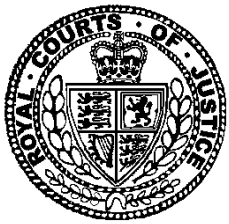

Neutral Citation Number: **[2024] EWCOP 17**

Case No: 14216100

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/03/2024

Before:

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between:

ROTHERHAM AND DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Applicant

-and-

(1) NR
(by her litigation friend, the Official Solicitor)
(2) ROTHERHAM METROPOLITAN BOROUGH COUNCIL

Respondents

- -

Mr Parishil Patel KC (instructed by Browne Jacobson) **for the Applicant**
Ms Katie Scott (instructed by the Official Solicitor) **for the First Respondent**
Ms Leonie Hirst (instructed by Rotherham Borough Council) **for the Second Respondent**

Hearing dates: 5th-6th March 2024

- -

Approved Judgment

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

.....

THE HONOURABLE MR JUSTICE HAYDEN
The judge has given leave for this version of the judgment to be published.

MR JUSTICE HAYDEN:

1. This application concerns NR, a 35-year-old woman who is 22 weeks pregnant and is currently detained pursuant to Section 3 of the Mental Health Act 1983 at a Psychiatric Hospital in Yorkshire. The applicant is the Trust responsible for meeting NR's mental health needs while an in-patient in hospital. This case comes before the Court of Protection because NR has been expressing ambivalence about carrying her baby to term.

Background

2. NR has an extensive history of drug and alcohol abuse. This is her fifth pregnancy. She has two daughters, H and L (now in their teens), both of whom were removed from her care. H was 10 years of age when removed and L, 9 years. The children's social care records reveal that NR experienced difficulties with her mental health during the pregnancy with H. When NR was approximately four months pregnant with H, she attended the hospital on what is described as *"multiple occasions",* reporting self-harm. Following the birth of her second daughter, she was identified as suffering from post-natal depression. NR was, in this period, living with the father of the children, BG, who is a violent man who subjected her to repeated domestic violence. At the time, she was unable to understand or confront the effect of this violence on either her or the children. BG has had no contact with the children for several years. NR has experienced a miscarriage in the past and a termination of pregnancy prior to the birth of her daughters when she was 15 years of age.

3. Though NR is in hospital in Yorkshire, the only available hospital (having regard to the timescales involved) with the necessary specialist experience of managing procedures of this kind for women with significant mental health problems is the Homerton Hospital in London.

Legal Framework

4. NR is currently detained pursuant to Section 3 of the Mental Health Act 1983, which provides for her detention in hospital for the purposes of being given medical treatment. Section 64A of the Act however makes it clear that the treatment provided under that Act must be for the mental disorder from which the patient is suffering. Termination of NR's pregnancy is clearly not treatment for her mental illness. Accordingly, the appropriate statutory regime under which this application must be considered is the Mental Capacity Act 2005 (MCA). None of this is controversial and requires nothing further to be said.

The Abortion Act 1967

5. The Abortion Act 1967 provides (in so far as is presently relevant) as follows:

> *"1(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 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;*
>
> *or*
>
> *(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or*
>
> *(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.*
>
> *(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection 1 of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.*

6. As Senior Judge Hilder sitting as a Tier 3 Judge remarked at paragraph 33 of **S *v* *Birmingham Women's and Children's NHS Trust* [2022] EWCOP 10***:***

> *"Consent, either by the pregnant woman capacitously or by the Court of Protection in the best interest of a non-capacitous pregnant woman, is fundamental to the lawfulness of abortion, as it is to any medical procedure. It is not, however, sufficient. Ultimately, lawful termination of a pregnancy depends on their being two medical practitioners who are satisfied that the conditions of the Abortion Act are met and one who is willing to perform it. Ethical considerations arise. The Court of Protection cannot require a clinician to perform this (or any) procedure if s/he is unwilling to do so".*

7. In **Re X (A Child) [2014] EWHC 1871 (Fam), 139 BMLR 142**, Munby J (as he then was) 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."*

Capacity

8. Capacity, in the context of a termination of pregnancy, has been considered in two recent judgments: ***Re H (An Adult; Termination)*** **[2023] EWCOP 183** and ***S v Birmingham Women's and Children's NHS Trust*** **[2022] EWCOP 10**. ***S*** was a case also involving a late (23 weeks) termination of a woman detained under s3 MHA 1983. In her judgment in ***S***, HHJ Hilder, sitting as a Deputy High Court Judge, Tier 3 in the Court of Protection, followed Holman J's approach in ***Re SB (A patient: capacity to consent to termination)*** **[2013] EWHC 1417 (COP)** and identified the 'relevant information' for the purposes of assessing capacity to make decision to terminate a pregnancy in these terms:

> *"[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".*

9. Section 3(4) Mental Capacity Act 2005 requires that information relevant to a decision includes information about *"the reasonably foreseeable consequences of (a) deciding one way or another, or (b) failing to make the decision"*. It is important to recognise, therefore, that what is required is not only an evaluation of the decision to terminate the pregnancy but an understanding of the consequences of the alternative course i.e., to carry the pregnancy to term.

10. I heard evidence from Dr A, Consultant Psychiatrist. He has been involved in the care of NR as her Responsible Clinician, at her current admission. His report contains a succinct summary of the circumstances of her admission.

> *"I have been involved in the care of [NR] as her Responsible Clinician ("RC") during her current admission to [O] Ward. She was initially admitted following a section 135 warrant being issued and executed at her home address on 16.01.2024 which resulted in an admission onto [S] Ward an Acute Mental Health Ward under section 2 MHA 1983. Whilst on the Ward [NR] had become increasingly agitated and irate and following verbal hostility towards staff and peers, the ongoing targeting of a staff member and threats to life and verbal abuse she was transferred into Seclusion on 22.01.2024 where she remained until 25.01.2024. On the ending of Seclusion, she was then transferred to [O] Ward an Acute Mental Health Ward where she remains detained under section 3 MHA 1983.*
>
> *4. As [NR]'s Responsible Clinician, I have reviewed her in weekly ward rounds. I have also reviewed her electronic psychiatric records for the purposes of making this statement.*

11. Dr A's report contains a similarly succinct of NR's mental health background:

> *"[NR] had been diagnosed with Emotionally Unstable Personality Disorder (EUPD) and was receiving support from community mental health services; however, she had stopped taking her medication for several months and was refusing to engage with health and social care professionals and the Community Mental Health Team, making threats to healthcare workers.*
>
> *She also has a history of substance misuse, is known to use cannabis and cocaine and was under the service of Rotherham Alcohol and Drug Service (ROADS).*
>
> *[NR]'s first admission within Rotherham Doncaster and South Humber NHS Foundation Trust (RDSH) was in 2015.*
>
> *She has had admissions in 2015, 2017 and 2018. Notes relating to the first two admissions are unavailable, but they are referenced in a discharge summary from the third admission. She*

> *was admitted to [S] Ward in 2015 and felt to be experiencing a first episode of psychosis. When admitted in 2017, the clinical impression was that her presentation was consistent with emotionally unstable personality traits.*
>
> *The circumstances of her 2018 admission were that she had voiced thoughts of jumping from a bridge and had also reported low mood and low energy levels. This had followed the stressor of children being removed from her care in July 2017. She was prescribed Mirtazapine and Sertraline, alongside Aripiprazole. She was discharged with short term follow up from the Home Treatment team. Diagnoses given on discharge were moderate depressive disorder and harmful use of cocaine and alcohol, alongside an 'historical diagnosis of psychosis'".*

12. On 23rd February 2024, Dr A met with NR in her room, which I note was at her request, supported by a staff nurse with whom she felt comfortable. The discussion revolved around *"termination of pregnancy"* in its broadest and non-specific sense. NR understood what the word involved but she declined to hear anything as to what the procedure would entail at this stage for her. When I say declined to hear anything, I should emphasise that she was completely adamant that she did not want to know anything about what would actually be involved. She has, by and large, stuck to this view throughout these enquiries. This poses rather a challenge in assessing her capacity. As I have set out above, an understanding of what the termination procedures is a significant facet of evaluating P's understanding. Of course, it is not axiomatic that a refusal to think about something infers an inability to do so. However, Dr A told me that it is the agitation caused by her mental health condition that prevents her from engaging in a consideration of what is involved in the termination. He told me that she was, in effect, *"unable"* and *"incapable of"* participating. It is this that renders her incapacitous. No party disputes this conclusion and I have accepted the analysis as rebutting the presumption of capacity erected by the MCA 2005.

13. Accordingly, the decision here focuses upon NR's best interests.

Best interests

14. Best interests are prescribed in statute by sections 1 and 4 of the 2005 Act. The leading judgment elucidating definition of best interests remains: ***Aintree University Hospitals NHS Foundation Trust v James*** **[2013] UKSC 67; [2014] AC 591**. Lady Hale identified the role of the court and the focus of the MCA in these terms:

> *"[18] 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.*
>
> *…*
>
> *"[22] 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."*

15. At paragraph 39, Lady Hale summarised the best interests test thus:

> *"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."*

16. Lady Hale also considered the correct approach to the court's assessment of '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."*

17. It is also important to consider Section 4 of the MCA which provides statutory guidance as to the proper approach to *"best interests"*:

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

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

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

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
(b) if it appears likely that he will, when that is likely to be.

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

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(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).

> ...
> *(11) "Relevant circumstances" are those –*
>
> *(a) of which the person making the determination is aware, and*
> *(b) which it would be reasonable to regard as relevant."*

18. The Mental Capacity Act 2005: Code of Practice provides guidance at Section 5: *"What does the Act mean when it talks about 'best interests'".* At 5.13, the Code recognises the wide and flexible range of factors that may be relevant to a best interests decision:

> *"Not all factors in the checklist will be relevant to all types of decisions or actions, and in many cases other factors will have to be considered as well, even though some of them may then not be found to be relevant."*

19. The Court of Appeal considered the approach to best interests in the respect of a termination of pregnancy, for an incapacitous woman, in ***Re AB (Termination of Pregnancy)*** **[2019] EWCA Civ 1215; [2019] 1WLR 5597**. King LJ, delivering the judgment of the court, observed:

> *"[27] 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 Servic***e [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".***

20. At paragraph 71, King LJ assessed the weight to be placed on P'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".*

21. Munby J in ***Re X (A Child)*** (supra) makes the same point in powerful language:

> *"[9]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."*

22. Those remarks of Munby J, for reasons that will appear below, have been foremost in my mind throughout the entirety of this case.

23. Analysis of NR's wishes and feelings is an extremely challenging exercise. She is as Mr Patel KC, on behalf of the Applicant Trust, submits highly *"conflicted"*. Ms Scott, who appears on behalf of the Official Solicitor, has provided a detailed and extremely helpful chronology of NR's expressed views which was brought entirely up to date at this hearing. NR has expressed views which indicate both that she might want a termination and that she could not bring herself to undergo it. It is important to set these out in full, a summary will not suffice. What strikes me is both the detail and pain of NR's thought processes:

> **December 2023:**
> *NR had one conversation with [Ms F]* (social worker) *about not being sure about having an abortion. NR also told her youngest daughter about the pregnancy.*
>
> **15th January 2024**:
> *NR reported to have said the following to her IMHA* [Advocate]
> ***"I don't want to kill it (baby) but I can't keep it, cause I am not well and... I Just don't know.... I am confused..... I love babies.... I wanted to be a nurse .... a midwife.... I just can't kill it.... I can't..."***
>
> **16th January 2024:**
> *Once on the ward, stated she did not wish to proceed with the pregnancy.*
> *Voiced wanting to take an overdose of cocaine to terminate the pregnancy.*
> *Reported to be scared of what the termination would be like.*
>
> **16th January 2024:**

She is reported to have said the following to the IMHA
*"I don't want this baby. I was drugged by a peodophile… I dont want it... this baby, it's a pedophilia f****. I didn't wanting in first place".*
……..
"... am I a killer? Will I be a killer?"
"... I am not happy about killing. I can't look after it, but I can't kill it...[NR]"

22nd January 2024:
IMHA visit. Reported to have said the following to the IMHA:
Advocate,- Are you wanting to keep the baby [NR]?
NR: "... No... get rid of it..." (started getting loud)

Advocate - Do you understand what is going to happen [NR]? About the baby?

NR: "... happy with getting rid of it ....but don't want it to feel pain [S] .....lady....., and I don't want to feel pain. ... I can't do it ....to it...I am scared lady..."

Advocate - can't do what [NR]?
"...lady([NR] refers to me as advocate as 'Lady')... I am not having it, (shouted) because I can't cope. But.... I don't want pain.

Advocate - that ok [NR], I just want to make sure people know what you want. What would you like them to know at?
"... I can't cope in here. - (started to cry)
……..
".... I don't want to talk about it anymore, it's too upsetting... (started crying again)"
……..
"... no... cause I just want to get rid if it..."

23rd January 2024:
*NR said '**I don't want this baby, but I can't watch them kill it. Do I have to be awake**?' She explained she would not be able to look at the baby if it resembled its father.*

26th January 2024:
IMHA visit. NR reported to have said:
"... I don't want to see it".
"... I want to be asleep; I don't want to be awake".
"I don't want to know...don't want to know".

3rd February 2024:
NR spoke clearly about not wanting to be pregnant and not wanting the baby, but also worrying about what is going to happen to it.

NR upset as she is sure the pregnancy is advanced enough that it is 'a little person or a blob' because if the baby is further along, she feels she will be 'killing a person'. Became tearful.

7th February 2024:
AMHP report for section 3 detention. Told AMHP that she wanted the baby and was aware a scan had to be arranged.

15th February 2024:
Conversation with NR re pregnancy. Noted that she had made a lot of reference to wanting a termination and also having said on several occasions that she wants to keep the baby.
NR reported as saying '*I don't want to keep it but I don't want to be awake to give birth to it. I can't see it;* ***I don't want to kill it but I can't have this baby.*** *I was drugged and that is how I conceived the baby. I don't want to bring another baby into this world to have it put in care and raped like my other children.* ***I don't want to have this baby but I can't give birth***. ***If I can't be put to sleep then I will just have the baby and die and the baby can live. I can't kill it, please don't let me kill it but I don't want it either. I can't make this decision. I don't want to make this decision. It's too late but I can't keep it.***'
She mentioned wanting to stop taking medications that will harm the baby but realising that she needs it to manage her presentation.

16th February 2024:
Discussion with NR re pregnancy. 'Fluctuant' in her thoughts about termination. Consistently states she does not want the baby but ***'doesn't want to be a murderer'****.*

NR informed of outcome of capacity assessment. Maintains she wants a termination.

Stated she is not happy with the process of the termination and stated that she didn't want to have to do it this way, however also stated that it is the best thing to do. Stated that she has to give birth to the baby.

27th February 2024:
NR reported by [Dr A] to say ***'I don't want to kill the baby; I can't do it'****.* ***She also said that she did not want to deliver the baby vaginally, and told us 'I'll have a Caesarean' before going on to say 'what if I look at it and want to be with it forever?'***

NR expressed some concerns about the termination, in that she doesn't want to kill her baby but that she also doesn't want to remain pregnant and doesn't want her baby to be given to social services. [NR] expressed that she is confused. I advised [NR] that the MDT are in the process of deciding whether a

> *termination is appropriate and not to worry about this. [NR] was advised that the issue will go to court and I asked her whether she would like legal representation.*
>
> *Became tearful about pregnancy, scared she's going to die because she nearly did last time.* ***Feels scared of everything. paranoid everyone's out to kill her. Doesn't want the baby but can not kill it, wants it via c section, does not want it to go to social services, but doesn't feel she can cope with a baby full time.*** *Fluctuation in thought, stated she doesn't have anything in life and would rather be dead. States she's constipated. Feels confused about the situation of being pregnant.*
>
> *Told us that she did not want to "kill the baby, I can't do it". Also does not want to deliver a baby. "I'll have to have a caesarean". Asked her how she would cope with antenatal care – "I've been tricked. I got taken off all my medication, including the contraceptive pill. I don't know what to do. I'm scared, of everything."*
> ***"They wouldn't let me have this baby, would they. But I can't kill it. It's not me". Agrees that she has had a termination before but "I was made to do that, by that horrible family". "Can I have a Caesarean, but then what if I look at it and want to be with it forever?"*** *Feels able to speak with a couple of members of staff about her thoughts and feelings.*

24. The above extracts contain what are manifestly ambivalent and contradictory statements, often juxtaposed against each other in the same exchanges. I have purposely highlighted those statements which point to NR's resistance to the termination. This is not because I regard those remarks as having greater weight but because I find myself in a position where each of the parties (the Trust, the Local Authority and the Litigation Friend) contend that NR's predominant or prevailing expressed wish is to have the termination. It is important, therefore, that I highlight the countervailing evidence.

25. It is also essential that I highlight the clearest expressions of NR's support for a termination. The most explicit of these is also the most recent. It occurred on the 4th March 2024. It incorporates a discussion between NR and a support worker. There is some evidence that NR is more comfortable speaking with women. In the light of her life experiences, which I have referred to above and which find some expression in the extracts I have set out, I consider this to be likely, perhaps even inevitable. The conversations began at 6am:

> *"Opportunistic discussion had with [NR] this morning as she asked for information about the termination. I explained to [NR] that I have been informed of some information relating to the termination, in that it would need to be carried out in a hospital in London, due to the fact that this would be a late on termination. [NR] became tearful and started to ask when she could see her dog. I continued to ask [NR] if she wanted to discuss the termination and she nodded. I explained that the*

> *procedure is reported to take 20 minutes and there is an offer of sedation. [NR] said* ***"I don't want to be awake, I don't want to see it"****. I asked her what her thoughts are at the moment, surrounding the termination and she said,* ***"I don't want to kill it but I can't keep it and I don't want it to go into care, so I've got to get rid of it, I think it's a boy and I don't want another baby or have another one in care".*** *[NR] became very tearful and distressed. Conversation was then suspended. I advised [NR] if she wanted to go through this again in more detail that we could and she said,* ***"I can't talk about it but I don't want it, don't make me have it""****.*

26. At just before 1pm, in a conversation with another support worker:

> *"[NR] said to writer that she was scared about Thursday and worried that she might die if they don't go through C-section, she got tearful and needed some reassurance but was ok withing minutes and not mentioned it again.*
>
> *NR met with Ms Crow, agent for the Official Solicitor.*
> *NR stated that she does not want to have the baby, but also does not want 'to kill it'...* ***She made it clear that she did not want to be awake during the termination*** *(which she at times appeared to call a caesarean) and did not want to see the baby."*

27. At 3:15pm, NR had a meeting with Ms. Crow, acting as agent for the Official Solicitor. The note of the support worker who was present records as follows:

> *"[NR] has had a meeting with solicitor regarding the court case for her baby's termination, [NR] engaged well however displayed flight of ideas and was flitting from topic to topic. She stated that she does not want the baby as she will not be able to cope with it, she said she wants to do what is best for her and the babies dad was not a nice person so she does not want the baby anywhere near him and she does not want to see the baby if it looks dad as she believes that he "drugged her" when impregnating her. She was asked if she wanted to attend the court in which she did not want to she just wants to know the outcome, she has stated that she wants a c-section and she does not want to see baby".*

28. Finally, there was a further conversation at 4pm which I include because it touches upon the practicalities of the transfer to Homerton:

> *"During the conversation with [NR] regarding her termination, she stated that she gets scared in new places and would more than likely "try to do a runner as new places scare me", tearful throughout however comment made about absconding whilst on way for the termination".*

29. The following day NR was unsettled. The notes record the following:

> *"[NR] seems unsettled, agitated and distressed. She was visible in the ward. Shouting and banging door intermittently. She is most worried about her condition and what will be final conclusion on her issues. couples of accompanied leave to local shops were provided to relief her from the distress, this went well".*

30. In the light of the parties' positions, it is also important to highlight some of the earlier recordings which indicate NR's support for termination:

> *"[Ms F] takes over as NR's social worker. NR consistently stated she wanted a termination."*

31. The following entries in the chronology also require to be set out:

> *"Attended ROADS. NR reported to make comment about taking enough crack cocaine to kill herself and her unborn baby".*
>
> **17th January 2024:**
> *Discussion with NR re pregnancy – very challenging due to erratic presentation. Pregnancy is with a man she does not like. She does not want to be pregnant. Debated having it then killing herself but 'it's not worth it for a baby from someone like him'. Unwilling to discuss how termination might work and options. Stated she has no experience with termination.*
>
> **18th January 2024:**
> *Social worker reports that in the community NR was consistent about wanting a termination, however, did not engage with appointments.*
>
> **29th January 2024:**
> *NR stated that she does not want the baby and cannot keep it.*
>
> **3rd February 2024:**
> *NR spoke clearly about not wanting to be pregnant and not wanting the baby, but also worrying about what is going to happen to it.*
> *NR upset as she is sure the pregnancy is advanced enough that it is 'a little person or a blob' because if the baby is further along, she feels she will be 'killing a person'. Became tearful.*
>
> **14th February 2024:**
> *NR said several times unprompted 'I don't want this baby'*
>
> *Discussion with NR's grandmother who gave information about previous termination and NR's expressed wish that she did not want to be a mother again and she would kill herself in the event*

> *she was. Grandmother believes termination in NR's best interests.*
> *Also spoke to NR's mother who she has not spoken to for some time.*

32. As is clear from the above extracts, there is an element of summarised reported speech. Evidentially, this is inevitably less cogent. I do not doubt that Ms F, the mental health social worker, has a good and constructive working relationship with NR. It is also clear that she likes her client, who she describes as, at times, witty, personable, loving (especially to her rescue bull terrier). She describes a person who is enthusiastic (particularly about shopping) and sometimes garrulous. However, Ms F's file keeping is, if she will forgive me for saying so, not her strongest suit. Her statement, which was prepared with sight of the notes, did not help me achieve a real understanding of why it was that Ms F thought that NR's strongest and most consistent view was in favour of the termination. In her statement, Ms F made the following observation:

> *"NR has always been open with me about her pregnancy. Whenever this was discussed prior to December 2023, she always stated that she wanted a termination, as she had not planned or wanted another baby. She has stated to me on several occasions that the pregnancy came as a complete shock to her, as she had previously tried to fall pregnant again with an ex-partner and this had not been successful. After that she was taking the oral contraceptive pill. NR told me that her medication, including her contraception, was stopped when she was discharged from mental health services in September 2023".*

33. As Ms F did not take over the case until the 28th November 2023, nor meet with NR until a few days later, I cannot infer, as the above paragraph appears to invite me to do, and indeed, as Ms F stated in evidence, that there were discussions about the pregnancy between her and NR in November and in which NR expressed a preference for the termination. Recognising this, Ms F speculated that where the note read *"December 2023"*, it should have read January 2024. However, on checking the chronology of her statement, that could not possibly be right either. Mr Patel invited Ms F to check her digital case notes. She had not done so prior to giving evidence. When she interrogated the notes, she was unable to find anything of substance relating to the central issue here i.e., the termination or the continuation of the pregnancy. I emphasise that I consider Ms F to be an entirely honest witness. My view is that she had absorbed a general professional consensus, coupled with her own impressions, to arrive at the following conclusion in her report:

> *"I believe a termination would be in NR's best interests. Prior to the deterioration in her mental health, when I was working with her in the community, NR consistently stated that she wanted a termination. Although she has been more ambivalent since her admission to hospital, she also displays trauma from the removal of her first two children and it is evident that she is understandably very worried about this baby being removed from her care at or after the birth by Children's Social Care. She*

> *has also expressed worry about the physical risks of giving birth. If the pregnancy was to continue, NR would be subject to parental assessments, which I do not think she could tolerate. I would also be concerned about the impact on NR's mental health of giving birth and having another child removed".*

34. Whilst I do not discard this evidence completely, I am unable to place significant weight on it, particularly, as any indicator of the perseverance of a dominant wish to undertake the termination. Similarly, I do not regard the grandmother's views as to NR's best interests to be reflective of NR's wishes. They are doubtless a sincere expression of what she thinks is best for her granddaughter.

35. Ms Hirst, who acts on behalf of the Local Authority has advanced a robust case to contend that the evidence, properly constructed, does establish a preponderant wish by NR for a termination. She emphasises that NR depersonalises the pregnancy and has never referred to *"her baby"* only *"it"*. She points to NR's florid mental ill health at the time she made some of the reported contradictory comments. She submits that the views of the medical staff, social worker and family members are not merely that a termination is in her best interests but reflect what NR would choose for herself. Ms Hirst places very great weight on the cogency of the conversation with Ms Crow, which I have set out above. Ms Scott is, broadly supportive of these submissions. Mr Patel has, to my mind, been rather more cautious and, if I may say so, reflective. Ultimately, and after giving the evidence a great deal of thought, I do not agree that the preponderant evidence, properly scrutinised, establishes evidence of sufficient cogency for me to conclude that NR's wishes are for a termination.

36. Not all the reported statements by NR strike me as carrying the same weight and cogency. One that I have found particularly compelling is her remark that she loves babies and had wanted to be a midwife. I also note that when confronted with the fact of her termination at 15 years of age, she disavowed responsibility for the decision, blaming it on *"that horrible family"*. There is also, in my judgement, an underlaying consistency in her attitude to termination, variously characterised as *"killing"* and *"murder"*. Moreover, it is important to remember that my obligation is to take account of not only NR's expressed wishes but also of her feelings. These two are often conflated but they should not be. Evaluating the feelings of another human being, particularly one who suffers from serious mental health problems, is not and can never be easy. But it is not impossible. I note that NR told her youngest daughter, with whom she has a markedly closer relationship than the elder sibling, of the fact of the pregnancy. On 13th February 2024, NR received the scan of the baby. She kept it with her and showed it to her daughter. Miss F agreed that she did so joyfully. It is difficult to see why she would do it otherwise. She considers that she is carrying a boy and there is an underlying sense in the recordings that this is something that, in different circumstances, would cause her pleasure. What is striking to me is that all these remarks and behaviours fit seamlessly and coherently together.

37. NR finds herself on the horns of the most invidious dilemma. She clearly, and most probably correctly, apprehends that if she carries the baby full term, it will be removed from her at, or shortly after birth. This may even be her wish, though she plainly anticipates the possibility of being ambushed her own emotions. Many of the notes set out above reflect NR, at very least contemplating these possibilities. Equally, she

plainly contemplates a termination, even though that may not sit easily with her prevailing beliefs. Ultimately, I do not, as I have said, find that the evidence in this case supports a determined view either to terminate or to continue with the pregnancy. The evidence, in my judgement, reflects a woman who is paralysed by conflict, which is pervasive. I accept Dr A's opinion that her unwillingness to confront the practical realities of the termination is also a facet of her mental ill health. However, NR certainly confronts the ethical and emotional aspects of both the termination and a continued pregnancy. Even if they are to be regarded as distorted by her condition, they are real for her and require to be afforded both weight and respect. I emphasise that I am entirely satisfied that it would be wrong and unsafe to draw a concluding view as to what NR's wishes and feelings truly are.

38. Accordingly, to discover where NR's best interests lie, I must look more widely at the evidential canvas. To do this and at risk of overburdening this judgment, I consider it necessary to set out the plan for the termination procedure. It does not make for easy reading. It is taken from the evidence of Dr G, Medical Director, a Consultant Psychiatrist and an approved clinician under the Mental Health Act 1983:

> *"NR will be required to travel down to Homerton hospital the day before her procedure. The journey will take approximately 4 hours. I attach at* ***Exhibit 1*** *the detailed conveyance plan that provides how she will be transported from the mental health unit where she currently is to the hospital. In summary, NR will be transported by Exclusive Secure Care Services (a specialist provider of secure transport) and will be accompanied by three staff members from the Trust (who are known to NR). Should require NR require sedation on the journey, she is being accompanied by A registered Mental Health Nurse who will be able to administer these to her, a Doctor at the Trust will also be on-call via telephone to provide any medical advice and oversight for NR during this journey".*

39. I have been told that the Trust would require authorisation to sedate NR to relieve her anxiety during the course of the extensive journey. For the avoidance of doubt, that is to relieve her anxiety, not to achieve compliance. In those circumstances, I do not consider that this amounts to chemical restraint. The plan continues as follows:

> *"On NR's arrival, the hospital would make their own assessment of whether NR wishes to go ahead with the procedure. [Dr D] has confirmed that whilst the overarching ethos is that it is safer to terminate a pregnancy rather than force a pregnancy to term and deliver a baby against a patient's wishes, should it not be a patient's wish to proceed with the termination on the day, coercing and forcing a person to have a termination can do lasting harm to a patient's mental health. Therefore, once the team have met with NR and assessed her wishes to proceed with the termination, they will begin the procedure. [Dr D] has confirmed that Homerton Hospital would be happy to have a telephone conversation with NR (supported by the RDASH team) on the evening before she travels down for the procedure in*

> *order to carry out an initial assessment of whether she wishes to go ahead with the procedure.*
>
> *A surgical abortion at this stage would take place as a two-stage procedure over two days in order to make this safe. The first stage involves the placement of four rod (osmotic dilators) into the cervix. Most patients will tolerate this in the same way they would tolerate a smear test but Homerton hospital does have experience of patients who may be anxious and require sedation for this stage. This sedation would be in the form of an IV opiate (fentanyl) with midazolam. Sometimes a small dose of a mild anaesthetic (propofol) can be administered if required in order to sedate a patient sufficiently. This would be administered by an anaesthetist who would provide appropriate monitoring and supervision.*
>
> *For someone at 22 weeks gestation or more, Homerton hospital would generally recommend an ultrasound guided injection to stop the heartbeat. This is to avoid delivery with signs of life. This would also take place at stage 1 at the same time the osmotic dilators are placed in the cervix. Therefore, if a patient was anxious at this stage the same sedative medication would be provided as referred to in the paragraph above. The insertion of the dilators/injection usually takes around five minutes. If NR required sedation at this stage, this would lengthen the process by a couple of minutes.*
>
> *At this point, NR would then be required to stay overnight at Homerton hospital. Arrangements will be made for her to have a separate room either on the delivery suite (barring unforeseen emergency limiting availability) or on one of the other wards. Homerton hospital have advised they will try to facilitate a side room for her to provide as much of a stress-free environment as possible, however this cannot be guaranteed. At least one member of staff from the Trust (who have accompanied NR to Homerton hospital) will remain with her overnight".*

40. The following day, NR will be escorted across to the day surgery unit. The plan continues as follows:

> *"… There is some privacy on the unit in the form of cubicles where patients are assessed. For patients who are anxious there is a curtain in the recovery room that can be utilised to provide further privacy and a more settled environment prior to the procedure. Most patients are not usually given pre-medication prior to the procedure but if NR were to become anxious or agitated, the anaesthetists would arrange for her to be provided some benzodiazepine or appropriate sedation prior to NR going into theatre.*

> *A surgical abortion involves a vaginal evacuation under general anaesthetic. In order to administer the anaesthetic this involves breathing oxygen from an oxygen mask; the anaesthetic itself is intravenous. The anaesthetic once administered works very quickly.*
>
> *Once the patient is asleep, the procedure itself typically takes 15 to 20 minutes and is done under ultrasound guidance. Following the procedure, NR will be taken out to the recovery area for the anaesthetic to wear off. As the anaesthetic is light and short acting, whilst a patient may feel groggy after the procedure, this effect is generally minimal.*
>
> *Following the procedure, NR will be taken to the recovery suite. In terms of the relevant aftercare, as the general anaesthetic used includes an opiate and other analgesia is given at the same time, patients usually wake up comfortable. However, nurse staff will be on hand to administer any pain relief if necessary.*
>
> *A patient will usually remain on the ward for two to three hours following the procedure before travelling home. This will be no different for NR. The nurse staff will keep NR in the recovery suite to monitor and to manage any bleeding following the procedure. NR will also be provided with something to eat and drink and nursing staff will want to ensure that she has passed urine before discharge. Nursing staff will monitor NR and will make sure her observations are satisfactory before encouraging her to go home. Both nurses and the surgeon from the abortion team would see NR again prior to discharge to provide her and the staff members from the Trust with all the relevant information regarding aftercare and what to expect.*
>
> *Most patients experience some bleeding in the first 24 hours following this procedure (this is usually more heavy than an normal period). Some patients experience some cramping over the next 12 to 14 hours (although this usually settles very quickly) and additional pain relief can be taken as needed. Homerton hospital will also prescribe NR with a 3-day course of antibiotics (Doxycycline) to be taken twice daily in the morning and evening, to minimize the risk of infection".*

41. Upon discharge, NR would be escorted back to Yorkshire. One significant feature of the plan needs to be emphasised:

> *"Between stage 1 and stage 2 there is the scope for a patient to change their mind about the termination. Should a patient change their mind following the insertion of the osmotic dilators these can be removed and the patient would continue the pregnancy. However, once the injection to stop the heartbeat has been administered the termination must proceed. Again, Trust*

> *staff are accompanying NR and will be there to support her through the process".*

42. There can be little doubt that this plan, however sensitively constructed, and however skilled the doctors and nurses involved undoubtedly are, nonetheless, represents a significant ordeal for NR. It cannot be easy for those assisting her either.

43. In his evidence, Dr A identified that the continuation of the pregnancy would, of necessity, entail NR receiving suboptimal medication for her mental health condition, in order to protect the foetus. I note that she shows some, at least tentative understanding of this, as recorded in the notes. He also considers that the consequence of this and of the birth process itself carries, predicated on NR's history, a high risk of post-partum psychosis and/or post-natal depression. To this, Ms Hirst adds the risk of self-harm that might arise given NR's *"expressed desire to die"*, as she puts it, if she has to continue with the pregnancy. That is a rather selective reference, of course, given the many statements she makes which condemn the termination. Dr A speculated that NR might experience *"a certain amount of relief"* following the termination because, whatever her wishes and feelings about it, she would be freed from the conflict that has been tormenting her. I hope Dr A is correct.

44. None of the advocates investigated with Dr A what the impact of the termination might be on NR's mental health. The process itself is traumatic and it is obvious that she has deep reservations. I think it is reasonable to infer that there are, at very least, real possibilities that this too may have adverse impact on her mental wellbeing.

45. It seems clear to me that NR has developed a good relationship with Ms Crow. I have read the accounts of their meetings in Ms Crow's statement. I have noticed how NR is gently kept to the point and questioned skilfully and sensitively. It is also clear that NR understands that Ms Crow is there to represent her best interests. I note that in one of their meetings, NR was smoking a flavoured vape. She apologised to Ms Crow for blowing smoke over her. Ms Crow said that the smoke had not reached her and she could not smell the flavour. NR said that she had stopped smoking cigarettes for seven weeks. She told Ms Crow *"It is the hardest thing ever"*. It is clear that she gave up smoking because of the pregnancy. Ms Crow asked if she thought she would go back to it if she had the termination. She replied, *"I don't know, maybe"*. I regard NR's concern for her baby, i.e., by giving up smoking, as a contraindicator of a wish to terminate the pregnancy.

46. Ms Crow considers that NR sometimes uses the word caesarean when she means termination. As I have said, I see that has occurred on several occasions. However, I am not prepared to infer that every time she says caesarean, she really means termination. Sometimes the word is plainly used in its correct context. Also, given that she appears to be generally articulate, I do not discount the possibility that the word termination is distasteful to her. The following passage strikes me as capturing a potentially important conversation:

> *"I explained to [NR] that my role is to make sure that the Judge knows what she would like to happen and so I wanted to be sure I had that right. I summarised that she had said that she didn't want to have the baby and that she would like a "caesarean" to*

> *terminate the pregnancy, and that she would like this to be done under a general anaesthetic. [NR] said that was right. She said that she was getting hot and so she moved seats and removed her fleece top; she had another jumper on underneath. [NR] said "you can't really tell [I am pregnant], can you?". I confirmed that if I didn't know then I wouldn't necessarily be able to tell. [NR] said "I don't really like people to see it [her bump]. I think it is a boy, I saw the scan and thought that. It is not like I don't want it, but I just don't think I would be able to cope". I told [NR] that I thought she was being very brave and she said "I don't want it, it will make me more ill and my family don't want me to have it. I need to make the right decision for me for once".*

47. On this occasion, Ms Crow helpfully uses "caesarean" and "termination" together to avoid confusion. NR's conclusion is that she needs *"to make the right decision for me"*. I agree. Moreover, I consider that captures where her best interests lie i.e., that this decision should be NR's.

48. In her very helpful closing submissions, Ms Scott told me that, as the evidence had evolved at this hearing, it had become clear that the objective of the parties was really, as she put it, to achieve something similar to the outcome in the case of ***Avon and Wiltshire Mental Health Partnership v WA & Anor (Rev 1)*** **[2020] EWCOP 37.** That was a particularly challenging case in which though I found WA lacked capacity on the central issue, I nonetheless left the decisions to him, because I considered that the priority was to recognise and enable him to assert his own autonomy. That is precisely what I wish to achieve with NR.

49. Declarations in the Court of Protection usually make reference to 'best interests'. This is not, however, required by the statute. Section 15 of the Mental Capacity Act 2005 provides:

> *(1) The court may make declarations as to—*
>
> > *(a)whether a person has or lacks capacity to make a decision specified in the declaration;*
> > *(b)whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;*
> > ***(c)the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.*** (my emphasis)
>
> *(2) "Act" includes an omission and a course of conduct.*

50. What is required is that the Court, having considered best interests, makes a declaration as to lawfulness. The care plan which has been dynamic and has evolved during this hearing now emphasises the importance of helping NR to reach a decision by giving her clear and tangible options but emphasising that the decisions are hers. The amended plan sets out its overall aim in the introductory paragraphs in these terms:

> *"Prior to the commencement of this plan (preferably in the days before), staff at [the Yorkshire hospital] will take [NR] through the stages involved in the plan, explaining to her what is involved at each stage, that it is [NR]'s choice whether to go through each and every stage and that she can stop the process at any stage until the termination has reached an irrevocable stage…"*

51. The centrality of NR's autonomy is emphasised throughout the plan, and I am entirely satisfied, is recognised by all involved:

> *[NR] will not be compelled to undertake the termination or to undertake any of the stages in the plan. The staff shall use their clinical judgment (including verbal encouragement and discussion) to support [NR] to make her choice whether to go through each stage in the plan. No coercion or force will be used".*

52. The initial application for a declaration was that I should state that it is lawful and in NR's best interests to have a termination. I expressly decline to make that declaration. I do, however, approve the proposed care plan and confirm the lawfulness of it. Thus, I make a declaration that the care plan, setting out the arrangements for a termination of NR's pregnancy is lawful. I go no further. So far, the options presented to NR have been uncoupled from the practical realities. There is now a finely structured plan where a decision, one way or the other, is unavoidable. It is important that NR knows that I am respecting her rights as an autonomous adult woman to make this decision for herself, with the help of those she chooses to be advised by. I should also like Ms Crow to explain to NR that whatever decision she takes, will have my fulsome support. As I discussed during the course of the hearing, a copy of this judgment is to be made available to all the key professionals involved in the plan in order that they know the reasoning behind the conclusions I have reached and what the objective of the plan is.

53. Finally, I should like to thank all involved in this case, but particularly the advocates, for the careful and considered thought they have given to it.