Neutral Citation Number: [2020] EWCOP 59

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/11/2020

Before :

Mr Justice Poole

- -

Between :

A London NHS Trust	**Applicant**
- and -	
(1) KB **(By her litigation friend, the Official Solicitor)**	
(2) A London Local Authority	**Respondent**

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- -

Nageena Khalique QC (instructed by **Hill Dickinson LLP**) for the **Applicant**
Bridget Dolan QC (instructed by **The Official Solicitor**) for the **First Respondent**
Victoria Butler-Cole QC (instructed by **A London Local Authority**) for the **Second Respondent**

Hearing dates: 12 November 2020

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APPROVED JUDGMENT

This judgment was delivered in public. An order is in place that prevents the publication or communication of material or information that identifies or is likely to identify KB, any member of her family, the Applicant NHS Trust, the Second Respondent Local Authority, and the place where KB lives. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the patient and members of their family, the applicant trust the local authority must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Poole:

Introduction

1. This judgment was delivered *ex tempore* at the conclusion of a short, remote hearing on 12 November 2020. At the invitation of the parties the judgment has been reduced to writing for publication.

2. A Transparency Order was made by Mr Justice Mostyn on 6 November 2020. It prohibits the publication or communication, or anyone causing, enabling, assisting in or encouraging the publication or communication, of material and information that identifies or is likely to identify the person who is the subject of these proceedings, any member of her family, any member of her treating team who has taken part or being referred to in these proceedings, or where those persons live or are being cared for, or any material that identifies or would be likely to identify the applicant Trust or the second respondent local authority. His order remains in force but, following application by PA Media Group, made after I delivered my *ex tempore* judgment at the hearing, but before publication of the judgment in writing, I have amended the order and directed that the parties shall be referred to as follows:

   The Applicant: “A London NHS Trust”
   The First Respondent: “KB”
   The Second Respondent: “A London Local Authority”

3. Although the parties are all agreed on the order that this court should make, and I agree with and approve the draft prepared by the parties, the order involves this court giving consent to a significant intervention and it comes to court against a background of some disturbing circumstances.

4. I shall deal first with the substance of the order that I am invited to make today which concerns a best interests decision in relation to the mode of delivery of the unborn child being carried by the first respondent. I shall then address three other issues, namely termination, delay, and contraception. Only the third of those requires any order from me today, and it is proposed to be addressed by way of directions leading to a further hearing.

5. The application concerns KB who suffered a hypoxic brain injury at the time of her birth that has left her with microcephaly, epilepsy which is now well controlled, and with moderate to severe learning disability meaning that her IQ is no higher than between 35 and 49. She has physical disabilities requiring support aids for walking more than short distances, and suffers bilateral optic nerve atrophy. KB is an adult but her learning disability means that she is not capable of independent living. Her communication is largely non-verbal and confined to a very few words.

6. KB lives in a flat that she shares with her sister, but her sister works and so KB needs care during the day. Until recent events, daytime care was provided by members of her family, sometimes at KB’s mother’s home, and two personal assistants who were funded by direct payments. KB also attended a day centre three times a week, but due to the Covid-19 pandemic she has been unable to visit there since March 2020.

7. On 30 July 2020, KB's mother took her to her general medical practitioner because she was feeling unwell. The GP noticed her swollen stomach and a pregnancy test was discussed and then performed on 3 August 2020. It confirmed that she was pregnant. In fact, she was over 22 weeks pregnant but up to that point no-one had noticed.

8. I have seen the capacity assessment carried out by KB's allocated social worker whose ("ASW") involvement only began in August. I have also read witness statements from the consultant obstetrician, midwife and consultant anaesthetist who are leading KB's management and care at the hospital where she will give birth. Even with support and assistance KB is wholly unable to understand that she is pregnant let alone what that will entail in terms of her need for obstetric care. Significant care has been taken to try to support her to understand that she is pregnant and how to recognise and report symptoms that might indicate difficulties for the baby or for her, such as headaches, bleeding or reduced fetal movements. The consultant obstetrician says that at her first meeting with KB, when she was present with her mother, "My clear conclusion was that she had no understanding of the pregnancy, of a baby growing within her and of the reasons for the examination." The midwife has tried at a series of meetings with KB to assist her understanding but says "My assessment is that KB lacked capacity to understand the information shared." That is also the clear view of the ASW.

9. On 6 November 2020, Mr Justice Mostyn made final declarations under s15 of the Mental Capacity Act 2005 ("MCA 2005") that KB lacks the capacity to conduct these proceedings and to make decisions in relation to her antenatal care, the manner and location of the delivery of her baby, long term contraception, including sterilisation, and deciding to engage in sexual relations.

10. There is no suggestion that KB would have had capacity to decide to engage in sexual relations at any earlier time including at the time that she conceived her unborn child.

11. It is indeed disturbing that KB, a very vulnerable woman who is unable to consent to sexual relations, and who was or ought to have been constantly supervised, has had intercourse. Not only that, but no-one caring for her realised that she was pregnant until the GP's involvement when she was already five months pregnant.

12. KB is now 37 weeks pregnant. There are no antenatal concerns about her physical health or the health of her unborn baby.

13. The authorities including the police are conducting investigations. As yet the father of the unborn child has not been identified. Interim safeguarding measures have been taken so that no male members of the family or carers are permitted to enter her home or otherwise have contact with her. One of the orders I am asked to make today is a police disclosure order so that information from the police investigations can be used to make safeguarding and best interests decisions for KB. I am also asked to authorise the taking of samples from KB to be given to the police to assist in the identification of the perpetrator of the sexual assault on her. It is in her best interests

that the perpetrator is identified so as to ensure her adequate safeguarding in the future. I make those orders as sought.

14. The applicant Trust now has responsibility for KB's obstetric care. It made the applications that are before the court on 30 October 2020. The Trust seeks orders that it is in KB's best interests to deliver her baby in hospital by Caesarean section and to undergo a non-therapeutic sterilisation procedure. Following discussions between the parties the Trust does not seek any final order today concerning sterilisation. I shall return to that issue later.

15. I am invited to, and shall, make an order that it is lawful, being in her best interests, for KB to be brought from her home to the maternity unit of the hospital if she goes into spontaneous labour, or in any event on 15 November 2020, for an elective Caesarean section to take place on 16 November 2020 and for her to receive obstetric, midwifery, and post-natal care in the maternity unit as is deemed appropriate, in the clinical judgment of the clinicians caring for her as set out in the birth plan.

16. I should say a little more about the plan for the birth and the reasons why I am making this order. The expected delivery date is 3 December 2020. The Trust submits, and the other parties agree, that it is in KB's best interests to undergo an elective Caesarean section under regional anaesthesia on 16 November 2020 and to receive the necessary obstetric and other care as the clinicians deem appropriate as set out in the birth plan.

17. Although declarations as to incapacity have been made, it is worth emphasising that the evidence shows that KB's lack of understanding in relation to her current condition, and what it entails for her obstetric care, is profound. She does not know that she is pregnant, she would not be able to understand why she would need anaesthesia, or what would happen at a vaginal delivery or a Caesarean section. Her antenatal and obstetric care will be likely to involve interventions such as examinations, the use of needles for taking blood and for intravenous access, the insertion of a catheter, monitoring, the administration of analgesia, anaesthesia, and the Caesarean section itself. KB would not understand what was happening to her or the reasons for any of those interventions. Her lack of understanding due to the brain damage suffered at birth, is such that it is not possible to ascertain her beliefs and values or her past and present wishes and feelings about the proposed obstetric care and manner of delivery of her child. She has had the support of an Independent Mental Capacity Advocate as well as the Official Solicitor. They and her mother and sister agree with the recommendation for an elective Caesarean section as the most appropriate mode of delivery.

18. I have had full regard to the evidence from the clinicians at the Trust. Great care has been taken to formulate a birth plan for KB. The professionals involved have striven to understand and weigh her needs and interests, as well as those of the unborn child, and to find the best way forward.

19. If KB goes into spontaneous labour before any planned Caesarean section then then she will require transfer to the maternity unit. If she is in late second stage labour then the clinical decision is likely to be to proceed immediately to a vaginal delivery

as the least distressing mode of delivery in those circumstances. This will be a matter for clinical judgment.

20. The plan for elective Caesarean section at 38 weeks gestation is designed to achieve delivery prior to spontaneous labour. Caesarean section is a serious surgical intervention. It does involve risk. However, the alternative is to trial vaginal delivery at or around term. The process of labour is complex and involves hour by hour, sometimes minute by minute, decision-making. Multiple examinations would be required. Urgent decisions might well have to be made. The process of labour and vaginal birth would be particularly distressing to KB because of her lack of understanding of what was happening to her. It is very unlikely that she would understand or be able to comply with instructions that might have to be given such as not to push, to move position, or to control her breathing. It is very unlikely that she would be able to communicate to the clinicians her pain or symptoms. Apart from the distress caused to KB, these difficulties would increase the risk of complications. A trial of vaginal delivery would not prevent the risk of the need for assisted delivery or even an urgent or emergency Caesarean section, and KB would be unable to understand what was happening let alone be able to contribute to the urgent decision-making required in such circumstances. It would be unconscionable to put KB through the experience of labour and trial of vaginal delivery when an elective Caesarean section is an alternative choice.

21. The benefit of an elective Caesarean section on 16 November 2020 is that it should result in the birth of a healthy baby with the least possible distress to KB, and avoid the traumatic experience that labour would entail for her. It will reduce the risks to her and the baby.

22. It is proposed that regional anaesthesia is used in the first instance. I am asked to consent on KB's behalf to the administration of general anaesthesia in the event that she becomes too distressed to proceed with the Caesarean section under regional anaesthesia, or if there is a clinical need to use general anaesthetic. I am satisfied that it is in her best interests so to consent on her behalf.

23. In weighing the respective risks and benefits of different modes of delivery the clinicians have taken into account all the relevant factors and come to a very clear conclusion as to what they regard to be in KB's best interests. I must have regard to all the relevant factors under section 4 of the MCA 2005.

> **4 Best interests**
>
> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
>
> (a) the person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

> (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
>
> (3) He must consider—
>
> (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
>
> (b) if it appears likely that he will, when that is likely to be.
>
> (4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
>
> (5) 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 ….
>
> as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

24. As I have noted it is not possible to ascertain KB's past or present wishes and feelings, or the beliefs and values that would be likely to influence her decision about mode of delivery. I am sure that, if she had capacity, KB's priority would be to do the best for her unborn baby. Her mother and sister support the birth plan, as do those treating and caring for her at hospital, and the local authority.

25. I am quite satisfied that the plans for the birth set out and referred to in the draft order including the elective Caesarean section and the provision of obstetric, midwifery and anaesthetic care deemed appropriate in the clinical judgment of the clinicians caring for her in accordance with the plan, are in her best interests.

26. The Applicant Trust has had regard to Guidance on Applications in Relation to Medical Treatment, authorised by the Vice President of the Court of Protection, Mr Justice Hayden, at [2020] EWCOP 2. This application was necessary under that guidance for two reasons. First, because it involves an issue of contraception, which I shall address later. Second, because the proposed treatment may require a degree of restraint. KB will have to be brought to the hospital for the Caesarean section and she will need to undergo anaesthesia and preparation for theatre. The court is being asked to authorise the use of proportionate restraint. The proposed order reads that it is in KB's best interests

> "To be brought from home to the maternity unit at Hospital B by the local authority/ambulance if she is or may be in spontaneous labour, or (otherwise) on 15 November 2020 for the elective Caesarean section to take place on 16 November 2020."

And that,

> "It is lawful, being in KB's best interests, for those conveying KB to use reasonable and proportionate measures, including those which involve physical or medical restraint to facilitate the transfers between home and the maternity unit at Hospital B."

The order further states:

> "The deprivation of KB's liberty arising from the implementation of the treatment as set out above is lawful and authorised pursuant to section 4A(3) and section 16(2)(a) of the MCA 2005, provided as always that:
>
> - The applicant complies with the steps at C above; and
> - Any measures that may be used to facilitate such transfers or treatment are the least restrictive possible commensurate with KB's best interests; and
> - All reasonable steps are taken to minimise distress to KB and to maximise her dignity."

27. The authorisation of restraint is not lightly given. KB is a very vulnerable woman who would not comprehend why she was being taken to hospital. The evidence to

date is that KB has been entirely compliant with visiting hospital, and examinations, save for recoiling when palpated during one examination. Nevertheless, authorisation is sought as set out above in the event that she is not compliant in the future. KB has human rights under Art 5 and Art 8 of the European Convention on Human Rights and it is troubling to be asked to authorise the deprivation of her liberty and the use of restraint if necessary, but the far more alarming prospect is of her not receiving the obstetric treatment that she will obviously need in the days ahead of this hearing. I am quite satisfied that the proposed deprivations of liberty, including the provision for the use of restraint, are necessary, proportionate and in her best interests.

Termination

28. The Official Solicitor has raised concerns about how the decision as to termination of KB's pregnancy was addressed. Ultimately no decision was made whether or not it was in her best interests to undergo a termination. It was not possible for KB to undergo a termination after the consultant obstetrician saw KB on 27 August 2020 by which time she was over 25 weeks pregnant. The Official Solicitor's concern is not that it would have been in KB's best interests to undergo a termination in early August 2020, but that the question was not properly addressed in a timely fashion.

29. The GP rightly raised the issue of termination more or less immediately. The first antenatal appointment with the Trust was on 5 August 2020 when it was recorded that KB was 22^{+3} weeks pregnant. The issue of termination was raised on numerous occasions in early August at safeguarding meetings, and in correspondence. There was concern that KB's mother would be strongly opposed not only on religious grounds but also because she did not seem to be unhappy that her daughter was pregnant. I do not know if those perceptions were justified or not, having not heard from KB's mother. On 8 August, when KB was 22^{+6} weeks pregnant the consultant obstetrician was copied in to correspondence from a midwife which raised concern that the first appointment with the obstetrician would not be until 27 August when KB would be over 24 weeks pregnant and it would be too late to consider whether to terminate the pregnancy. That is exactly what happened. The consultant obstetrician says by the time she saw KB it was in effect too late to consider a termination and that termination would involve inducing labour which would be traumatic for KB.

30. For the Official Solicitor, Ms Dolan QC expresses significant concerns about the lack of urgency and the failure of any one professional to take ownership of the decision regarding termination. The Official Solicitor's concern that a best interests decision about termination should have been taken promptly in the exceptional circumstances of this case, appears to me to be justified. However, the role of the Court of Protection is forward looking and it is not for me now to make a detailed inquiry into why that was not done at the time. I am pleased to note that the order includes a recital that the Trust and the Local Authority have agreed to review the circumstances of this case in respect of the decision regarding termination. I am sure that lessons will be learned.

Delay

31. This application was made on 30 October 2020. That was nearly three months after the pregnancy had been recognised and weeks after it had been proposed that it would be in KB's best interests to undergo an elective Caesarean section and contraception by sterilisation. It was known in early August that there was a risk to KB if the pregnancy went to full term. It was recorded by Trust staff on 25 August 2020 that there would be a need for a court application. On any view the application was made late. The Official Solicitor only became aware of the applications very soon before the order made by Mostyn J on 6 November.

32. In *Re FG* [2014] EWCOP 30 Kehan J said that "an application should be made to the court at the earliest opportunity" in a case such as this. Guidance was given in that judgment regarding the need for early and thorough case planning in pregnancy. The Vice President stated in *Sherwood Forest NHSFT v H* [2020] EWCOP 5 at para 13,

> "Whilst avoidance of delay is not incorporated into the framework of the Mental Capacity Act in specific terms, it is to be read into that Act as a facet of Article 6 and Article 8. It is self-evident and indeed striking that delay is likely to be inimical to P's welfare and best interests"

33. The Vice President's guidance from January 2020, already referenced, says that the Official Solicitor "should be given as much notice as possible of any application".

34. In the present case the Official Solicitor was notified weeks after the date when she should have been. As a result the Official Solicitor has had to deal with a complex and sensitive case at very short notice. The Trust recognises that there was delay in this case. The delay has not prevented KB from receiving what appears to be exemplary clinical care. The court and the Official Solicitor recognise that the current Covid-19 pandemic places restrictions on the Trust and that this is a complex and difficult case involving an allegation of rape, consideration of termination, and liaison with many different professionals and agencies. Those factors provide more reason than otherwise to involve the Official Solicitor as soon as possible. The Official Solicitor's involvement at the earliest possible stage, which was in early August 2020, would have been of considerable assistance to the professionals having to consider difficult choices, and especially helpful in ensuring KB's best interests were protected in relation to all the relevant decisions.

Contraception

35. The issue of contraception, including by sterilisation is complex. I do not need to go into the principles to be applied in this judgment because the parties are agreed that directions should be given today with a view to resolving the issue in early 2021. I am not being asked to make any final declaration or order about contraception and I am content to make the directions sought.

36. An order for the non-therapeutic sterilisation of a person with learning difficulties would be a draconian step and one only rarely authorised by the court. In this case, decisions about contraception, including sterilisation, are entwined with issues concerning KB's care and safeguarding. As has been noted by the allocated social worker, if KB were in a safe environment she would not need contraception. The current position is that the perpetrator of the sexual assault on KB has yet to be identified. His identification will inform decisions about safeguarding, residence, and care in the future. Depending upon those arrangements, the need for this court to make any decision on contraception may resolve itself. The directions will allow for further evidence to be obtained, a round table meeting in January, and court directions if needed in early February 2021.

37. I am grateful to the parties and their representatives for their collaborative and constructive approach to the hearing before me.

Postscript

Since my judgement, I have been informed that KB delivered her baby by Caesarean section on 16 November 2020 and that the mother and baby are well.