ms G spoke with Ms H's father. He is of the view termination is the "right decision" for Ms H as she could not look after a baby and cannot look after herself. He believes

in respecting nature as part of his religious beliefs but understands it is not in Ms H's best interests to have the baby.

Yee Fon Mac – Agent for Official Solicitor

42. The Official Solicitor was able to instruct Ms Yee Fon Mac to visit Ms H on 13 October 2023. A detailed note of her attendance is provided. It sets out Ms H's wishes and feelings. I think Ms H was quite unwell that day. I provide just one excerpt from the note:

> "YFM – And what are your views about the termination?
> [Ms H] – I need to get it the fuck out my stomach. My family is Royal blood and is direct to be next on the throne. I am now pregnant with the doctor's baby. The doctor tried to f.... three members of my family. I am the granddaughter of Queen of India. I am an important person and that's why the doctor wanted to make me pregnant. I am not having this baby. No one believes me that I was raped. My water broke last night at 12:15am. There was a big pile of water. The nurse called the maternity ward, and I was to be seen in 20 mins and it has been over 15 hours since they said that. It is fucking disgusting what they are doing to me. I am in so much pain."

Other

43. Within the bundle is a proposed care plan. This is the product of a multi-disciplinary team. It explains the proposed medical termination and ancillary care in detail.

44. A best interests meeting took place on 10 October 2023. A large number of people attended including Ms H's mother, representatives from the two legal firms, clinicians from both Trusts which included specialists in psychiatry and obstetrics, midwifery and mental health nursing. Ms H did not attend and there is no record of why she did not attend or whether the decision was taken not to invite her and if so, why.

45. Dr K is recorded as saying the following:

> "Conclusion is that she doesn't have capacity. She did not explicitly indicate that she wanted a termination. She said it at one point, but on the fact that it is a rape child. She said that she wanted to have a child straightaway after the termination. It then changed to I'm not ready for a child. A very confusing picture. She was able to communicate. She was able to understand the question 'do you want a termination'. She explicitly gave two views. We think that the father might be her boyfriend. At some point she mentioned that she wanted a child straightaway with her boyfriend. Equally she also said she didn't. She doesn't have capacity and it is not possible to establish clearly her wishes about this pregnancy from what she told us. Whether she wants a termination or not is very unclear."

46. The notes set out that Dr D and a specialist mental health midwife said:

> "RD: Me and Michele went to see her on the 4th. We explained to her that she needs to take medication, that she needs to go to the labour ward. She agreed to having tablets on the labour ward. We also explained that there was a possibility that she would go to the theatre. She even told us that when she was 17, she had a surgical termination. We told her that we were doing a medical termination, which she understood.
> RD: She understood what we were talking about. She understood that she would be taking the tablets.
> AN: The plan before we went in was that we were going to keep it concise. [Ms H] was listening, we had to keep her on track a couple of times. We asked her to repeat the process to us, and she was very able to do so. She even went to the depth of saying that her mum would be there, and she would be comfortable with her mum there. In terms of the procedure, she was able to understand it and repeat it back to us."

47. Of importance, Ms H's mother, Mrs MH is recorded as saying:

> "It's frustrating because it was going on for weeks. I became aware of it when she was 11 weeks. Staff knew when she was 8 weeks. That could have been an option then. Now my daughter is going to have that additional trauma."

Evidence for the Hearing on 23 October 2023

48. In compliance with the directions made on 16 October 2023, further evidence was filed and served on 19 October 2023. I received an updated bundle and helpful position statements on 20 October 2023. I received further position statements on the morning of 23 October 2023.

Dr A

49. Dr A is a consultant psychiatrist employed by the second applicant. His witness statement is dated 19 October 2023. Helpfully he has been involved in Ms H's care since 2015, when she was first admitted to hospital. She was then suffering from her first psychotic episode thought to be brought about by drug use. Dr A was then Ms H's responsible clinician for a number of years and saw her regularly. Dr A chose to become involved in Ms H's care in September 2023 by providing a second opinion. He assessed her in person on 28 September 2023 and met with her a second time by MS Teams on 18 October 2023. He makes a clear diagnosis of Schizoaffective disorder of a nature and degree to warrant treatment in hospital under the 1983 Act. He states:

> "It is my opinion that [Ms H] does not currently have the capacity to make the decision regarding the pregnancy and what she wants to do with it. My view is due to the effects of the symptoms of her mental disorder on her ability to make very clear logical decisions about the pregnancy."

50. Dr A then sets out the delusional beliefs that underpin Ms H's views in respect of her pregnancy. He continues in his evidence:

> "Due to the complexity of her current delusions and other symptoms, she is unable to engage in the process of weighing up the pros and cons of keeping the pregnancy or having a termination. She is unable to engage in the process of examining the pros and cons of the method of termination of pregnancy, either surgically or with the use of medication. While she has been very clear and

consistent about the method of which she wants the termination, it is very clear that she is unable to fully appreciate the risks between both procedures."

51. Dr A then discussed with Ms H her wishes and feelings in respect of a medical versus surgical termination. Importantly, Dr A records:

> "She was able to clearly discuss with me the process before the surgical procedure, during the procedure and her recovery following the procedure. She was very clear to me that she did not want to go through the same thing. I explored with her why this was and she said that she was worried about some of the process that needs to occur before the actual procedure such as having to lie down on a bed, the position she needs to adopt prior to the termination and the "intrusion" into her body. She was particularly worried about the fact that the pregnancy was more advanced than when she had her previous termination, and she could suffer more harm if she was to have another surgical termination. I tried to clarify what she meant by more harm and she repeatedly stated that she was unhappy to lie down and have the baby pulled out of her body by someone else."

52. Dr A then helpfully sets out the risks to Ms H of continuing the pregnancy. I summarise these as follows. The continued pregnancy and birth of a child present significant risks to Ms H's wellbeing and her ability to stay well. She would be at risk of failing to take her medication and there would be "an escalation in her risks both for and the child". Ms H would be at risk of self-harm. Her aggressive behaviours would be very difficult to manage when pregnant and the likelihood of restraint would place her and the unborn baby at risk. There is an increased risk of post-natal depression. There are risks of physical harm to Ms H as she has tried to "pass" the foetus. There is a risk that full term delivery would put her at risk of "psychiatric deterioration". Dr A concludes as follows:

> "In summary, having known [Ms H] since 2015 and having addressed these issues explicitly with her in our discussion on 18 October, it is my strong view that proceeding with the pregnancy is an option of very high psychiatric risk to [Ms H] in her current circumstances.

> I have been asked to provide a view specifically as to the balance of psychiatric risk to [Ms H] between terminating and continuing the pregnancy. I am strongly of the view that the psychiatric risk to [Ms H] of continuing the pregnancy is significantly more than the psychiatric risk of terminating the pregnancy."

53. Helpfully Dr A also discussed with Dr D, Ms H's obstetric needs. He has reviewed the care plan. He opines that a medical termination is likely to have the least impact on her mental health. Dr A also believes that Ms H is likely to be "compliant both with the termination medication and any associated pain relief". He states that he would be opposed to the use of restraint should Ms H be non-compliant during the medical termination, other than in the context of a medical emergency and sudden deterioration. Dr A discussed Ms H's case with Professor R at a hospital 130 miles away. Prof R explains that Ms H would likely require to lie on a couch in the lithotomy position (flat on her back with her calves in stirrups) awake for around six hours. Dr A considered this could be traumatising for Ms H. Dr A warns of a significant escalation in risks to Ms H of surgical termination. Dr A states: "*Due to the nature of the delusions around how she became pregnant (sexually assaulted by eight men), it is my opinion that a procedure as described above (i.e. the insertion of instruments into her vagina when she is awake) at this point in time will only make things worse for her.*" Dr A also raises concerns about the termination taking place under a general anaesthetic and whether this might feed further delusions on Ms H's part.

54. Dr A states that:

> "She is aware that if she was to have a medical termination, she will require a tablet initially and then five other tablets three hours apart, 24 hours after the initial one. She is aware that she is likely to bleed with expulsion of foetal parts. In spite of her current mental state, it is my view that [Ms H] is relatively ready for the procedure and has the necessary support available ([A] ward staff and her mother) to help her manage this safely. As this is something she has maintained she wants to go through, there is a likelihood that she will comply with the procedure itself."

55. Dr A gave clear and focused oral evidence. He told me that Ms H had been 'very' consistent in wanting a termination. She had sought out his assistance and contacted him in LinkedIn and he sought consent to become involved in assisting her with the issues before the court, which was granted. He said that whilst she was pregnant he could not optimise the treatment of her Schizoaffective disorder and that Clozapine could not be administered whilst she was pregnant. He said a clear benefit of medical termination was that she could be supported locally by staff who knew her. He volunteered to be available to oversee support and assist a medical termination if this took place in Greater Manchester. He said she wants the pregnancy over "as soon as possible" and that she is tired of having conversations about her pregnancy. "She wants it to end". She told him there would be no need for restraint if she were to have a medical termination. When asked if he had misunderstood how long she would need to be in "stirrups" to have a surgical termination (six hours versus a short period of time to have the dilatory rods inserted) he said that was not a material matter. He was concerned that a surgical termination could perpetuate her delusions about what medical professionals had done to her. His evidence was that she does not "fully grasp" what a surgical termination involves. He said that she had been given covert medication "fairly successfully". She understood a medical termination would involve around 5 tablets, not just one. He asked her about this only yesterday and she "understood it". He told the court that she informed him that she had broken her ribs and understood what pain is and wanted "to get it [the termination] done". He accepted in answer to a question from Ms Richards that in the context that Ms H might have pain, bleeding, cramps, and the need to actively 'push' that her compliance was "not straightforward but challenging but she had maintained and been consistent" in her wish for a medical termination. He said it would be very "tricky" to get her to Newcastle for a surgical termination. That she knew a medical termination would be local and she would "suspect" if conveyed somewhere else. He said Mrs MH's presence at the termination would be "really positive" and she is "really helpful and supportive". In answer to a question from Mr Sachdeva he said that Ms H "is keen for the pregnancy to end, she wants control over that. Anything done forcibly is likely to have a significant effect on her". It was important to "to give her some control and autonomy and to be supported with the termination." He was clear it was more damaging to have the surgical termination.

Mr G

56. Mr G provides a short updating statement agreeing with Dr A's opinion that a medical termination is in Ms H's best interests. It is dated 19 October 2023.

Dr AD

57. Dr AD has provided a witness statement, dated 19 October 2023. She is a consultant obstetrician and gynaecologist employed by the first applicant. She is also the clinical director for obstetrics in the perinatal division. She surveys all the evidence filed within these proceedings, including Dr A's statement (summarised above). She states that the section 1 1967 Act test is met because Ms H's pregnancy is less than 24 weeks and continuing the pregnancy involves greater risk to her mental health than if the pregnancy of terminated. Helpfully she has produced for the court the signed HAS 1 Abortion form which is also signed by Dr D. It is dated 20 October 2023.

58. She provides an update in respect of the search for a placement which could offer a surgical termination. Her evidence is that a hospital in Manchester would not offer surgical termination for patients over 14 weeks. A hospital in Newcastle will not offer the surgical termination if Ms H continues to request a medical termination. A hospital in London could have a consultation with Ms H on 30 October 2023 and perform the termination on 2 November 2023. Another hospital in London could see Ms H and carry out cervical preparation on 7 November 2023 and perform the termination on 8 November 2023. Dr D states that the transfer of Ms H from her current hospital to one of these hospitals could present challenges to Ms H and could further impact on her mental health.

Dr D

59. Dr D has provided a helpful second witness statement, dated 19 October 2023. She agrees with Dr AD in respect of section 1 of the 1967 Act.

60. In this statement she makes reference to the Royal College of Obstetrician and Gynaecologists (RCOG) guidance on terminations. It states:

"Surgical abortion between 14 and 24 weeks can be performed using dilatation and evacuation (D&E). D&E requires preparation of the cervix using osmotic dilators or pharmacological agents, and evacuating the uterus using long forceps and vacuum aspiration with cannulas.

…."

61. The Guidance sets out the following risks which I reproduce:

Table 2 Complications and risks of abortion; adapted from the NICE (2019) ***Abortion Care*** guideline and the RCOG (2011) ***Care of Women Requesting Induced Abortion*** guideline

Complication/risk	Medical abortion	Surgical abortion
Continuing pregnancy	1–2 in 100	1 in 1000 Higher in pregnancies <7 weeks
Need for further intervention to complete the procedure	<14 weeks: 70 in 1000 >14 weeks: 13 in 100	<14 weeks: 35 in 1000 >14 weeks: 3 in 100
Infection*	Less than 1 in 100	Less than 1 in 100
Severe bleeding requiring transfusion	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000
Cervical injury from dilation and manipulation**	–	1 in 100
Uterine perforation	–	1–4 in 1000
Uterine rupture	Less than 1 in 1000 for second-trimester medical abortions***	–

* Upper genital tract infection of varying degrees of severity is unlikely but may occur after abortion and is usually associated with pre-existing infection. Infection after surgical abortion is reduced with use of prophylactic antibiotics.
** Cervical injury is less likely if cervical preparation is undertaken in line with best practice.
*** The presence of a uterine scar (e.g. following a previous caesarean) is a risk factor.

62. In the light of this, Dr D states that if the medical termination is completed it is less likely to cause Ms H further trauma than if she is conveyed for a surgical termination.

63. She sets out the circumstances of when surgery would be available to Ms H at her hospital. She says that if Ms H has heavy bleeding the clinical team would seek to remove the foetus or placenta vaginally if expelled from uterus. If that is not possible, the team may need to perform a hysterotomy (an abdominal incision) which would also require uterotonics. In the case of torrential bleeding, Ms H may require a hysterectomy. The risk of a hysterectomy is said to be less than 1%. In such circumstances another consultant would become involved. Dr D's evidence is:

> "It follows that there is a stark difference between the Trust offering emergency surgery by way of a hysterotomy if medical termination does not proceed as planned, and a surgical termination. Hysterotomy requires an abdominal incision to be made. Whereas a surgical termination can be performed vaginally, at later gestation the cervix needs priming by either chemical or mechanical methods. The 'emergency' procedure is not something that we would offer at the outset and hence cannot be seen as an alternative to the two options available to the court which are (i) medical termination at my Trust; or (ii) surgical termination with an alternative provider (if they are willing to proceed to a surgical termination after assessing [Ms H]). A surgical termination will involve a delay before assessment and then treatment which cannot be considered to be desirable for [Ms H]."

64. The care plan attached to Dr D's statement notes that 13 in every 100 women will require surgery to 'evacuate retained products of conception'. 1.4 women in 100 will have heavy bleeding requiring transfusion. 4 in 100 women will have an infection. If Ms H requires to go to theatre for placenta removal or because of heavy bleeding, then 'most patients' would receive a spinal anaesthetic, which is a local anaesthesia. This will depend on Ms H's presentation. If that is not possible then general anaesthesia would be offered. When anaesthetised, then the placenta could be removed manually or by suction. A hysterectomy would be a measure of last resort if necessary to save her life.

65. Dr D was questioned by the parties. She told me that Ms H's pregnancy is now at 17 weeks + 4 days. She said that if there were to be a medical termination, arrangements could be put in place so that Ms H did not see the delivered foetus should she not want to. She reiterated her written opinion that a medical termination was better for Ms H because it was consistent with her wishes, there was no risk of perforation of the womb or risk of damage to the neck of the womb. It was also better as it did not involve travel to a hospital in Newcastle. In answer to questions from Ms Richards she said that as the surgical procedure was not offered at her hospital they did not really explain to Ms H what it involved. Dr AD and a midwife went last Friday to try to explain it but Ms H did not engage. She referred me to Dr A's discussion. She said that the pain involved

in a medical termination was predominantly in the second 24 hours of the 24-48 hour period. She had no experience of Ms H's pain threshold. She said there was not much active involvement on the part of the patient to deliver the foetus but sometimes more effort was needed to remove the placenta. She said most woman only required 5 doses of misoprostol and it was "very rare" that a short break was needed and the process started again.

66. In terms of restrictions, Dr D said that if she were non-compliant they would first encourage her and then consider and use covert medication. Dr D understood she has received covert medication in apple juice. If there was a partial procedure and she was not compliant with all medication, then there could be risks to Ms H's physical health. If the foetus remained in "its bag of fluid" there would unlikely be an infection. She said that if she was bleeding but the foetus/placenta did not come out then they would need to do a vaginal examination. There may need to be more than one. If they are unsure as to the location of the foetus and placenta then an examination would be needed. She was asked by Ms Richards about the care plan which states:

> "Once [Ms H] starts the termination process (i.e. has commenced Misoprostol) she would need to continue it. Leaving it halfway means the pregnancy may continue and it is uncertain what harm it may cause to the unborn baby or could cause delayed intrauterine death of the fetus and therefore the fetus would need to be removed."

67. This would involve Ms H remaining on the labour ward or going to theatre if there were concerns about bleeding and the location of the placenta/foetus.

68. She was asked about the 13 in 100 women requiring further intervention. She accepted "risks are greater if [Ms H] does not comply and doesn't take all medication". She accepted the spinal anaesthesia would require a compliant patient so that in reality if Ms H were non-compliant, then general anaesthesia would be required in the event of complications particularly if the placenta was not delivered. She reiterated her written evidence that the risk of a hysterotomy was less than 1 %. She said in her 7-8 years she had not seen this. She accepted most patients she sees are compliant and most woman have made a choice. She further said there Ms H was not at higher risk of hysterotomy

than any other women. She said that if the medical termination was not complete then consideration could be given to surgical termination but she did not explain the practicalities of that.

69. Dr D said the benefits of medical termination were that it avoided the risk of perforation of the womb and the risk of damage to the neck of the womb. In answer to questions from Ms Richards she accepted that, given she would have a private room, if she wanted to leave, for example to smoke when she was bleeding, "we might have to prevent her leaving". Once she starts the medical termination she would need to continue. Attempts would be made to persuade her and then use of covert medication could be deployed. There was a risk that if she began the process and did not complete it because of non-compliance she was at risk of infection if the foetus' "bag" broke. She was concerned that vaginal examinations would be needed if the foetus and placenta were not delivered after taking the medication. Clinicians would need to check the location, particularly of the placenta. It might be in the uterus, not having come into the vagina and would need to be removed surgically under general anaesthesia. She said that some of the placenta remaining was "pretty common" and happened in 13/100 patients subject of a medical termination. She accepted Ms Richards' question that Ms H was at risk of a greater than 13/100 chance of the need for surgical intervention given her mental health co-morbidity because she might be non-compliant with the medication. In answer to a question from Mr Berry in re-examination she said that Ms H was not at higher risk of a hysterotomy than the average woman.

Professor R

70. Professor R is a consultant obstetrician and gynaecologist in Newcastle. I had not expected to hear evidence from him and (understandably) no witness statement was provided. His involvement was hinted at in the written evidence which made reference to a hospital in Newcastle. He was provided papers over the weekend. He was able to give evidence remotely. I am most grateful to Professor R for absorbing the information in the papers at such short notice and giving evidence to the court.

71. His evidence was that he was content to provide a surgical termination. This would likely take place on Wednesday 1 November 2023 in Newcastle. Given the complexity

and arranging staffing it was not likely to take place earlier. He emphasised certain studies that demonstrated the patient's choice of termination procedure was very important. He agreed the risk of further intervention at the risk of 13/100 was likely with a medical termination. He explained the three options for "priming" the cervix in advance of the surgical termination. The first was with the use of small rods inserted into the cervix to procure mechanical dilation. These would be inserted with the patient resting on their back with their feet in stirrups. With skilled clinicians and cooperation this could take place quickly. There was no need for the patient to be in situ for six hours. This was his preferred method of dilation and was the most effective. It required 6-8 hours from insertion of the rods for dilation to take place. A patient could be ambulant after insertion. The second option was pharmacological priming. At 17 weeks +4 days this involved one dose of drugs six hours before and then a further dose three hours before the general anaesthesia prior to the surgical termination. The most effective administration of the drugs was vaginally but they could be given orally. There were two important risks of pharmacological dilation: the first was that the dilation would be ineffective and the second was the risk of termination before theatre. The third option was insertion of the rods under general anaesthesia and then waiting before a second general anaesthetic to carry out the surgical termination. This ran the risks of two general anaesthetics. He said this was a low risk but deferred to an anaesthetist. He was alive to the risks of non-compliance. He had no prior experience of requiring restraint in patients the subject of a surgical termination.

72. He acknowledged, like Dr D, the risk of infection if the medical termination was tried but was incomplete and the foetal membrane ruptured. This would need to be treated quickly. He said the chance of failure of the medical termination was 1/200 patients (0.5 %). If the patient was non-compliant at some stage with the medical termination, it having begun with taking some of the medication, then there was still a "high chance" there would be an abortion but the timescale could be several days for the bleeding. This would still involve the risk of the placenta not being expelled which would require surgery.

73. In answer to questions from Ms Richards he accepted the RCOG Guidance, that a surgical termination could take place with insertion of rods or pharmacological dilation. In answer to a question from me, he offered to carry out the surgical termination without

rods and based on pharmacological dilation. He said that Ms H would need to be admitted to a ward the evening before a surgical termination to allow sufficient time for the dilation (around 6 hours) before the general anaesthesia and surgical intervention.

74. In answer to questions from me whether it was possible to have arrange a medical termination and arrange for a follow up surgical termination at his hospital in Newcastle, he noted this would require more days on a ward and he had not asked about that but could try to respond within 24 hours.

Mrs MH

75. Mrs MH gave brave evidence focused on her daughter's welfare. She had not seen her daughter in person for some time. She last met with her on Zoom on 27 September 2023. She was very concerned she had not been informed about her daughter's pregnancy and found out by accident. She was concerned her daughter would not cooperate with a medical termination. She was concerned about the pain of a medical procedure. She felt a surgical termination would be less traumatic. She said she felt Ms H would become very distressed and would be in pain with a medical termination. She said that on reflection she would be with her daughter if there was a medical or surgical termination. She wanted a screen in place so as not to see the delivery of the foetus. She was re-assured by Dr A's involvement.

The Professional Guidance

76. I have also been assisted by Guidance in respect of termination procedures. I was sent the following guidance:

    a. The Royal College of Obstetrician and Gynaecologist (ROCG) "Best Practice Guidance In Abortion Care"
    b. The National Institute for Health Care and Excellence ("NICE")/ ROCG "Abortion Care" NICE Guidelines published on 25 September 2019
    c. The NICE "Abortion Choosing Between Medical or Surgical Abortion from 14 weeks up to 24 Weeks" lasted updated in February 2023.

77. I have read and considered this guidance. I have not set it out in detail in this judgment because it largely represents the evidence I received and time dictates against it.

The Law

78. Section 1 of the Abortion Act 1967 states:

> "1. **Medical termination of pregnancy**.
> (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; or
> (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman."

79. Sections 1-4 of the 2005 Act set out the statutory framework in respect of mental capacity and best interests.

Capacity

80. MacDonald J set out the relevant capacity principles in the light of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC52; [2022] AC 1322 in *North Bristol NHS Trust v R* [2023] EWCOP 5. I have particular regard to paragraphs 43 and 46, which state:

> "The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in *A Local Authority v JB* [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the Mental Capacity Act 2005, the court

must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in *Re DD*, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.

…

In *A Local Authority v JB* at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is *because of* an impairment of, or a disturbance, in the functioning of the mind or brain."

81. HHJ Hilder considered the question of capacity in the context of an application to terminate a pregnancy in *S v Birmingham Women's and Children's NHS Trust And Another* [2022] EWCOP 10; (2022) 185 BMLR 201. The court began by focusing clearly on the s. 3 of the 2005 Act relevant information at paragraph 52:

> "In my judgment and specifically in respect of *this* case, the relevant information for the purposes of assessing whether S has or lacks capacity to decide to undergo termination of her pregnancy is:
>
> a. what the termination procedures involve for S ('what it is');
>
> b. the effect of the termination procedure / the finality of the event ('what it does');
>
> c. the risks to S's physical and mental health in undergoing the termination procedure ('what it risks');
>
> d. the possibility of safeguarding measures in the event of a live birth."

82. Holman J in *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1471 (COP) concluded that the patient in the proceedings before him, had capacity to make a decision not terminate her baby, he held at paragraph 44:

> "It seems to me, therefore, that even if aspects of the decision making are influenced by paranoid thoughts in relation to her husband and her mother, she is nevertheless able to describe, and genuinely holds, a range of rational reasons for her decision. When I say rational, I do not necessarily say they are good reasons, nor do I indicate whether I agree with her decision, for section 1(4) of the Act expressly provides that someone is not to be treated as unable to make a decision simply because it is an unwise decision. It seems to me that this lady has made, and has maintained for an appreciable period of time, a decision. It may be that aspects of her reasons may be skewed by paranoia. There are other reasons which she has and which she has expressed. My own opinion is that it would be a total affront to the autonomy of this patient to conclude that she lacks capacity to the level required to make this decision. It is of course a profound and grave decision, but it does not necessarily involve complex issues. It is a decision that she has made and maintains; and she has defended and justified her decision against challenge. It is a decision which she has the capacity to reach. So for those reasons I conclude that it has not been established that she lacks capacity to make decisions about her desired termination, and I will either make a declaration to that effect or dismiss these proceedings"

Best Interests

83. These proceedings concern serious medical treatment. Best interests are determined by sections 1 and 4 of the 2005 Act and by following the dicta of Lady Hale DPSC (as she then was) in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67; [2014] A.C. 591. At paragraphs 18 and 22 the role of the court and its proper focus pursuant to the 2005 Act is identified:

> "Its [the court's] role is to decide whether a particular treatment is in the best interests of a patient who is incapable of making the decision for himself.
>
> …
>
> Hence the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it."

84. At paragraph 39, Lady Hale encapsulated the best interests test and held:

> "The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

85. At paragraph 45, Lady Hale described the correct approach to the court's assessment of the patient's wishes and feelings, within the context of the statutory factors identified in section 4 of the 2005 Act:

> "Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

86. The question of how the best interests of an incapacitous woman should be approached in respect of a termination of her pregnancy was considered by the Court of Appeal in *Re AB (Termination of Pregnancy)* [2019] EWCA Civ 1215; [2019] 1WLR 5597 where King LJ (with the agreement of McCombe and Peter Jackson LJJ) held at paragraphs 27 and 31:

> "However one looks at it, carrying out a termination absent a woman's consent is a most profound invasion of her Article 8 rights, albeit that the interference will be legitimate and proportionate if the procedure is in her best interests. Any court carrying out an assessment of best interests in such circumstances will approach the exercise conscious of the seriousness of the decision and will address the statutory factors found in the Mental Capacity Act 2005 (MCA) which have been designed to assist them in their task….
>
> …

It is well established that the court does not take into account the interests of the foetus but only those of the mother: *Vo v France* (2005) 10 EHRR 12 at [81-82]*; Paton v British Pregnancy Advisory Service* [1979] QB 276; *Paton v United Kingdom* (1980) 3 EHRR 408. That does not mean that the court should not be cognisant of the fact that the order sought will permit irreversible, invasive medical intervention, leading to the termination of an otherwise viable pregnancy. Accordingly, such an order should be made only upon clear evidence and, as Peter Jackson LJ articulated it in argument, a "fine balance of uncertainties is not enough".

87. I also have regard to the decision of Munby J (as he then was) in a case that considered a child's best interests in *Re X (A Child)* [2014] EWHC 1871 (Fam), 139 BMLR 142 where he held at paragraphs 6 and 7:

> "6. In a case such as this there are ultimately two questions. The first, which is for the doctors, not this court, is whether the conditions in section 1 of the 1967 Act are satisfied. If they are not, then that is that: the court cannot authorise, let alone direct, what, on this hypothesis, is unlawful. If, on the other hand, the conditions in section 1 of the 1967 Act are satisfied, then the role of the court is to supply, on behalf of the mother, the consent which, as in the case of any other medical or surgical procedure, is a pre-requisite to the lawful performance of the procedure. In relation to this issue the ultimate determinant, as in all cases where the court is concerned with a child or an incapacitated adult, is the mother's best interests.
>
> 7. An important practical consequence flows from this. In determining the mother's best interests this court is not concerned to examine those issues which, in accordance with section 1 of the 1967 Act, are a matter for doctors. But the point goes somewhat further. Since there can be no lawful termination unless the conditions in section 1 are satisfied, and since it is a matter for the doctors to determine whether those conditions are satisfied, it follows that in addressing the question of the mother's best interests this court is entitled to proceed on the assumption that if there is to be a termination the statutory conditions are indeed satisfied. Two things flow from this. In the first place this court can proceed on the basis (sections 1(1)(a) and (c)) that the continuance of the pregnancy would

involve risk, greater than if the pregnancy were terminated, to the life of the pregnant woman or of injury to her physical or mental health or (section 1(1)(b)) that the termination is necessary to prevent grave permanent injury to her physical or mental health. Secondly, if any of these conditions is satisfied the court is already at a position where, on the face of it, the interests of the mother may well be best served by the court authorising the termination."

88. Any decision of this court, as a public authority, must not violate any rights set out in the schedule 1 to the Human Rights Act 1998 and in particular Articles 3 and 8. The best interests test should accommodate an assessment of the patient's rights.

The Parties' Submissions

89. All represented parties sought an adjournment on 16 October 2023.

90. At the conclusion of the hearing on 23 October 2023 the parties' positions were as set out below. I have, out of necessity, only very briefly summarised each parties' position. I am sorry I cannot do justice to the eloquence of the submissions.

91. No party sought to submit that Ms H had capacity to conduct the proceedings or had capacity to decide whether to terminate her pregnancy. No party submitted it was in Ms H's best interests to continue with the pregnancy.

92. Mr Berry submitted a medical termination was in Ms H's best interests. He posed the following questions:

    a. What option was the safest in medical terms?
    b. Which option was most likely to obtain her agreement?
    c. Which option would most likely secure a successful conclusion (meaning a safe termination)?
    d. What option was most likely to damage Ms H's mental health?

93. He submitted that a medical and a surgical termination were not materially different in terms of safety, a medical termination would most likely secure her compliance and

would most likely lead to the termination she wanted. He submitted a surgical termination was more likely to be damaging to her mental health.

94. Mr Sachdeva submitted delay in decision making was contrary to Ms H's best interests given she was at 17 weeks +4 days. He submitted the termination decision was "exquisitely personal" and significant regard had to be made to Ms H's wishes and feelings on the mode of termination. He submitted Ms H knew what she was turning down when she refused a surgical termination. He elucidated the written submissions set out in his helpful second position statement.

95. Ms Richards set out the pros and cons and in forensic detail. She submitted the issue of medical versus surgical termination was "not an easy decision" and on behalf of the Official Solicitor the decision was "very finely balanced".

96. She submitted in respect of a surgical termination:

    a. It was less painful;
    b. It involved a shorter period of time;
    c. It involved less active involvement and compliance by Ms H;
    d. The scope of non-cooperation was less;
    e. It was 'potentially' more likely to be successful. There was only a 3 % chance of further intervention. A termination was more likely. There was no risk of incomplete termination;
    f. It would not involve days/weeks in case of a non-compliant medical termination with not all medication being taken by Ms H;
    g. At aged 17 Ms H chose surgical termination.

97. In respect of a medical termination she submitted:

    a. If Ms H was compliant and leaving aside the 13 % risk of further intervention, given what Ms H wants it was "clearly" in her best interests, she relied in particular on Dr A's evidence
    b. However, rightly she submitted that the court cannot ignore the 13 % risk of further intervention and the unknown risk of Ms H's non-compliance – there was a significant risk she would not comply with medical termination

c. Covert medication would help up to a point;
d. Vaginal examination increased the risks, what role was there for restraint?
e. There was a "huge potential for [the medical termination] to go wrong";
f. If the medical termination was not completed a surgical route would be required anyway;
g. In summary it was a "very very finely balanced" decision but "ultimately" medical termination should be attempted because of Ms H's threats to self-harm/kill herself. That was the "tipping point".

98. The Official Solicitor did not seek an adjournment to explore a combined medical and the surgical termination at Newcastle. Albeit it was pointed out if Ms H was to be conveyed there for a medical termination in the first place this might alleviate concerns about her being conveyed there with restraint. Furthermore, Ms Richards urged me to direct there should be a contingency plan for surgical intervention on Wednesday 1 November 2023, if the medical termination was tried and failed.

99. I am very grateful to the Official Solicitor for her adroit assistance with this difficult matter. I am particularly grateful that she was able to give instructions to Ms Richards to take a position. Whilst Ms Richards is entirely right to describe it as very finely balanced decision, it is most helpful to the court for the Official Solicitor to assist in taking a position, as she has done and to make the clear submission that a medical termination is in Ms H's best interests.

100. Mr FS asked the court to take the decision for him. He was concerned about his daughter's safety and welfare.

101. Mrs MH pointed out many of the concerns in respect of both surgical and medication termination. She remained concerned about Ms H's non-compliance. She told me at the end of the day: "I don't know what is best".

Analysis

102. I must consider the following issues: (i) has the section 1 1967 Act test been met?; (ii) have the applicants demonstrated, on the balance of probabilities, that Ms H

lacks capacity to conduct these proceedings?; (iii) have the applicants demonstrated, on the balance of probabilities, that Ms H lacks capacity to make a decision to consent to a termination of her pregnancy?; (iv) if, Ms H lacks capacity to make a decision about her termination, is it in her best interests to have a termination of her pregnancy?; (v) if it is in Ms H's best interests to have a termination, where do her best interests lie in respect how such a termination should take place?; and (vi) should the court authorise covert medication or restraint in respect of the proposed termination?

Section 1 1967 Act

103. As the summary of the evidence filed for the hearing on 16 October 2023 notes, there was a lack of clarity in respect of whether two registered medical practitioners were satisfied the section 1, 1967 Act test was met. At the hearing on 23 October 2023, I was in receipt of the first statement of Dr AD and the second statement of Dr D. I had received the relevant form signed by Dr D and Dr AD. Their conclusions were plainly supported by Dr A's clear and persuasive psychiatric evidence.

104. As Munby J (as he then was) makes clear this is an issue for two registered medical practitioners, not the court. It is, however, a necessary statutory prerequisite. As they are satisfied the statutory test is met for a termination to lawfully take place, I go on to consider the other issues identified above.

Capacity to Conduct the Proceedings

105. I was referred by Mr Sachdeva to the cases of *Re P* [2021] EWCOP 27; [2021] 4 WLR 69 at paragraph 33 and the decision of *Re Q* [2022] EWCOP 6; [2022] COPLR 315 at paragraph 22. As he notes, there was no dispute on this issue. I am satisfied that Ms H lacks capacity to conduct the proceedings. The Official Solicitor has not contested this issue. I make the declaration necessary. I am satisfied on the evidence I have read and heard that Ms H is unable to understand weigh up and use the relevant information to conduct these proceedings because of her Schizoaffective disorder. Her delusional beliefs in respect of the circumstances of her pregnancy wholly undermine her ability to understand and weigh the information which would permit her to participate in the proceedings to litigate the underlying medical issues and instruct a solicitor.

Capacity to Decide Whether to Have a Termination of her Pregnancy

106. I have set out above the core principles elucidated in the case law. I have reminded myself of section 1-3 of the 2005 Act. No party has argued that the applicants' case on capacity is incorrect.

107. I place particular weight on the evidence of Dr A. Dr A was an impressive witness. His written and oral evidence was clear and assured. He has the benefit of having known and assessed and assisted Ms H since 2015. He is clear that Ms H is *unable* to make a decision to consent to the termination of her pregnancy for the reasons set out in his evidence, summarised above. His evidence, which I accept, is that her delusional and false beliefs result in her being unable to understand the relevant information in respect of the matter. He is clear that her inability is *caused* by her Schizoaffective disorder. No party filed evidence contrary to this position and no party made submissions on the available evidence contrary to this position.

108. The relevant matter for the purposes of the 2005 Act is whether to consent to a termination of Ms H's pregnancy. This includes how the termination would take place. It is clear that Ms H, faced with the decision whether to consent to a termination, must understand, weigh up and use the relevant information which includes the nature of the proposed procedure, whether it is medical or surgical termination.

109. HHJ Hilder in *S* set out the relevant information for the decision in those proceedings. Much of that relevant information is relevant information, suitably adapted, for the purposes of the application before me. It includes:

a. what the termination procedure (either by medical or surgical means) involves for Ms H ('what it is');
b. the effect of the termination procedure / the finality of the event ('what it does');
c. the risks to Ms H's physical and mental health in undergoing the termination procedure either by medical or surgical means ('what it risks');
d. the possibility of safeguarding measures in the event of a live birth.

110. No party sought to add or amend to this relevant information.

111. I have carefully considered the learning of Holman J in *Re SB*. Each case must be determined on its own facts. Ms H's delusional and false beliefs in respect of her pregnancy are of an order and magnitude of a different complexion. Her pregnancy is not the result of rapes by health care professionals. She is not pregnant with twins. She is not carrying 'debris' but a live foetus. She has not spat out her foetus or delivered it by squatting. Her Schizoaffective disorder has robbed her of the rational basis to understand her pregnancy and the options available to her. As a result she is unable to weigh up the necessary information. She cannot reach a capacitous decision.

112. She is not able to regain capacity to make such a decision in the timescales demanded by her pregnancy, given she is now at 17 weeks + 4 days. Whilst Dr A was concerned in the note exhibited to Mr G's first witness statement that she needed to be provided with the relevant information in respect of the decision, she has now been provided with that information, as far as is practicable. Dr A has explained to her what surgical termination involves. Clinical staff attempted to meet with her (with specialist midwifes) on Friday 20 October 2023 to reiterate the information to provide her with every opportunity to make a capacitous decision but she was unable to engage with them. This is because of her Schizoaffective disorder.

113. The applicants have discharged the burden of proof and I declare that Ms H lacks capacity to decide whether to consent to a termination of her pregnancy.

Best Interests: Termination

114. It is necessary (by operation of the law) and forensically helpful to the trial judge, reviewing the evidence, to consider the sub-section 4 (6) and (7) 2005 Act factors. I remind myself that section 4 (6) and (7) states:

> (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)anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

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

(c)any donee of a lasting power of attorney granted by the person, and

(d)any deputy appointed for the person by the court,

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

115. In respect of Ms H's past wishes and feelings, when she was pregnant when aged 17 (when she had capacity) she consented to a surgical termination of that pregnancy. Her mother told me in evidence that she Ms H told her recently in the context of a conversation about her then relationship and the use of precautions that Ms H said she "would get rid of it anyway, I am not even able to look after myself".

116. Ms H's present wishes and feelings are very clear. She wants a termination. The evidence is that, with the exception of being "happy" about the news of her pregnancy in July 2023, she has been consistently negative about her pregnancy. She has consistently sought a termination. Mr Sachdeva has prepared a detailed chronology of Ms H's wishes and feelings in respect of her pregnancy and the proposed termination. It sets out in detail the extent of Ms H's sustained wishes and feelings against her pregnancy and in favour of a medical termination over a surgical procedure. This presents, in my judgement, a sustained negative view of her pregnancy and a sustained wish for a termination.

117. I must consider what weight to attach to Ms H's wishes and feelings. I have found she lacks capacity to make this decision and that her understanding of the circumstances of her pregnancy are false and delusional.

118. The MCA Code of Practice says the following on wishes and feelings at paragraph 5.38:

> "In setting out the requirements for working out a person's 'best interests', section 4 of the Act puts the person who lacks capacity at the centre of the decision to be made. Even if they cannot make the decision, their wishes and feelings, beliefs and values should be taken fully into account – whether expressed in the past or now. But their wishes and feelings, beliefs and values will not necessarily be the deciding factor in working out their best interests. Any such assessment must consider past and current wishes and feelings, beliefs and values alongside all other factors, but the final decision must be based entirely on what is in the person's best interests."

119. In *AB (Termination)* the Court of Appeal at paragraph 71 focused on the need to fully absorb the issue of the patient's wishes and feelings, beliefs and values:

> "Part of the underlying ethos of the Mental Capacity Act 2005 is that those making decisions for people who may be lacking capacity must respect and maximise that person's individuality and autonomy to the greatest possible extent. In order to achieve this aim, a person's wishes and feelings not only require consideration, but can be determinative, even if they lack capacity. Similarly, it is in order to safeguard autonomy that s1(4) provides that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".

120. This reinforces what was said by Peter Jackson J (as he then was) in *Wye Valley NHS Trust v B* [2015] EWCOP 60 at paragraph 11:

> "…..As the Act and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an *"off-switch"* for his rights and freedoms. To state the obvious, the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone

else, and may even be more important. It would therefore be wrong in principle to apply any automatic discount to their point of view."

121. As set out above Lady Hale in *Aintree* exhorts the need to focus on the "the choice which is right for him as an individual human being" which will be driven by their wishes and feelings and beliefs and values. It is hard to think of a decision which is more central to a woman's choice in respect of being human and her autonomy, than the termination or otherwise of her pregnancy.

122. I take into account the wisdom of Munby J in *Re X* at paragraph 9 where he held:

> "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."

123. Any court, notwithstanding *Aintree*, *AB (Termination)* and *X*, must also factor in the learning of Munby J in *ITW v Z And others* [2011] WLR 344 where careful consideration was given to the weight the court can properly attach to P's wishes and feelings. See in particular paragraphs 35 and in particular paragraph 35 (iii):

> 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.

124. Considering the terms of section 4 2005 Act and the case law above, in the context of this personal and profound decision for Ms H, I attach significant weight to her wishes and feelings. The fact that her wishes and feelings are supported by the two applicants, their professional witnesses and the Official Solicitor on her behalf, adds significant weight within my assessment of the section 4 2005 Act factors.

125. The psychiatrist who knows her best, Dr A, supports a termination. Her responsible clinician, Mr G supports a termination. Her treating obstetric team support a termination. Her mother supports a termination. Her father is not opposed to a termination. Her litigation friend supports a termination.

126. I accept Dr A's evidence, set out above, that the pregnancy presents a variety of serious risks to Ms H's mental health. These are serious in nature. They are supported by the evidence of Mr G, her responsible clinician. In as much as Dr A and Dr K reached differing conclusions on this issue, I have no hesitation in finding that Dr A is more likely to be correct that Dr K. He has the benefit of a long involvement in Ms H's psychiatric ill-health. He has charted her challenges for some time. He had full command of the papers and has discussed matter in detail with Professor R and Dr D. I accept his evidence that there are multiple risks to Ms H's psychiatric and wider mental health of continuing the pregnancy and this could be very damaging to her.

127. I set out below the risks to Ms H's physical health of the termination (whether surgical or medical) and whilst not repeated in this section of the judgment, I have

considered these risks carefully when considering whether it is in Ms H's best interests to have a termination at all. I find that the risks to her mental health of the pregnancy comprehensively outweigh the risks to her physical health of a termination.

128. Applying significant weight to Ms H's wishes and feelings and the clear medical evidence which points to the significant harm to her mental health, and in the context of manageable risks to her physical health of what is often a routine medical procedure, I am satisfied that a termination represents the correct balancing of the section 4 2005 Act factors and make an order to that effect.

Medical or Surgical Termination

129. The more difficult matter, and the focus of the evidence and submissions at the hearing, is whether the termination should take place by a medical or surgical procedure. I now turn to resolve this profoundly difficult issue.

130. A medical termination can take place locally in Greater Manchester. It can be offered by Dr D's team. The obstetricians and midwives have now met with Ms H several times they know each other. Ms H can also be supported by staff known to her from the second applicant's Trust because of the close proximity. Importantly, Dr A can also be present on and off over the 24-48 hour period of a medical termination. He would, I find, provide considerable support and re-assurance to Ms H. The medical termination can take place as early as 25 October 2023. It avoids delay. I agree with Dr D's evidence that each passing day counts. This is because the foetus will continue to grow and therefore the risks to Ms H gradually increase. More importantly however is the damage to her mental health. I accept Dr A's evidence that Ms H is frustrated and tired of talking about the termination. I accept she wants the medical termination and for the matter to be resolved as soon as possible.

131. A surgical termination can take place under Professor R's care at a hospital in Newcastle on 1 November 2023. Ms H would have to be conveyed from Manchester to Newcastle. It is likely she would need to be informed of why she is being transferred. She is, as set out in the summary of her wishes and feelings below, likely to be strongly opposed to a surgical termination. I find that she is likely to be non-compliant and anguished by this prospect. It is not clear in the evidence but a sizeable team from the

second applicant's staff would likely be required to travel with her. Possibly a ratio of 3:1, at least, would be required. The journey itself would be risky. Ms H would need to travel the afternoon before the surgical termination as Professor R told me, so that she would be present on the ward early in the morning to allow for the dilation to begin. She may have to be restrained from leaving the ward overnight. Of the three possible options for dilation, in my judgement, the second would be the least harmful to Ms H. This would avoid the need for insertion of rods into her vagina. It avoids the possible trauma of her legs being placed in stirrups given her strong feelings of having been sexually abused. The pharmacological dilation would be less damaging to her mental health. However, I note it is less effective and creates the risk of abortion before theatre. This could be very distressing. Professor R, as I have noted above, is prepared to carry out a surgical termination based on the pharmacological termination. I have discounted the third option involving two general anaesthetics and the insertion of rods for dilation, as the pharmacological option appears better and less stressful for Ms H.

132. After a night on the ward in Newcastle, Ms H would then be provided with the pharmacological dilation medication six hours and three hours before going to theatre. She would then be prepared for theatre and would be given a general anaesthetic and the foetus and placenta would be removed. The operation would be short and this evidence is that, notwithstanding the low risk of the general anaesthetic, the operation is medically safe.

133. However, Ms H is implacably opposed to this procedure. Mr Sachdeva's chronology sets out her repeated wish for a medical termination and her opposition to a surgical termination. I detect the longer this process goes the more distressed she is becoming and the more her views against a surgical termination harden. The notes record her most recent wishes and feelings as conveyed to a doctor she trusts, Dr A, on 18 October 2023 as follows:

> "Asked for her view if forced to have surgical termination: this upset Ms H, she shouted "it will scar me for life and I will kill myself afterwards!" You can't vacuum a 16 week baby out of my vagina it will ruin me I've hardly had sex it will destroy my body! I don't want the vacuum or mediation procedure I want the tablets and codeine afterwards"

134. The risk of suicide is one I approach, obviously, with the utmost gravity. I do not assess this to be a fanciful gesture. Dr A's evidence is to be very concerned for her mental wellbeing. Notwithstanding the precautions that could be taken by the second applicant whilst Ms H remains detained on section, there is a real risk of very significant mental harm if Ms H is forced to have a surgical termination. Those risks include the risk she would kill herself. The Official Solicitor is entirely correct to factor this matter in as a decisive factor in favour of medical termination.

135. In terms of the respective medical risks of the medical versus surgical termination, I adopt what is set out in Dr D's evidence above and in particular Table 2 from the RCOG Guidance on terminations. The clear evidence of Professor R was that both procedures are for patients without co-morbidities essentially safe and effective treatments. I accept a medical termination runs a less than 1% risk of a hysterotomy or a hysterectomy. Dr D's evidence was that she had never seen a hysterotomy performed in 7-8 years of clinical practice. I accept the evidence that 13% of woman will require a further 'intervention' most likely caused by the placenta not being discharged. This may cause bleeding and require a general anaesthetic and surgery. However, whilst I acknowledge the risks of the anaesthesia, this is a routine and generally safe procedure. I also accept that for Ms H's the 13 % risk of intervention is, for her, likely to be a higher risk given the risks of her non-compliance. However, I note on the other hand that a general anaesthetic will be required with a surgical termination. I also accept the risks of perforation of the womb or damage to the neck of the womb of the surgical termination. There is a the risk of an infection caused by the amnionic sack bursting but the foetus not being delivered, which would require surgery in the event of a medical termination.

136. What concerns me most, however, is the risk of Ms H's non-compliance with a procedure that might take 2 days. A procedure that could leave her distressed, in pain, bleeding and with cramps and other side effects from the medication. There is also the risk of her seeing the foetus being delivered. This is likely to be distressing and is exacerbated by her mental ill-health. Her mother is particularly worried about this. There is also the risk that the termination is not successful and a surgical termination would then in any event be required.

137. In summary, I agree with the pros and cons set out by Ms Richards above. In my judgement, Ms H's very strong wish for a termination and her stronger wish not to have a surgical termination have a powerful role in the section 4 2005 Act best interests analysis. Whilst I have found her to lack capacity to make this decision and I have found her to have false and delusional beliefs, the termination of her pregnancy remains a profoundly personal one for her. It may not matter very much to her whether the foetus is alive or dead, whether it is one foetus or twins or whether the conception was a result of rape. She has a visceral desire to be free from her pregnancy and she has elaborated consistently and clearly her firm desire for a medical termination and opposition to a surgical termination. This perspective is not one the court is unable to give effect to. On the contrary, it is supported by two NHS Trusts. It is also, on balance, supported by the Official Solicitor. Notwithstanding my concerns in respect of Ms H's non-compliance with a medical termination and the risks of her being deeply anguished during the 24-48 hour period, I consider this less psychologically harmful to her than being conveyed and possibly restrained *en route* to Newcastle, where she would then be faced with being in hospital against her will for around 24 hours and would quite likely require chemical or physical restraint, given her opposition to a surgical termination.

138. I have briefly considered whether there is merit in planning a medical termination with arrangements for a surgical termination to follow in the event the medical termination is not successful at Newcastle. Professor R said he would consider this. No party sought an adjournment for this purpose. All recognised that further delay was wholly contrary to Ms H's welfare. I consider such a plan to be practically and clinically very difficult. It would likely involve multiple mental health staff working shifts to cover the 4-5 days required. It is not a realistic option and is not one properly before the court.

139. Sadly, there is no good option for Ms H. Both procedures are fraught with risk to her mental health and lesser risks to her physical health. Having heard all the evidence and met with Ms H, when she clearly told me she wants a medical termination, respect for her autonomy and dignity in matters of her reproductive health, lead me, by

applying section 4 of the 2005 Act, to authorise a medical termination in her best interests. I will make that order accordingly pursuant to section 16 of the 2005 Act.

140. I also authorise the administration of covert medication. Pain relief and sedatives may well provide a powerful role in comforting Ms H. This is in her best interests and I note covert medication has been successfully used before.

141. The question of restraint was also raised. I am profoundly uncomfortable about authorising restraint to give effect to the medical termination. This arises primarily because the case articulated by the Trusts is that such a procedure is consistent with Ms H's wishes. I also consider that the state must pause very carefully before authorising the restraint of a vulnerable young woman as she undertakes an intimate procedure in respect of her reproductive health. However, I am persuaded to authorise restraint only in circumstances where the medical termination has begun, Ms H has been administered the medication described above, but after the passage of time, either the foetus or placenta or both have not been discharged and the clinicians require, to protect Ms H's safety, to carry out a vaginal examination.

142. I am not prepared to make further orders or declarations beyond those identified above. If there is a medical emergency then clinicians must be guided by what is necessary to safeguard Ms H's life. Those clinicians, in the moment, are likely to have better information than the court has, considering hypotheticals now.

143. I will also direct that the applicants prepare a care plan, and request that Professor R's Trust cooperates in the preparation of a care plan, for a surgical termination on 1 November 2023. This is to provide for a further option given the possible failure of the medical termination. Whether the matter requires to be returned to court is a question the clinical team and the family will need to consider carefully as against the available options and the law and guidance on serious medical treatment.

144. I have been entirely focused at the hearings on Ms H's wellbeing. I have not had time to consider whether this application has been delayed and whether it should have been brought earlier. If an application is made for further relief, I shall consider that matter. I note Mrs MH's anguish that it has taken until now for a decision to be made on behalf of her daughter.

145. I thank all solicitors and counsel for their considerable assistance and ask they amend the care plan and draft an order to give effect to his decision.