England and Wales Court of Protection Decisions

Neutral Citation Number: [2018] EWCOP 10

Case No: 11757726T

IN THE COURT OF PROTECTION
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF P (SEXUAL RELATIONS AND CONTRACEPTION) v.2

Royal Courts of Justice
Strand, London, WC2A 2LL
18 April 2018

B e f o r e :

THE HONOURABLE MR JUSTICE BAKER

Between:

A LOCAL AUTHORITY **Applicant**

- and -

P (by her litigation friend, the Official Solicitor) (1)
THE NHS TRUST (2)
A FAMILY MEMBER (3) **Respondents**

David Lawson and Asma Nizami (instructed by Local Authority Solicitor) for the Applicant
Jenni Richards QC (instructed by P's solicitors who are retained on her behalf by the Official Solicitor) for the First Respondent
The Third Respondent appeared in person
There was no attendance by or on behalf of the Second Respondent

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HTML VERSION OF JUDGMENT

Mr Justice Baker :

1. This judgment in long-running proceedings involving a vulnerable young woman, hereafter referred to as "P", addresses difficult issues concerning her sexual relationships and the covert insertion of a contraceptive device.

2. The parties to the proceedings are the applicant local authority for the area where P lives, represented by David Lawson and Asma Nizami of counsel, and three respondents - P herself, the NHS Trust responsible for her medical treatment, and a member of P's family ("M"). P appears by her litigation friend, the Official Solicitor, represented by Jenni Richards QC. The Trust, with the court's agreement, played no part in the hearing, although it has made some representations about the draft order submitted after lengthy negotiations following the hearing. M has appeared in person. I am very grateful to all the lawyers for their efforts in this difficult and troubling case, and also to M who has put forward the family's case with great clarity.

Summary of background

3. The background to the hearing can be summarised briefly as follows. P is a young woman with learning disabilities. She previously lived with her family but took part in a number of social and community activities. Concerns arose that, by reason of her learning difficulties, she was vulnerable to sexual exploitation, pregnancy and sexually transmitted diseases (STDs). There is evidence that she was sexually assaulted and Dr D, expert, reported that the police expressed concern that P should not access the community unsupervised as she appeared to be a target for exploitation and was extremely vulnerable.

4. P has two children who are in the care of her family.

5. Some years ago an application was made to the court for an order that P be sterilised. In the event, it was decided not to pursue the application for sterilisation. Instead, consideration was given to providing P with long-acting contraceptive treatment and, if so, in what form and how it should be administered. The other main issue considered in the proceedings concerned the measures which should be put in place to protect P from sexual exploitation. Various psychiatric and other assessments were commissioned to inform the court. The expert evidence of Dr A, consultant psychiatrist, was that P lacked mental capacity to consent to sexual relations, to consent to contraceptive treatment and to litigate. Dr A further recommended that P should be supervised at all times when in the presence of sexually active men to whom she may be vulnerable unless and until it was established that she was able to make a decision with regard to sexual activity. It was further recommended that P should receive further education about sexual matters, in particular with a view to enabling her to protect herself against predators. Dr B, a specialist in community sexual and reproductive health, considered the various options for long-term contraception and recommended that it would be in her best interests for P to undergo the insertion under general anaesthetic of a copper inter-uterine device (IUD) which was envisaged to be effective for about ten years. It was proposed that this be carried out covertly under sedation, and that P should not be informed of the procedure. Following extensive discussion between members of the multidisciplinary team and legal representatives of all parties, a detailed plan was devised and submitted for approval by the court. There was some evidence at that time that P might acquire the mental capacity to consent to sexual relations and contraception if educational work

was undertaken.

6. At a substantive hearing in 2012, Parker J made an order in which, having declared that P lacked capacity to litigate and to make decisions with regard to contraceptive treatment, she further declared that it was lawful for P (with or without her agreement) to undergo under general anaesthetic the insertion of a copper coil IUD, to receive a Depo-Provera contraceptive injection, to undergo a full sexual health screen, and to be subject to proportionate restraint if necessary including sedation. By a further order that day, the judge directed a further assessment of P's capacity and the filing of further information as to the support package for her, with a view to a final hearing on a date to be fixed. Following the hearing, P duly underwent the operation for the insertion of the IUD. No reasoned judgment was given at the hearing in 2012 and, in the event, no further hearing took place for several years.

7. For some time P has lived in a supported living placement provided by a domiciliary care agency ("X Care Agency"). She has regular contact with her family. Sexual health training was provided by the community health trust ("CHT") over a period of several years.

8. In 2016, the local authority made an application to restore the proceedings. The purpose of the restored application was several-fold: to revisit the question of P's capacity to engage in sexual relations in the light of the work undertaken with her in the intervening years; to assess and evaluate the clinical risks to P's health presented to her by any further pregnancy; to revisit P's capacity to consent to contraceptive treatment; to re-evaluate the options for P's contraceptive treatment in view of the fact that the IUD inserted in 2012 has a life of approximately ten years; to reassess the best interests decision not to inform P of the fact of the insertion of the IUD in the light of any improvement of her understanding; and to authorise P's deprivation of her liberty at her placement, which hitherto had been unauthorised. Directions were given for, amongst other matters, the preparation of further expert evidence.

9. Following the preparation of a report on future care support by the CHT, and a number of professionals' meetings, at which it was agreed that the IUD should remain *in situ* until the end of its natural life, the local authority concluded that, as a result, the risk of pregnancy was significantly reduced and therefore proposed that the level of support and supervision in the community provided to P should be decreased, to enable her to exercise greater autonomy. A statement from the social worker C set out four options:

    (1) option A(i) - the IUD remains in place, P is not informed of its existence, and care and supervision remains at its current level;

    (2) option A (ii) - the IUD remains in place, P is not informed of its existence, but the level of care and supervision is reduced;

    (3) option B - the IUD is removed without informing P and the risk of sexual exploitation is managed "through social means" with the current level of care and supervision;

    (4) option C - the IUD remains in place and P is informed of this.

    Having analysed the benefits and disadvantages of these options, C on behalf of the local authority concluded that option A(ii) was in P's best interests. She summarised the conclusion in these terms in her statement:

    "This option will allow P the opportunity to develop her independence and have the chance to start forming sexual relationships. This option is seen as the least restrictive whilst ensuring risks are minimised. It is felt that the IUD has not had a negative impact on P's

well-being as advised by the medical professionals. The IUD remaining mitigates the risk of further pregnancies. A decreasing care would enable P to take more control of her daily routines and promote the chance of forming meaningful relationships. This will be done under subterfuge as it was highlighted within the medical expert reports (Dr D) that informing P would be detrimental to her well-being and impact on her relationship with family and professionals."

10. It became clear that M had not been given an opportunity to express views on the various issues. I therefore gave further directions and M became a party to the proceedings

11. At the hearing before me in late 2017, the three principal issues between the parties were as follows. (1) Does P has capacity to consent to sexual relations? (2) If she does, what steps should be authorised to facilitate the relationship between P and her boyfriend, or between P and any other person with whom she wished to have a sexual relationship? (3) Is the proposed relaxation in supervision in her best interests? In addition, however, it was thought appropriate for the court to review wider issues concerning her treatment, including the question whether it should continue to be covert or whether P should be informed about it. Although there was a measure of agreement between the parties about some of these issues, it was thought appropriate for this court to set out its conclusions on all matters supported by a reasoned judgment, which as stated above had not been provided at the earlier stage of the proceedings when the treatment was first authorised. In addition, notwithstanding extensive negotiations between the parties for several weeks after the hearing, there remain a number of details within the draft order about which the parties have been unable to agree and on which I am therefore asked to rule.

12. I shall address these issues in the following order:

(1) Capacity – general principles.

(2) P's capacity other than sexual relations.

(3) P's capacity to consent to sexual relations.

(4) Best interests: general principles.

(5) Best interests: contraception.

(6) Best interests: covert treatment

(6) Best interests: sexual relationships and supervision.

(7) Further issues arising from the draft order.

Meeting P

13. The rules concerning the participation of an incapacitated adult in proceedings in the Court of Protection, formerly in rule 3A of the Court of Protection Rules 2007 and Practice Direction 2A, are now set out in rule 1.2 of the Court of Protection Rules 2017 ("COPR 2017") supplemented by Practice Direction 1A. Paragraph 1 of the Practice Direction explains the purpose underlying the rule:

"Developments in the case law both of the European Court of Human Rights and domestic courts have highlighted the importance of ensuring that P takes an appropriate part in the proceedings and that the court is properly informed about P; and the difficulties of securing

this in a way which is proportionate to the issues involved and the nature of the decisions which need to be taken and avoids excessive delay and cost."

To that end, rule 1.2(2) identifies a number of directions which may be made by the court, including joining P as a party and directing that P has the opportunity to address the judge directly or indirectly. In determining the appropriate direction, the court is required under rule 1.2(1) to consider *inter alia* the nature and extent of the information before the court, the issues raised in the case, and whether a matter is contentious.

14. In this case, in which P is a party represented by the Official Solicitor as litigation friend, it was agreed that P should have an opportunity to meet me and a meeting duly took place.

Capacity: general principles

15. The general legal principles to be applied when determining whether a person has capacity are set out in the Mental Capacity Act 2005 and in the Mental Capacity Act 2005 Code of Practice, supplemented by a series of reported cases. Those principles can be summarised as follows:

(1) A person must be assumed to have capacity unless it is established that she lacks capacity: s.1(2). The burden of proof therefore lies on the party asserting that P does not have capacity. The standard of proof is the balance of probabilities: s.2(4).

(2) A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in, the functioning of the mind or brain: s.2(1). Thus the test for capacity involves two stages. The first stage, sometimes called the "diagnostic test", is whether the person has such an impairment or disturbance. The second stage, sometimes known as the "functional test", is whether the impairment or disturbance renders the person unable to make the decision. S.3(1) provides that, for the purposes of s.2, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision; (b) to retain that information; (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means.

(3) Capacity is both issue-specific and time-specific. A person may have capacity in respect of certain matters but not in relation to other matters. Equally, a person may have capacity at one time and not at another. The question is whether at the date on which the court is considering the question the person lacks capacity in question.

(4) A person is not to be treated as unable to make a decision unless all practicable steps to help her to do so have been taken without success: s.1(3). The Code of Practice stresses that "it is important not to assess someone's understanding before they have been given relevant information about a decision" (para 4.16) and that "it is important to assess people when they are in the best state to make the decision, if possible" (para 4.46).

(5) It is not necessary for the person to comprehend every detail of the issue. It is sufficient if they comprehend and weigh the salient details relevant to the decision (per Macur J, as she then was, in ***LBL v RYJ*** [2010] EWHC 2664 (Fam).

(6) A person is not to be treated as unable to make a decision merely because she makes an unwise decision: s.1(4).

(7) In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently instructed expert will be likely to be of very considerable importance, but as Charles J observed in *A County Council v KD and L* [2005] EWHC 144 (Fam) [2005] 1 FLR 851 at paras 39 and 44, "it is important to remember (i) that the roles of the court and the expert are distinct and (ii) it is the court that is in the position to weigh the expert evidence against its findings on the other evidence… the judge must always remember that he or she is the person who makes the final decision".

(8) The court must avoid the "protection imperative" – the danger that the court, that all professionals involved with treating and helping P, may feel drawn towards an outcome that is more protective of her and fail to carry out an assessment of capacity that is detached and objective: *CC v KK* [2012] EWHC 2136 (COP).

16. In a series of cases, it has been held that the test for capacity in relation to contraception decisions should be applied so as to ascertain the woman's ability to understand and weigh up the immediate or proximate medical issues surrounding contraceptive treatment which would include (1) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (2) the types available and how each is used; (3) the advantages and disadvantages of each type; (4) the possible side effects of each and how they can be dealt with; (5) how easily each type can be changed; and (6) the generally accepted effectiveness of each (see *A Local Authority v Mrs A (by the Official Solicitor) and Mr A* [2010] EWHC 1549 (Fam) per Bodey J and *The Mental Health Trust and another v The Council and another* [2014] EWCOP 13 per Cobb J at paragraph [16]).

17. The law relating to the capacity to consent to sexual relations has also been specifically addressed in a series of cases considered later in this judgment.

P's capacity other than sexual relations

18. Dr D, consultant psychiatrist, confirmed that P has a diagnosis of mild learning disability which amounts to an impairment of the function of the mind or brain so as to meet the diagnostic test in s.2(1) of the MCA. As a result of her disability, P struggles to understand information and concepts, particularly those of an abstract nature. Dr D noted that, throughout their conversation, P obviously had difficulty in weighing up the pros and cons of a particular course of action.

19. On the specific issues of capacity, leaving aside the capacity to consent to sexual relations, Dr D reached the following conclusions:

(1) P lacks capacity to conduct these proceedings.

(2) Although P is aware of various types of contraception and how they work, she lacks the capacity to consent to contraceptive treatment because of her inability to understand the relative effectiveness of each form of contraception, and she is unable to weigh up the positives and negatives of the different forms of contraception in relation to her own circumstances.

(3) (4) She also lacks capacity to make her own decisions in relation to her personal welfare (residence, care and contact) because of her lack of understanding of the need and purpose of the support she receives. Dr D concluded that she is vulnerable to others and is unable to keep herself safe from others who may seek to do her harm. In her interview with Dr D, P was unable to identify the risks which others might pose to her in the

community or how she would judge whether another individual would pose a danger to her. In her supplemental report, Dr D confirmed that P over-estimates her ability to keep herself safe and lacks capacity to make decisions in relation to contact with others, particularly potential sexual partners, and remains in need of 24-hour support.

20. Save with regard to the capacity to consent to sexual relations considered separately below, no party sought to challenge Dr D's assessment of capacity at the hearing before me which, in respect of her capacity to litigate and to consent to contraceptive treatment, was consistent with the earlier assessment of capacity carried out by Dr A. Having considered all the evidence, I accept Dr D's assessment. Although P has a basic understanding of the purpose of contraception and is aware of the various methods, she is unable to weigh up the relevant information in order to decide which form of contraception she should use. Similarly, I find that, although P recalls her past experiences and is aware of the need to keep herself safe, she lacks the ability to assess the risk posed by other people or judge whether another person poses a threat to her.

21. I therefore conclude and declare that P lacks capacity to (1) conduct these proceedings, (2) consent to contraceptive treatment, and (3) make decisions about personal welfare including residence, care and contact with other people.

P's capacity to consent to sexual relations

22. In assessing whether P has the capacity to consent to sexual relations, I apply the law as clarified by the Court of Appeal in *IM v LM and others* [2014] EWCA Civ 37, in which the Court of Appeal confirmed that the correct approach was as identified in a series of first-instance judgments including the decisions of Munby J (as he then was) in *Re MM, Local Authority X v MM* [2007] EWHC 2003 (Fam), Mostyn J in *D Borough Council v AB* [2011] EWHC 101 (Fam) and my own decision in *A Local Authority v TZ* [2013] EWHC 2322 (COP).

23. The basic principle, as identified by Munby J in *Re MM*, at paragraph 86, is that:

> "capacity to consent to sexual relations is … a question directed to the nature of the activity rather than to the identity of the sexual partner."

At paragraph 87, he continued:

> " … capacity to consent to sexual intercourse depends upon a person having sufficient knowledge and understanding of the nature and character – the sexual nature and character – of the act of sexual intercourse, and of the reasonably foreseeable consequences of sexual intercourse, to have the capacity to choose whether or not to engage in it, the capacity to decide whether to give or withhold consent to sexual intercourse. It does not depend upon an understanding of the consequences of sexual intercourse with a particular person. Put shortly, capacity to consent to sexual relations is issue specific; it is not person (partner) specific."

24. In *D Borough Council v AB* at paragraph 42, Mostyn J concluded that

> "the capacity to consent to sex remains act-specific and requires an understanding and awareness of:
>
> (i) the mechanics of the act;
>
> (ii) that there are health risks involved, particularly the acquisition of sexually transmitted

and sexually transmissible infections;

(ii) that sex between a man and a woman may result in the woman becoming pregnant."

25. In *A Local Authority v TZ*, I observed (at paragraphs 24 and 25):

> "24. I adopt and follow the approach of Munby J in *MM*, namely that capacity to consent to sexual relations is act specific and has to be assessed in relation to the particular kind of sexual activity in question.
>
> 25. In passing, I observe that there may be cases where, having held that P has the capacity to consent to sexual relations, the Court of Protection subsequently holds that P lacks the capacity to make decisions as to contact, either generally or with one or more named individuals. There may therefore be circumstances in which P's sexual relationship with a specific person may be curtailed by the court notwithstanding the fact that he has capacity to have sexual relations."

At the conclusion of that judgment, I held that TZ had capacity to consent to sexual relations. But in a subsequent judgment, reported as *A Local Authority v TZ (No.2)* [2014] EWCOP 973, after a further hearing and argument I held that TZ did not have the capacity to decide whether a person with whom he may wish to have sexual relations is safe nor the capacity to decide what support he required when having contact with an individual with whom he may wish to have sexual relations. On the basis of those findings, I made a detailed order in his best interests, defining the terms of a plan prescribing the support to be provided to assist him in developing a sexual relationship without exposing him to a risk of harm, and including provisions as to education and empowerment, support, intervention and decision-making.

26. Although the law is clear, it is not without controversy. I anticipate that many people would agree with the strong views expressed by M in a statement filed for the hearing before me in which M said *inter alia*:

> "if P lacks capacity to make decisions regarding contact (in particular of people who may cause a risk to her) how on earth can she have capacity in respect of sexual relations? A decision just to have sex with a person surely needs to include a decision based on STDs and other risks involved. Such a decision in my view is narrow-minded and does not include any thought of consequences for care, accommodation, family etc."

Plainly this is an area upon which there are different points of view. I must, however, apply the law as confirmed by the Court of Appeal.

27. In 2011, Dr A, after a detailed assessment and interview of P, reached this conclusion:

> "P is able to understand some basic information regarding sexual activity and retain that information, although at times the information that she retains is inaccurate and unfounded. However, at the present time, P does not appear able to use that information appropriately at the time that she needs to be able to make the decision. She appears, due to her vulnerability, to allow herself to get into situations where inappropriate, exploitative and possibly non-consenting sexual activity occurs.
>
> It is my opinion that with further sexual education she would gain greater knowledge about sexual activity. What is unclear, however, in view of her … history … is whether she is able to use the information at the time it is required in order to make herself safe and

clearly state whether she is consenting or not consenting to sexual activity. Ongoing sex education, coupled with consistent advice and boundaries from a family and those professionals involved in her care may enable her to gain further knowledge and be facilitated to act in a way that reduces the significant risk that she currently places herself at."

28. In 2016, after she had received further education, P was interviewed at length by Dr D who, having set out the details of their conversation at length in her report, reached a different conclusion:

> "At interview, P could give me a basic but reasonable description of the physical mechanics of sexual intercourse and also understood the potential consequences were pregnancy. She has a reasonable understanding of sexually transmitted infections and the potential impact on her own physical health should she contract an infection. P could tell me that she knows she could say 'no" to a man who asked for sex if she did not want it to go ahead and she understood that forcing a woman into sex was a criminal offence.
>
> Given the current case law regarding sexual relationships, it is my opinion that P has capacity to consent to sexual relations.
>
> However, I would state that, in my opinion, P has limited insight into her own vulnerability and could not make a judgement as to whether an individual was a potential risk to her or understand the motives of a potential partner in wanting to have sex with her."

In her supplemental report, Dr D added this observation:

> "It is my opinion that P is unable to recognise those who may be a risk to her. I believe she overestimates her ability to keep herself safe in relationships and struggles to understand the motivation of others. I believe that P lacks capacity to make decisions regarding contact with others, particularly potential sexual partners."

29. In her oral evidence, Dr D confirmed that P understood the mechanics of sexual intercourse and that it led to pregnancy and a baby. She understood sexually transmitted disease and that she might contract such a disease through sexual intercourse. She was less obviously aware of the emotional consequences of having multiple partners. Dr D acknowledged that people with capacity sometimes choose to have sex with multiple partners but, in contrast with many such people, P does not have control over the emotional consequences of such actions. She understood, however, that people get into trouble from forcing sex upon others. Overall, however, Dr D thought that the course of sex education which had been provided to P had given her an increased understanding of sexual relations and that this education had had a positive impact on P's understanding of the issues.

30. The local authority and the Official Solicitor on behalf of P accept Dr D's assessment and invite the court to make a declaration that P now has the capacity to consent to sexual relations. M disagrees and in a highly articulate and strongly worded statement, disputes the finding that P has developed the capacity.

31. It is clear from M's statement and oral evidence that M is very worried indeed about the consequences if a reassessment of her capacity to consent to sexual relations, coupled with a reduction in the level of supervision, exposes P again to the risk of sexual exploitation.

32. On behalf of the Official Solicitor, Miss Richards accepts that these comments by M are important factors to be considered when assessing the proposed care plan but submits they are not relevant to the issue of capacity. She describes the test for the capacity to consent to sexual relations as being set at a

relatively low level which the evidence suggests that P has now achieved.

33. I accept Dr D's evidence and Miss Richards' submissions. I find that P has now achieved a sufficient understanding of the mechanics of sexual intercourse, the fact that it can lead to pregnancy and the risks of sexually transmitted diseases. I accept Dr D's analysis that P has demonstrated that she can retain this information and use it and that she therefore satisfies what is undoubtedly, as Miss Richards describes, a relatively low level test. Accordingly, I shall make a declaration that she has the capacity to consent to sexual relations.

34. As I indicated in my judgments in the earlier case of *Re TZ*, however, where a person has the capacity to consent to sexual relations but lacks the capacity to make decisions as to her contact with other people, there may be – indeed, are likely to be – circumstances in which her relationships need to be supported, managed and, if necessary, controlled by the court. I consider this to be a paradigm example of just such a case.

Best interests - general principles

35. The criteria to be applied when making decisions about what is in the best interests of an incapacitated adult are set out in s.4 of the MCA:

> "(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.
>
> ….
>
> (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 sub-section (6).

…."

36. The leading case as to the application of the best interests criteria is now the decision of the Supreme Court in *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67. At paragraph 39 of her judgment in that case, Baroness Hale of Richmond observed:

"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."

At paragraph 45, she added:

"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. …. 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."

I also bear in mind the insightful observations of Peter Jackson J in *Wye Valley NHS Trust v Mr B* [2015] EWCOP 60. At paragraph 6 of his judgment, he reiterated that, whether or not a person has the capacity to make decisions for himself, he is entitled to the protection of the European Convention on Human Rights. In the context of that case, the relevant rights were Article 2 (the right to life), Article 3 (prohibition on torture – "no one shall be subjected to torture or to inhumane or degrading treatment or punishment") and Article 9 (freedom of thought, conscience and religion). The rights protected by the Convention also include, of course, Article 8 (right to respect for private and family life) and Article 12 (right to marry and to found a family). At paragraphs 10 to 12 of his judgment, Peter Jackson J made the following observations:

"10. Where a patient lacks capacity it is accordingly of great importance to give proper weight to his wishes and feelings and to his beliefs and values. On behalf of the Trust in this case, Mr Sachdeva QC submitted that the views expressed by a person lacking capacity were in principle entitled to less weight than those of a person with capacity. This is in my view true only to the limited extent that the views of a capacitous person are by definition decisive in relation to any treatment that is being offered to him so that the question of best interests does not arise. However, once incapacity is established so that a best interests decision must be made, there is no theoretical limit to the weight or lack of weight that should be given to the person's wishes and feelings, beliefs and values. In some cases, the conclusion will be that little weight or no weight can be given; in others, very significant weight will be due.

11. This is not an academic issue, but a necessary protection for the rights of people with disabilities. 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.

12 …. It is, I think, important to ensure that people with a disability are not – by the very fact of their disability – deprived of the range of reasonable outcomes that are available to others. For people with disabilities, the removal of such freedom of action as they have to control their own lives may be experienced as an even greater affront than it would be by others who are more fortunate."

37. In earlier cases, including *PH v A Local Authority, Z Ltd and R* [2011] EWHC 1704 (Fam) and *CC v KK* [2012] EWHC 2136 (COP), I have drawn attention to a potential risk that all professionals involved with treating and helping a person with disability – including a judge in the Court of Protection – may feel instinctively drawn towards an outcome that is more protective of the adult. The risk was identified in the well-known passage in the judgment of Munby J (as he then was) in *Re MM (An Adult)* [2007] EWHC 2003 (Fam):

> "A great judge once said, 'all life is an experiment', adding that 'every year if not every day we have to wager our salvation upon some prophecy based upon imperfect knowledge' (see Holmes J in *Abrams v United States* (1919) 250 US 616 at 630). The fact is that all life involves risk, and the young, the elderly and the vulnerable are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be brought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's *happiness*. What good is it making someone safer if it merely makes them miserable?"

38. In a number of cases, applying these dicta, I have made an order authorising an outcome notwithstanding the inherent risk on the grounds that it is an appropriate price to be paid to achieve the

individual's happiness - see for example, *CC v KK*, supra, and, more recently, *Re D* [2017] EWCOP 15. But, as Munby J makes clear, such decisions must always be taken on the basis of sensible appraisal of risk.

39. In making its assessment as to what outcome is in the adult's best interests, the court must also bear in mind the UN Convention on the Rights of Persons with Disabilities, ratified by the UK in 2009, and in particular the general principles set out in Article 3, including respect for inherent dignity: individual autonomy including the freedom to make one's own choices and independence of persons; non-discrimination; full and effective participation and inclusion in society, and respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.

Best interests: contraception

40. The right to a private life protected by Article 8 of the ECHR includes *inter alia* the right to establish relationships with other human beings: *Niemitz v Germany* (1993) 16 EHRR 97. It also includes the right to respect for both the decisions to become and not to become a parent: *Evans v UK* (2006) 43 EHRR 21, [2006] 2 FLR 172, *Re DD (No.4) (Sterilisation)* [2015] EWCOP 4 per Cobb J. The application for a declaration that it is in P's best interests and lawful and proportionate that her IUD remains in place clearly involves an interference with that right which, under Article 8(2), can only be justified if the court is satisfied that the interference is in accordance with the law and necessary for the protection of P's health. "Health" in this context should plainly be interpreted broadly to include not only physical health but also mental health, emotional wellbeing and all other aspects of P's best interests. The ECtHR has held that an interference with family life which is justified under paragraph 2 of Article 8 of the Convention cannot at the same time constitute a violation of Article 12: *Boso v Italy* (50490/99) [2002] ECHR 846.

41. The specific principles to be applied when determining whether sterilisation or contraception is the best interests of an incapacitated woman have been considered in a number of cases, including *Re A (Male) (Sterilisation)* [2000] 1 FLR 549 (per Thorpe J, as he then was), *Re M, ITW v Z and others* [2009] EWHC 2525 (Fam) (per Munby J, as he then was), *A Local Authority v K* [2013] EWCOP 242 (per Cobb J), *A Health Authority v DE* [2013] EWHC 2562 (Fam) (per Eleanor King J, as she then was), and *Re DD (No.4) (Sterilisation)*, (*supra*, per Cobb J). They can be summarised as follows:

    (1) The court must have regard to all the circumstances.

    (2) The weight to be attached to the various factors will differ from case to case depending on the individual circumstances.

    (3) "Best interests" are not limited to best medical interests but include the wider interests of P.

    (4) The court's decision must be the least restrictive of P's rights and freedoms.

    (5) The court is not tied to any clinical assessment of what is in P's best interests and must reach its own conclusion on the evidence.

    (6) The benefits and disadvantages of treatment must be carefully balanced.

42. In this case, there are a number of arguments against retaining the IUD. It is a clear infringement of P's human rights and freedoms. Furthermore, this infringement has been brought about without P's knowledge and without providing her with any opportunity to express her wishes and feelings. In her oral evidence, the X Care Agency manager said that she thought that P would not want to keep the IUD

if asked.

43. Another factor, which Miss Richards emphasises on behalf of the Official Solicitor, is that, if the IUD is maintained in place until 2022, the end of its normal ten-year lifespan, P's fertility will by then be reduced by reason of her age.

44. A further consideration is that it is arguably unnecessary for P to have the IUD, given that she is subject to constant professional supervision. If the aim is to prevent P becoming pregnant in her best interests, it could be argued that the fitting of the IUD was not the least restrictive option in the circumstances.

45. In addition, according to Dr E, the consultant obstetrician and gynaecologist asked to provide an expert opinion for the court, there are in this case no significant physical risks to P were she to become pregnant again. There is no risk of P sustaining an abdominal rupture as a result of a further pregnancy and the risk of a uterine scar rupture is very small (<0.5-1%). Even if there were to be a rupture, the risk of death to P or the foetus are very small indeed. Dr E further advised that the general risks of pregnancy are enhanced to a small degree with each subsequent pregnancy, the risk being of contracting a "morbidly adherent placenta" whereby the placental tissues implant over the uterine scar making it difficult to separate at the time of delivery. In overall terms, the best indicator of risk of a subsequent C-section are any findings in relation to the previous one, and on this basis Dr E would not anticipate any major complications in P's case of a C-section. The condition can usually be diagnosed in the course of antenatal care and appropriate plans put in place.

46. There are, therefore, several arguments in favour of removing the IUD. On the other hand, there are a number of other factors in favour of the IUD being retained.

47. First, although Dr E's assessment is that the risk of physical harm to P from a further pregnancy is low, there is clearly a risk that P would suffer significant emotional and psychological harm were she to become pregnant again. As I understand his evidence, it is this factor which led Dr E to his overall conclusion that P's best interests would be best served by her avoiding any further pregnancy at present and for the foreseeable future. The risk of emotional and psychological harm would be compounded if, as seems almost certain, any further child born to P would be removed from her care at birth.

48. Secondly, although P has not been expressly asked about her wishes and feelings concerning contraception, she has consistently said that she does not want to have a baby at this stage.

49. Thirdly, M, who is very closely involved with P and understandably has great concerns about her welfare, is strongly of the view that the IUD should remain in place given P's extreme vulnerability.

50. Fourthly, although P is subject to constant supervision at present, there is inevitably a risk, albeit probably very small, that she will elude the supervisors and put herself at risk of sexual exploitation once again.

51. Fifthly, the insertion of an IUD was thought at the time to be the most appropriate form of contraception. That remains the view of both Dr E and Dr D who have considered all the options. It is considered to be the most reliable form of contraception in the circumstances, with little or no need for further medical treatment until it is removed at the expiry of its lifespan.

52. Finally, the court is being asked to consider this question at a point when the IUD is already in place. Removal of the IUD is not clinically necessary and would involve a procedure which is likely by itself to be emotionally and psychologically harmful to P.

53. Having considered all the circumstances, I have reached the clear conclusion that it is in P's best

interests for the IUD to remain in place until the end of its normal ten-year span. At that point, further careful consideration will have to be given as to what contraceptive treatment, if any, should then be provided.

Best interests: covert treatment

54. Covert medical treatment is a serious interference with an individual's right to respect for private life under Article 8. In *An NHS Trust v The Patient* [2014] EWCOP 54, Holman J observed (at paragraph 22):

> "My own view is that even in the case of incapacitous or very incapacitous patients (leaving aside those who lack consciousness), it remains extremely important in any civilised society that they are not subjected to anaesthesia or invasive surgery without, as a minimum, being informed in sensitive and appropriate language as to what is about to be done to them before it is done."

In that case, there were concerns that, were the individual to be informed about the surgery proposed for treating his cancer, he would "go berserk". Holman J did not regard this as sufficient reason not to inform him of the procedure before it was carried out:

> "I regard it as acceptable that he has already been sedated to a degree before he is informed, and the hope must be that provided he has been sedated he will not in fact go berserk in the way that his sister predicts. But even at the risk of his going berserk, I insist that an integral part of the order (and this is mandatory) is that he must be informed in clear but sensitive terms of what is going to happen to him before it actually does happen.

55. No reported authority has been cited to me in which contraception has been provided without informing the patient. As already stated, there was no reasoned judgment in the present case when the decision was taken to authorise the covert insertion of the IUD. The only reported cases concerning the covert provision of medication to which I was referred were decisions of District Judge Bellamy in *AG v BMBC and another* [2016] EWCOP 37 in which the court authorised the covert provision of medication to a patient suffering from Alzheimer's disease, and of HHJ Farquhar in *BHCC v KD* [2016] EWCOP B2, in which the court authorised the cover provision of medication to a patient suffering from long-term schizophrenia and frontal lobe dementia. In *AG*, the district judge observed (at paragraph 38):

> "Covert medication is a serious interference with a person's autonomy and the right to self-determination under Article 8. It is likely to be a contributory factor giving rise to the existing DOL [deprivation on liberty] Safeguards by way of review are essential."

In that case, the district judge endorsed the following guidance produced by the supervisory body:

> "(i) if a person lacks capacity and is unable to understand the risks to their health if they do not take their prescribed medication and the person is refusing to take the medication, then it should only be administered covertly in exceptional circumstances;
>
> (ii) before the medication is administered covertly, there must be a best interests decision which includes the relevant health professionals and the person's family members;
>
> (iii) if it is agreed that the administration of covert medication is in their best interests, then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed;

and

(iv) all of the above documentation must be easily accessible on any viewing of the person's records within the care/nursing home;

(v) If there is no agreement, then there should be an immediate application to the court."

56. The covert provision of medication to an incapacitated adult is always an interference with personal autonomy and thus a very significant step. The covert insertion of a contraceptive IUD is, arguably, an even more serious interference with an individual's personal autonomy and Article 8 rights. The recent rescission of Practice Direction 9E has removed from the Court of Protection Rules the special procedural rules requiring all cases of serious medical treatment of incapacitated adults to be brought before the court. At the date of this judgment, the Supreme Court is still deliberating the appeal from the decision of O'Farrell J in *NHS Trust v Y and another* [2017] EWHC 2866 (QB), which addresses the question whether it is mandatory to bring before the court the withdrawal of clinically assisted nutrition and hydration from a patient who has a prolonged disorder of consciousness in circumstances where the clinical team and the family are agreed that it is not in the patient's best interests that he continues to receive that treatment. The ramifications of the rescission of the Practice Direction are therefore at present unclear. On one view, cases involving serious medical treatment now fall to be treated in the same way as those concerning any other issue concerning a mentally incapacitated adult. If so, it would only be necessary to bring such a case before the court either where there is a disagreement between professionals and/or family members as to what course is in the adult's best interests or alternatively there is some other reason why it is thought appropriate to refer the matter to the court. Given the serious infringement of rights involved in the covert insertion of a contraceptive device, it is in my judgement highly probable that, in most, if not all, cases, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of best interests, with P having the benefit of legal representation and independent expert advice.

57. The question which the court is now being asked to consider is not whether P should have been told before or immediately after the IUD was inserted but, rather, whether she should be told now, several years on.

58. Miss Richards on behalf of the Official Solicitor, whilst ultimately supporting the consensus view that P should not be told about the IUD, rightly considers the issue from all angles and in particular the position of P herself. She submits that the principal advantage of telling P about the IUD would be to restore her autonomy and bodily integrity and end the significant interference with her rights. Although her wishes and feelings cannot be known on this issue with certainty, it is highly likely that she would be opposed to any covert treatment. Telling P about the presence of the IUD in a planned way would also avoid the risk of an inadvertent disclosure of the existence of the device. Given the high turnover of care and medical staff, it is submitted that there is a risk that a new member of staff working with P, perhaps in a medical emergency, may be unaware of the situation and reveal the truth. Preserving confidentiality about this issue may present other challenges to medical and care staff.

59. The consensus amongst professionals working with P, however, is that disclosure of the existence of the IUD would cause her distress and significant emotional harm. The knowledge that a device had been inserted without her knowledge could cause serious and lasting damage to her relationships with family and professional staff on whom she depends. In her report, Dr D expressed this opinion:

" … the negatives of telling P that she has an intrauterine device in place are significant. I believe that she would lose trust in her carers and professionals who support her, in

addition to her family members. I believe that P would become distressed at the thought that something had been done to her without her knowledge and consent. This may make it significantly more difficult for her to trust those around her in the future, leading to potential breakdowns in relationships, which would have a negative impact on P's emotional well-being. I also believe that it will be more likely that she may engage in sexual relationships, if she believed that she had a form of contraception, placing her at risk of sexually transmitted infections if she did not use condoms."

60. This position is supported by the local authority social work team. Her key worker is concerned that there may be a risk that her current placement would break down should P discover that the staff at X Care Agency had withheld information from her. She thought that P would not understand that professional staff had acted in her best interests. Disclosure of the covert treatment would also jeopardise future relationships with medical professionals. If P were to be informed about the existence of the IUD, she would probably ask for it to be removed, and a refusal by professionals to comply with her wishes would further exacerbate difficulties in their relationship. It is submitted that the original decision to treat covertly was taken after detailed discussion and a court process which was thorough, careful and compliant with Article 8. It was justified by the great concerns about P's sexual exploitation. It is submitted that there is no reason now for reversing this decision. Any risk of inadvertent disclosure can be managed by a robust and well-managed health action plan.

61. The local authority's position on covert treatment is supported by the Official Solicitor and also by M. M is concerned that, were P to be informed of the existence of the IUD, her relationship with her family would be damaged.

62. I recognise that the fact that P has been fitted with an IUD without her knowledge is a very significant interference with her personal autonomy and her human rights. Given that it is plainly in her best interests for the IUD to remain fitted, however, I reach the clear conclusion that she should not be told about the presence of the IUD at this stage. I accept the argument that to do so would cause very considerable harm to her relationships with professionals and her family on whom she is utterly dependent. I acknowledge the risk of inadvertent disclosure but agree that it should be possible to manage this risk through a robust health action plan.

63. It has to be recognised, however, that in all probability this state of affairs cannot continue indefinitely. Covert treatment should only be countenanced in exceptional circumstances. When the time comes for the IUD to be renewed or replaced, every effort will have to be made to include P in the decision-making process about future contraception. The need to take this course will be even greater if P is at that stage in a relationship with a partner with whom she is contemplating sexual relations. In other words, although I approve the plan to retain the IUD, and not to tell P about it at this stage, I regard it as imperative that professionals working with P keep this issue under review at all times and start planning now for ways in which further decisions about contraception can be taken in a way that includes P and respects her personal autonomy and human rights.

Best interests: sexual relationships and supervision

64. There are two further interlinked matters relating to P's best interests which now fall to be considered by the court. They are matters on which the parties are in sharp disagreement. First, what steps, if any, should be taken to support P in having sexual relationships in future, including with her current boyfriend? Secondly, should the current regime of continuous 1:1 supervision be relaxed at all?

65. The fact that P has someone whom she now regards as her boyfriend and with whom she wishes to have a long-term relationship means, as Miss Richards put it in her opening submissions, that the

possibility that she may wish to exercise a capacity to consent to sexual relations is no longer an abstract issue. Miss Richards rightly submits that, if P can consent to sex with any person and may wish to exercise that capacity in circumstances where the person with whom she wishes to have contact is someone with whom she has a benign and non-exploitative relationship, it would be a significant interference with her rights if she were not to be permitted to do so. On the other hand, Ms Richards also submits, rightly, that the court is entitled – and I would add obliged - to protect P from the risk of future harm, abuse or exploitation, provided that the risks are real, are not fanciful and that the measures put in place are pragmatic, common sense and robust.

66. In submissions on these issues, both the local authority and the Official Solicitor cite my earlier decision in *A Local Authority v TZ (No.2)*, *supra*. That case concerned a young man who had the capacity to consent to such relations but lacked the capacity to make decisions about whether or not an individual with whom he may wish to have sexual relations was safe, or the capacity to make a decision as to the support he required when having contact with an individual with whom he may wish to have sexual relations. The challenge for the parties and the court in that case was to develop a best interests framework which permitted the young man sufficient autonomy of decision-making and respected his right to private life whilst balancing the need to protect him from harm. Having considered a draft plan and submissions, I put forward proposals for the sort of measures that should be in the plan, as part of a collaborative process between the court and the parties, and identified five particular elements: (a) basic principles; (b) education and empowerment; (c) support; (d) intervention, and (e) decision-making. The details of my proposals, which were substantially included in ultimate care plan, are set out in paragraphs 56 *et seq* of the judgment.

67. On behalf the local authority in the present case, Mr Lawson submits that the care plan for P has been drafted with an eye to the structure and contents of the plan proposed in the *TZ* case. The plan includes measures to be taken to assist P in developing new relationships and facilitating sexual relationships alongside 1:1 supervision, and incorporates a flowchart of steps to be followed in the event that P starts a relationship. Mr Lawson submits that the plan should now be approved by the court in a final order and further best interests decisions left to the professional agencies in consultation with M and any other person with an interest in P's welfare.

68. M, who, as stated above, does not believe that P has the capacity to consent to sexual relations, is opposed to these proposals being incorporated in the care plan.

69. In her closing submissions, Miss Richards informed the court that the Official Solicitor does not endorse the proposal that these proceedings should now come to an end, leaving the professionals to agree on any additional relaxation and supervision. The Official Solicitor considers that the circumstances are too uncertain and fluid for the proceedings to be terminated at this stage. There is also insufficient information about P's boyfriend - for example, his level of functioning is unclear, as is the question whether or not he has the capacity to consent to sexual relations himself. In oral evidence, the local authority social worker acknowledged that, before the relationship between P and her boyfriend progressed any further, much more would need to be known about him and his circumstances, including whether he has the capacity to consent to sexual relations. It is clearly possible that the relationship may develop, but the Official Solicitor is concerned that this will need careful monitoring and believes that this should be done within the context of ongoing court proceedings.

70. Linked to this issue is the local authority's proposal to relax the level of supervision provided to P. For the last six years, P has been subject to 1:1 supervision at all times. The local authority now proposes to begin a process of reducing that supervision, in accordance with P's expressed wish to have more freedom and in the light of the statutory obligation, under s.1(6) of the MCA, to have regard to whether

the purpose for which any act or decision is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. P is said to be a very sociable person who enjoys having the opportunity to go out to social events, see friends and meet new people. Professionals wish to help her enjoy these activities without exposing her to the risk of further exploitation.

71. The local authority's proposal is that, for a period of four weeks, the 1:1 direct supervision should be very slightly reduced.

72. The specific proposals are set out in an amended care plan. If this reduction in supervision is deemed to be successful, it may then be agreed for there to be a further reduction of the level of supervision. The local authority's proposal is supported by the agency responsible for P's care. In her evidence, the manager of X Care Agency supported the proposed reduction in supervision, describing it as "a really good idea".

73. M is strongly opposed to any reduction in the level of supervision. M is understandably concerned about the history of sexual exploitation.

74. In closing submissions, Miss Richards on behalf of the Official Solicitor supported the slight relaxation in the level of supervision proposed by the local authority, provided that the periods when P is on her own are properly monitored. It is unclear whether the planned reduction in supervision will be successful and there is a considerable degree of uncertainty about what is going to happen. Miss Richards added that realistically it is unlikely that there will be any consensus between professionals and family members about what should happen at the conclusion of the four-week period.

75. I accept the point, plainly underpinning Mr Lawson's submissions, that decision-making about the best interests of incapacitated adults should, wherever possible, be resolved without reference to the court. It seems to me, however, there is much force in Miss Richards' submission that the current circumstances are too uncertain and fluid to justify bringing the proceedings to an end at this stage. My reasons for this conclusion are as follows.

76. First, in contrast to the *TZ* case, where all parties and interested persons were broadly agreed as to the direction of travel, there is a deep and sharp disagreement between the professionals and P's family, in particular M, about whether any steps should be taken which might lead to P having a sexual relationship. I think it extremely unlikely that this disagreement will be resolved in the near future, if ever. Furthermore, there is clearly a risk that the disagreement on this issue may in fact damage the good relationship which M has with many of the professionals and workers involved in P's care. It would be most unfortunate if this apparently good relationship were to be undermined by disagreement on this one issue. For that reason, there is good reason for the court retaining the role of arbiter. I acknowledge that court proceedings are a cause of stress for everyone, including the family, but I consider that the court has an important role to play at least at this stage in the process.

77. Secondly, it is plain that the decisions concerning P's future relationships will be difficult. A balance will have to be struck between her right to establish relationships, which is an integral part of her private life which must be respected, and the need to protect her from harm. I accept M's characterisation of P as extremely vulnerable to exploitation. Any comparison between cases needs to be undertaken with caution, but it is significant that, whilst the young man in the *TZ* case had been exploited as a teenager, he did not exhibit behaviour of the sort which P has displayed in the past and which is said to have contributed to her vulnerability. This is, in my judgment, a further reason why this aspect of P's care plan needs to be monitored by the court, at least for the time being.

78. Thirdly, again in contrast with the *TZ* case, P is at the start of a specific relationship about which there are a number of uncertainties as identified by Miss Richards. I agree with her submission that it would be wise to ascertain more information about P's boyfriend and undertake further analysis of this relationship within the context of the court proceedings before any final order is made.

79. Fourthly, the ongoing proceedings will enable P to continue to enjoy the benefit of representation by the Official Solicitor and her legal team. In this very complex and concerning case, where there is a significant disagreement between professionals and the family, it would in my view be to P's advantage to be represented in this way, albeit at additional public cost.

80. The final reason relates to the proposed relaxation of supervision. Whilst acknowledging the strong views and concerns expressed by M, I accept the professional view of the local authority and the Care Agency, endorsed by Dr D, that the proposed slight relaxation of supervision would be in P's best interests and should be put in to effect. In my judgment, however, it should be put in place for longer than four weeks - I would propose three months - and then reviewed. If all has gone well, it is conceivable that the parties may agree a further relaxation. Realistically, however, that seems unlikely and in those circumstances there would have to be a further referral to the court. No one has suggested that a further personal welfare deputy be appointed to make decisions about this matter, so that any disagreement will have to be resolved by this court. Frankly, it is difficult to see at this stage precisely how far the relaxation of supervision can safely go. In those circumstances, it is plainly necessary for these proceedings to continue.

81. I therefore direct that the matter be listed for a further hearing before me in the autumn, the date to be agreed between the parties in consultation with my clerk.

82. In the interim, I shall make the following order. I grant permission for the slight relaxation in supervision proposed by the local authority, but on the basis that it should continue for three months before there is a further review. The order will further provide that the parties may agree a further relaxation of the supervision thereafter, and may also agree for P to have unchaperoned time with her boyfriend. In the absence of agreement on those issues, there will be no further relaxation of supervision, nor any unchaperoned contact between P and her boyfriend, until further order.

83. At this stage, I do not consider it appropriate to include in the order a provision that it is lawful for the local authority to facilitate a sexual relationship between P and a potential partner in accordance with the draft care plan. I think it better to postpone a decision on that issue until the next hearing I recognise that this represents much slower progress than envisaged by some of the professionals working with P, but in my judgment this is the appropriate course to take in all the circumstances, in particular given P's history of sexual exploitation.

Further issues arising from the draft order

84. There are three further incidental issues which have arisen between the parties as to the detailed terms of the order which I am asked to resolve.

85. First, the local authority invites the court to include a recital in the order to this effect: "the applicant reserving for future decision / submission whether a new Care Act assessment might lead to changes in the support available to the first respondent which it would submit were not matters to be determined in best interests proceedings". The reason behind the local authority's invitation is that it is argued that it should be clear to those reading the order in the future that it cannot require a particular level of services under the Care Act 2014 or suggest that the Court of Protection has primary decision-making power about any future disputes about community care services to be provided to P. The Official

Solicitor does not agree to the inclusion of this paragraph. He argues that, if, as the local authority asserts, these are not matters to be determined in best interests proceedings, then this recital has no place in an order in best interests proceedings. Moreover he contends that it is important that this order is, as far as possible, capable of being easily understood by non-lawyers (including family members and carers) and this recital is confusing and unhelpful in that regard.

86. I agree with the Official Solicitor on this issue. There is nothing in this order which compels the local authority to provide services. The local authority has put forward a care plan which the court has approved in part.

87. Secondly, there is an issue as to which authority should be responsible for bringing the matter back to court if further decisions need to be made about the IUD. The local authority contends that an application concerning P's health is an application for the health bodies to bring. The Trust did not appear at the hearing, but, in an email submitted some weeks after the hearing via my clerk, contended that it should be the local authority that should bring the matter back to court in such circumstances. In the email, it is pointed out that the draft order gives no indication as to whether or not P's ability to consent to sexual relations or birth control and her care plan will need to be re-examined if further decisions need to be made in relation to her IUD. On this basis, the Trust assumes that any further decisions relating to P's IUD, including what is to happen once it requires removal between 2022 and 2024, will require an application to court to re-examine all of these issues. It is pointed out that, at present, the Trust's role in implementing and monitoring the health action plan is narrow. Its focus is on ensuring the safety of the IUD from a medical perspective via implementation of the health action plan. The Trust has very little day-to-day involvement with P and her social circumstances which, as the draft order makes clear, are central to the reasons that the IUD is *in situ* under subterfuge in the first place. The Trust submits that the local authority, by virtue of the fact that it commissions P's social care and employs the social workers that have developed P's care plan, has day-to-day involvement with P's social circumstances. It is therefore the Trust's view that, if an issue does arise with the IUD, the local authority is better placed to make the application as it will have greater understanding of P's wider social circumstances which ultimately will require addressing if further decisions in relation to P's IUD need to be made. A further point made on behalf of the Trust is that the possibility of new commissioning arrangements over the next five years runs the risk of loss of institutional knowledge about P's circumstances and that this is a further reason why it would be more appropriate to nominate the local authority as the appropriate body to bring this matter back to court.

88. The submissions put forward on behalf of the Trust are persuasive. I therefore order that the local authority should be responsible for bringing the matter back to court if further decisions need to be made about the IUD.

89. The provisions of the order relating to the IUD plainly involve a deprivation of liberty. I shall include in the order a clause in the usual terms that such a deprivation is lawful.

90. Further issues raised on the draft order related to the steps to be taken by the local authority prior to facilitating a sexual relationship between P and her boyfriend or another person. As stated above, however, I have decided not to include in the order a provision that it is lawful for the local authority to facilitate a sexual relationship between P and a potential partner. That issue will be reconsidered at the next hearing. Accordingly I have deleted a number of paragraphs from the draft submitted by the parties and shall circulate with the draft of this judgment a re-draft of the order I propose to make. I believe that all relevant matters have been covered, but would be grateful if the parties would consider the re-draft and inform my clerk of any suggested alterations.

[Judge's note - This version of the judgment has been substantially redacted to remove information

which, if published, might lead to the identification of P. I am very grateful to counsel and their instructing solicitors for the additional work they carried out agreeing and drafting the redaction.]
