EDITORIAL NOTE: CHANGES MADE TO THIS JUDGMENT APPEAR IN [SQUARE BRACKETS].

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IN THE FAMILY COURT
AT WELLINGTON

I TE KŌTI WHĀNAU
KI TE WHANGANUI-A-TARA

FAM-2021-085-000297
[2021] NZFC 7685

IN THE MATTER OF	THE PROTECTION OF PERSONAL AND PROPERTY RIGHTS ACT 1988
BETWEEN	[NA] Applicant
AND	[LO] Person In Respect of Whom the Application is Made

Hearing:	3 August 2021
Appearances:	I Reuvecamp for Applicant E Lewes for Subject Person B Yeoman as Counsel to Assist A Gray, District Inspector of Mental Health
Judgment:	10 August 2021

JUDGMENT OF JUDGE M N E O'DWYER

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[1] This is an application for a personal order for medical treatment for Ms [LO] under s 10(1)(f) of the Protection of Personal and Property Rights Act 1988 ("the PPPRA"). The application is for an order that medical treatment is permitted to

terminate the pregnancy of Ms [LO] if this is considered clinically and ethically appropriate by qualified health practitioners.

[2] The application is filed by Mr [NA], Executive Clinical Director of Mental Health, Addictions and Intellectual Disabilities Services ("MHAIDS"), for the [District Health Board] ("[the DHB]") where Ms [LO] is receiving medical and mental health services and treatment.

[3] The order was sought considering Ms [LO]'s previous and current expressed wishes (albeit that these are not always consistent), the assessment that Ms [LO] lacked mental capacity to consent or refuse consent to the procedure, and the consequences of either proceeding or not proceeding with the termination of pregnancy.

[4] The application was filed on 29 July 2021 as a matter of urgency. The matter was referred to me and a hearing was scheduled on 3 August 2021. Ms Lewes was appointed as Lawyer for the Subject Person, and Mr Yeoman was appointed as Lawyer to Assist the Court. Specific directions were given to ascertain that the views of Ms [LO]'s partner, Mr [DB], and her mother.

[5] At the date of the hearing, Ms [LO] was 19 weeks and four days pregnant. The evidence established that the termination can be carried out by surgical termination under a general anaesthetic up to 20 weeks. After 20 weeks gestation, a termination is by way of induction of labour which would be traumatic for Ms [LO].

[6] The hearing took place at the hospital, [the mental health and assessment treatment service] on 3 August 2021. At the end of the hearing I advised the parties and counsel that I had reached my decision to grant the application, and because of time constraints and urgency, the reasons would be delivered in writing. I issued a Minute so that an order could be made and sealed. A copy of that Minute is attached to this decision. [EDITORIAL NOTE: Minute not attached].

Background

[7] The background is drawn from the evidence at the hearing from 5 doctors, two maternity social workers, their written reports and extensive clinical notes. It is also drawn from Ms Lewes' reports for Ms [LO] and Mr Yeoman as Lawyer to Assist, for Mr [DB]. The views of Ms [LO]'s mother were sought.

[8] I had the opportunity to meet Ms [LO] before the hearing and obtain her views directly. She did not attend the hearing as that would have been too stressful, but she was represented by Ms Lewes.

[9] Ms [LO] is [in her late 30s] and has a difficult history of enduring mental illness and alcohol and solvent use disorders. She has one daughter, now aged [under 10] years, who lives with Ms [LO]'s mother. The relationship between Ms [LO] and her mother and whānau deteriorates when Ms [LO] is unwell.

[10] Ms [LO] has been in a relationship with Mr [DB] for approximately three and a half years. He is described as her closest whānau. Mr [DB] is in custody in [Prison], charged with assaulting Ms [LO] on 17 July 2021. There is a long history of family harm in the relationship.

[11] In late April 2021 Ms [LO] sought assistance for a termination of pregnancy. She was living in [location deleted – "the first location"] with Mr [DB] in very unsettled and unsafe circumstances. When she was located by the maternity social workers through the Family Violence Interagency Response System ("FVIARS") team, she was homeless and living in a car with Mr [DB]. The social workers were unable to speak to Ms [LO] but spoke to Mr [DB]. Ms [LO] was referred to obstetric and detox services.

[12] During May and June 2021 maternity social workers could not locate Ms [LO]. She and Mr [DB] moved from place to place. She visited her GP; was referred to the hospital and had a pregnancy scan in June. There were frequent family harm reports.

[13] On 12 July 2021 Ms [LO] presented to the Alcohol and Other Drug ("AOD") Service at [the first Hospital] seeking treatment at the Social Detox Facility. She

sought admission for treatment at the detox unit for alcohol withdrawal. She was seen by Dr [DT], psychiatrist, AOD Services. He noted a long history of severe alcohol use disorder, that Ms [LO] was 14 weeks pregnant, and that she was living on the street. He recommended her admission to the unit.

[14] Ms [LO] was admitted to the Detox Facility and on 15 July 2021 she met with two maternity social workers, [two names deleted]. She discussed her wish for a termination. The procedure, continuation of the pregnancy and options for care were discussed. She wanted to think about it overnight.

[15] Ms [LO] left Detox on 15 July 2021. Her reason, given to Dr [DT], was that she wanted to continue drinking.

[16] On 17 July 2021, Ms [LO] was assaulted by Mr [DB]. She suffered a split lip and bleeding mouth from the assault. The police were involved, consequently Mr [DB] is charged with assault on a person in a family relationship. There is a long history of Ms [LO] being a victim of family harm with Police records of 94 previous family harm incidents between Mr [DB] and Ms [LO].

[17] Following the assault Ms [LO] was treated at [the first Hospital]. She received nursing and social work care. On 19 July 2021, Ms [LO] spoke with the maternity social workers and said that she had decided to have a termination of the pregnancy. It was not possible to provide the medical procedure at [the first location] due to the stage of the pregnancy. Arrangements for Ms [LO]'s admission to [the abortion unit at the second location] were confirmed.

[18] Ms [LO] travelled to [the second location] to stay at Māori Women's Refuge emergency accommodation prior to her admission to [the abortion unit]. She was assigned a support worker. At the Refuge, her behaviour was of concern. It was reported that Ms [LO] left the Refuge and slept on the street.

[19] When Ms [LO] was admitted to [the mental health and assessment treatment service], she was reported to be agitated, paranoid and appeared to be responding to non-apparent stimuli. Dr [LM], consultant psychiatrist, considered that she was

experiencing a relapse of schizophrenic disorder. She was noted to be markedly unwell and lacking capacity to consent to a termination of pregnancy and her capacity to care for herself was seriously impaired. The medical notes recorded the context was likely to be prolonged discontinuation of anti-psychotic medication, and recent stresses including the assault and the pregnancy that was planned for termination.

[20] Since admission to [the mental health and assessment treatment service], Ms [LO] has been assessed frequently. Her responsible clinician, Dr [CP] made an assessment that she did not have the capacity to consent to a termination of pregnancy. Her presentation and level of agitation was such that he considered she was unable to comply with the procedure.

[21] The medical notes and assessments record that Ms [LO]'s views changed daily. She was in contact with her mother who had the care of Ms [LO]'s daughter but her responses were confused and inconsistent.

[22] By 27 July 2021, Ms [LO]'s mental state was reported to have improved as she was less disorganised in thought, speech and behaviours. She demonstrated a marked ambivalence regarding the pregnancy and lack of capacity. She was reported as saying she did not know what she wanted. At times she said she wanted to continue with the pregnancy and at other times she said she did not want to. She was unsure whether she would be considered fit to look after a child if Oranga Tamariki were involved. She often presented confused and disinhibited.

[23] On 28 July 2021, a second opinion was sought from a consultant psychiatrist, Dr [EL]. Ms [LO]'s views were in favour of termination at that point in time. He assessed that Ms [LO] lacked capacity to consent to a termination of pregnancy and there was a worrying degree of ambivalence in the face of her currently unwell mental state.

[24] Between 27 and 30 July 2021, Ms [LO] was reviewed by the Psychiatric Registrars. The medical reports and nursing notes record that Ms [LO] continued to appear disorganised, delusional and very distressed regarding the pregnancy. She was unable to grasp the urgency of her situation.

[25] Ms [LO] discussed her pregnancy by telephone with Mr [DB]. Following those conversations, she appeared to have more positive views towards the pregnancy. She expressed a strong view that if she wasn't able to keep the child, she would not continue with the pregnancy.

[26] Dr [CP]'s assessment on 2 August 2021 was that Ms [LO]'s mental state had improved since her admission, but she still presented with paranoia and impaired judgment, with possible intellectual or learning disability and neuro-disability, and poor insight into her mental health. Dr [CP]'s evidence is that Ms [LO] presents with a degree of intellectual impairment or learning disability, alcohol issues, cognitive impairment and the possibility of an underlying neuro-developmental disorder. His assessment was that she did not have capacity to make a decision regarding the continuation or termination of the pregnancy.

[27] In addition to the reports from Dr [CP] and Dr [EL], Ms [LO]'s medical needs have been considered by Mr [AC],[1] and Dr [MM][2] who have advised on the clinical services available for termination of pregnancy. The procedure up to 20 weeks gestation is considerably less invasive than procedures after 20 weeks.

[28] Ms Lewes endeavoured to have contact with Ms [LO]'s mother without success. I was satisfied that Ms [LO]'s mother is aware of the proceedings, although she has not been served, through many discussions she has had with health professionals.

Summary

[29] The evidence establishes that Ms [LO] has sought advice on her pregnancy and wish for termination from late April 2021. Social workers met with Ms [LO] on three separate occasions regarding her pregnancy between May and July 2021. On 15 July 2021 at [the first location] Social Detox Facility there was a discussion about pregnancy options available to Ms [LO], where Ms [LO] expressed a wish for a termination and the procedure. At a meeting with Ms [LO] on 19 July 2021, the social

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1 Mr [AC], Senior Medical Officer, Gynaecologist and Chief Medical Officer, [the DHB].
2 Senior Medical Officer, Clinical Head of [the Abortion Services], [the DHB].

workers formed the view that Ms [LO] was requesting a termination and understood that the procedure would be under general anaesthetic in [the second location].

[30] Since Ms [LO]'s admission to hospital under the Mental Health Act on 21 July 2021 in [the second location], she has expressed inconsistent views about her pregnancy. At times she has expressed a very strong wish for a termination of the pregnancy; at other times she has expressed a wish to maintain the pregnancy.

[31] As a result of her mental health difficulties, the medical evidence establishes that Ms [LO] does not currently have the capacity to make a decision in respect to termination of pregnancy.

[32] The application was filed to seek the Court's consent for a termination of pregnancy given the evidence that Ms [LO] had sought a termination of pregnancy in May and was now not capable of giving consent.

The law

Jurisdiction of the Court

[33] Under s 6(1) of the PPPRA, the Court has jurisdiction to make an order, in this case a personal order, under Part 1, if a person wholly or partly lacks capacity to make their own decision or lacks the ability to communicate that decision.

[34] Since Ms [LO]'s admission on 21 July 2021 to [the mental health and assessment treatment service], Ms [LO] has consistently been assessed as lacking capacity to understand the nature, and to foresee the consequences, of a termination of pregnancy.[3]

[35] Ms Reuvecamp has referred me to the key principles to guide the Court's exercise of jurisdiction. All counsel agree that Ms Reuvecamp's summary accurately reflects the principles that should be applied and the approach the Court should take.

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[3] See MHAIDS Clinical Records Progress Note dated 27 July 2021, Second Opinion provided by Dr [EL] dated 28 July 2021 and report of Dr [CP] dated 2 August 2021.

[36] The PPPRA recognises that a person with a disability, including a mental health disability, is entitled to enjoy legal capacity on an equal basis with others in all aspects of life. Section 4 of the PPPRA provides:

> **4 Legal capacity of persons subject to orders under this Act**
>
> Except as provided by or under this Act or any other enactment, the rights, privileges, powers, capacities, duties, and liabilities of any person subject to an order under this Act whether in a personal, official, representative, or fiduciary capacity, shall, for all the purposes of the law of New Zealand (whether substantive, procedural, evidential, or otherwise), be the same as those of any other person.

[37] This principle reflects Article 12(2) of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which states:

> **Article 12 – Equal recognition**
>
> …
>
> 2. State Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
>
> …

[38] Ms Reuvecamp referred me to the important principles in Article 12(3) requiring State Parties to provide support for persons with disabilities to enable the person to exercise legal capacity and ensure safeguards to prevent abuse. These rights are recognised under the PPPRA and have been uppermost in the minds of the doctors and other professionals addressing these issues for Ms [LO] and in the process that the Court has followed.

[39] Section 8 of the PPPRA provides the primary objectives for the Court when considering an application under s 10. The primary objectives are:

> **8 Primary objectives of court in exercise of jurisdiction under this Part**
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> The primary objectives of a court on an application for the exercise of its jurisdiction under this Part shall be as follows:
>
> (a) to make the least restrictive intervention possible in the life of the person in respect of whom the application is made, having regard to the degree of that person's incapacity:

> (b) to enable or encourage that person to exercise and develop such capacity as he or she has to the greatest extent possible.

[40] If a Court accepts that the subject person is unable to consent to a termination of pregnancy, it may make a direction under s 10(1)(f) for a direction that the subject person consents to the procedure.

[41] The role of the Family Court under the PPPRA is to determine whether grounds for giving consent have been established. If the Court does consent, then its role is complete; the decision as to whether a pregnancy is to be terminated must be made by qualified health practitioners providing termination services and only if it is considered clinically and ethically appropriate by the practitioners.

[42] In *X v Y (Mental Health: Sterilisation:)*,[4] Miller J discussed the principles to be considered by the Court when considering the issue of consent. *X v Y* was considered in *RLW v RL-JW*, a decision of Judge A P Walsh.[5] It is convenient that I set out the summary of the principles expressed by Miller J in that decision:[6]

> 1. He noted the provisions of ss 5 and 6 of the Act. Under s 6(3) the fact that the person in respect of whom the application is made had made a decision that a person exercising ordinary prudence would not have made given the same circumstances was not in itself sufficient grounds for the exercise of jurisdiction. The threshold question under Part 1 was whether the presumption of competence had been displaced. An order may not be made under s 10 unless the subject lacks, wholly or partly, the capacity to understand the nature and to foresee the consequences, of a decision to have a child.
>
> 2. Four factors are particularly relevant in determining whether a person has capacity to make the relevant decision –
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>   - Ability to communicate choice;
>   - Understanding of relevant information;
>   - Appreciation of the situation and its consequences;
>   - Manipulation of information – the person's ability to follow a logical sequence of thought in order to reach a decision.

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4 In *X v Y (Mental Health: Sterilisation):* [2004] 2 NZLR 847 and 23 (FRNZ) also reported as *R v R* [2004] NZFLR, 797.

5 *RLW v RL-JW*, FAM 2008-032-000991, 29 January 2009.

6 At paragraph [41].

3. Once the presumption of competence is displaced the Court can make a personal order under s 10.

4. Under s 10 the Court may make an order that the person be *"provided with medical advice or treatment of the kind specified in the order"*. Miller J noted it had been held this jurisdiction extended to an order for sterilisation or termination of the pregnancy. He referred particularly to the decision of Judge Inglis QC in *Re H* [1993] NZFLR 225.

[43] If the Court finds that the subject person lacks capacity, the Court must go on to consider the principles that should guide the Court's decision on whether consent should be given for the proposed medical treatment.

[44] In *X v Y* a personal order was sought to terminate the pregnancy of a disabled woman as well as her sterilisation. Miller J agreed with Judge Inglis QC that the welfare of the subject person lay at the heart of the jurisdiction under Part 1 of the Act.[7] Miller J emphasised that the primary objections of the Court was to make the least restrictive intervention possible in the life of the person, having regard to the degree of the person's incapacity, and to enable or encourage the person to exercise and develop such capacity as he or she has to the greatest extent possible. The statute presumes that the welfare of a person who is subject to Part 1 of the Act is best served if intervention is directed towards these objectives.

[45] Miller J went on to explore what the "welfare principle" means. At paragraph [63] he said:

> … As the cases illustrate clearly, the welfare principle is capable to being viewed from a range of perspectives. It is susceptible to prevailing social norms and the personal values of the decision maker. It is not an objective test and its workability depends on informed fact finding and the wise exercise of discretion. This point is equally true of decisions made under s 10 of the Act because intervention is directed to securing the welfare of the person in respect of whom the decision is made. The principle objectives also are quite plainly envisaged that there may be "secondary" objectives which are unspecified. Nonetheless from the point of view of the person in respect of whom the decision is being made, the principle objectives are a surer guide to the exercise of the decision maker's discretion than is a general appeal to the welfare principles.

[46] The relevant parts of s 10 are:

10 Kinds of order

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7 *X v Y,* ibid at [61].

(1) On an application for the exercise of a court's jurisdiction under this Part in respect of any person, the court may make any 1 or more of the following orders:

…

(f) an order that the person be provided with medical advice or treatment of a kind specified in the order:

…

(2) No person (other than the person in respect of whom the application is made) shall be bound by a personal order unless that person is a party to the proceedings in which the order is made.

…

(3) In any order made under any of paragraphs (a) to (i) of subsection (1), the court may specify a date by which the order is to be reviewed by the court; and, if it does so, the court shall also specify in the order the person or persons who is or are to be responsible for applying to the court for a review of the order before the specified date.

(4) Where a court makes any personal order, it may also make such other orders and give such directions as may be necessary or expedient to give effect, or better effect, to the personal order.

[47] Therefore, when considering an application for a personal order for the provision of medical treatment, in this particular case, termination of pregnancy, the Court must be guided by the primary objectives of the Act, that is to make the least restrictive intervention in the person's life and to encourage the person to develop such capacity as he or she has to the greatest extent possible. Guided by Miller J in *X v Y* above, I accept the submission that it is a secondary objective of the Act to determine the welfare of the subject person in respect to the decision that is to be made.

[48] Ms Reuvecamp submits that in the absence of a clear framework for determining Ms [LO]'s welfare and best interests, I should be guided by the "best interests" test found in s 4 of the Mental Capacity Act 2005 (UK) ("the MCA"). I note that the MCA framework has found approval in New Zealand academic literature.[8]

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8 Emily Jackson from (*Doctor Knows Best To Dignity: Placing Adults Who Lack Capacity At The Centre Of Decisions About Their Mental Treatment*, (2018) 81 MLR, 247. Alison Douglass (*Best Interests – A Standard For Decision Making* in Reuvecamp and Dawson, Mental Capacity Law in New Zealand.

[49] I accept Ms Reuvecamp's submission that the following considerations are relevant:

(a) Whether the person is likely to gain capacity in respect to the decision, and if so when that is likely to be.

(b) How the Court can enable and encourage the person to participate as fully as possible in the decision affecting her.

(c) The Court should consider:

- The person's past and present wishes and feelings – in particular any relevant (written) statement made by them when they had capacity.

- The beliefs and values that would likely influence their decision if they had capacity.

- Other factors they would likely consider if they were able to do so.

(d) The Court should take account of the views of:

- Anyone the person says should be consulted;

- Anyone caring for the person or interested in their welfare.

- Any welfare guardian or EPOA.

[50] It has been held in the United Kingdom that the Court must consider these matters from the person's subjective point of view and that it is not an objective question. The observations of Lady Hale in the Supreme Court are helpful.[9]

> [45] 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

[9] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591.

> what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his wishes were in the past, they might well have changed in light of the stresses and strains of the current predicament …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.

[51] I accept the submission that where a person's views can be ascertained with reasonable certainty, they should be afforded great respect, although they are not automatically determinative. The person's views will be an important guide in determining what is in the person's welfare and best interests, and therefore the application.

[52] I gave directions at the outset to ensure that Mr [DB]'s views would be ascertained and taken into account. Mr Yeoman was appointed to assist the Court for that purpose. I am grateful to Mr Yeoman for the care that he took in ensuring that Mr [DB]'s views were heard and placed before the Court.

[53] Mr [DB]'s views must be heard and afforded respect. He is Ms [LO]'s partner and she has said that he is the father. Ms [LO] has sought his support following her admission to hospital although he is in custody on remand in [Prison]. They have spoken several times on the telephone. I accept that Mr [DB]'s wishes and rights are a consideration, but they are secondary to the welfare of the mother.

[54] I have also sought information as to the views of key people in Ms [LO]'s whānau, particularly her mother. I am confident that the information provided from several sources regarding Ms [LO]'s mother's views is sufficient for this hearing.

The hearing

[55] I will now address the evidence given at the hearing as it applies to the issues and record my findings.

Assessment of mental capacity

[56] The application was filed to seek the Court's consent for a termination of pregnancy given the evidence that Ms [LO] had sought a termination of pregnancy in May and was now not capable of giving consent.

[57] At the hearing evidence was given by Dr [CP] and Dr [EL] as to Ms [LO] capacity. I have considered the doctor's evidence, specifically in respect of the four factors that are particularly relevant in determining capacity: ability to communicate choice; understanding of relevant information; appreciation of the situation and its consequences; and ability to evaluate information and follow a logical sequence of thought in order to reach a decision.

[58] Dr [CP]'s assessment is based on his six meetings with Ms [LO] since admission and his review of her daily care from the psychiatric Registrars and nursing staff.

Medical Notes

[59] Dr [CP]'s reports show that Ms [LO]'s mental state and capacity was assessed daily. Dr [CP]'s assessment is that Ms [LO]'s mental state has improved since her admission, but she still presented with paranoia, impaired judgment and poor insight into her mental health. Dr [CP]'s evidence is that Ms [LO] presents with a degree of intellectual impairment or learning disability, alcohol issues, cognitive impairment and the possibility of an underlying neuro-developmental disorder. His assessment was that she does not have capacity to make the decision herself regarding the continuation or termination of the pregnancy.

[60] Dr [CP] explained that Ms [LO] has the ability to communicate her wishes and choices regarding her immediate situation, but she is impaired in evaluating complex information. He is uncertain whether the impairment is acute as a response to the trauma of assault and immediate stresses, or chronic impairment due to an underlying intellectual impairment or neuro-disabilities. His evidence is that her decision-making ability will have been compounded by her enduring alcohol and substance abuse problems.

[61] Dr [CP] said that Ms [LO]'s ability to communicate choice regarding termination is impaired. She expressed a firm wish that her family are not involved in the decision and she does not want her family to care for the child if she continues with the pregnancy. She expressed a clear wish that she does not want the pregnancy to continue if she cannot keep the child. She also expressed a wish to Dr [CP] that she wants to have a house and stay with Mr [DB].

[62] Dr [CP] said that Ms [LO]'s ambivalence regarding the decision was marked, and she had been unable to maintain a choice, or communicate a clear choice since her admission to hospital. He was not confident that she fully understood the relevant information regarding the procedure. She presented at times as confused and she was not able to follow a logical sequence to reach a decision. Her views fluctuated frequently, even in the course of an interview they fluctuated several times.

[63] Dr [CP]'s assessment is that Ms [LO] did not have the capacity to make the decision herself regarding the pregnancy because of the complexity of the decision. He confirmed that Ms [LO] has some insight to the violence she suffered, that she was homeless, and she had alcohol problems. In answer to Ms Gray, the District Inspector, the doctor confirmed that Ms [LO] aspires to improve her life and can make basic decisions but is challenged by more complex decisions.

[64] His impression is that her underlying cognitive impairment is likely to impact on her capacity to make this specific decision. He confirmed that information from Ms [LO]'s mother suggests that the cognitive difficulties may be chronic and long-lasting, but he is not certain in his specific cognitive testing. He confirmed that despite her lack of capacity, Ms [LO]'s views should be given weight.

[65] Dr [EL] provided the second opinion as to her capacity to consent to the termination of pregnancy. His assessment at the hearing was that as the complexities of questions grew, Ms [LO]'s ability to follow the logical sequence of the questioning declined. His impression is that Ms [LO] may be experiencing a more longitudinal decline in cognitive ability. He recognised that Ms [LO] had scheduled a termination of pregnancy, but intervening trauma and stress has affected her capacity. He confirmed that Ms [LO] is able to express response in a concrete discussion, but her

difficulties are apparent when the information becomes more complex. He recognised Ms [LO]'s ambivalence, which is said could be one of the symptoms of her mental health disorder.

[66] With regards to the procedure, Dr [EL]'s opinion is that Ms [LO] would need a high level of support. Dr [EL] said that Ms [LO] had demonstrated an ability to communicate choice in July to the social workers in [the first location] and Dr [DT] regarding detox treatment, but her ability had deteriorated due to intervening trauma and events. Dr [EL] said that in his assessment, Ms [LO] does not have the capacity to consent because she cannot weigh up the outcomes of the decision.

[67] Dr [DT] assessed Ms [LO] on 12 July for the purposes of admission to the social detox unit. He did not assess her capacity to make a decision regarding termination and was not able to specifically give an opinion on this issue. However, he confirmed that Ms [LO] was able to understand the treatment option regarding detox and she knew she had the option not to continue treatment, which she later exercised on 15 July 2021.

[68] I am satisfied from the medical evidence that Ms [LO] does not currently have the capacity to make the decision regarding termination of pregnancy. Addressing the four factors in *X v Y*,[10] the evidence establishes that Ms [LO] is ambivalent when communicating her choice; has limited understanding of all relevant information; and has significant difficulty in appreciating the consequences of the decision, although she understands some consequences. The major difficulty for Ms [LO] is her current inability to follow the sequence of thought and weigh up the outcomes to reach the decision.

[69] As a result of her mental health difficulties, the medical evidence establishes that Ms [LO] does not have the capacity, currently, to make a decision in respect to termination of pregnancy.

Timeframe for regaining mental capacity

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[10] Above, n 4.

[70] Dr [CP] was unable to estimate the time that it would take for Ms [LO] to regain mental capacity. Ms [LO]'s mental capacity to make the decision has been reviewed on a continuing basis. I accept Dr [CP]'s evidence that it is not possible to accurately predict when Ms [LO] is likely to regain her capacity regarding this decision. Dr [CP] said it was not expected this would occur within the next two weeks.

Participation of person

[71] The medical notes show that the hospital staff have continued to involve Ms [LO] in discussions about her current wishes and preferences regarding her pregnancy. The daily notes show that Ms [LO] has been given encouragement to express her wishes, to think about the consequences, to discuss her wishes with her partner, Mr [DB] and kaumatua.

[72] Ms [LO] has participated in the proceedings through the appointment of Ms Lewes as lawyer for the subject person. Ms Lewes has filed two reports. She met Ms [LO] on several occasions at the hospital prior to the hearing. Her reports show that Ms [LO] was unable to sustain a long conversation with Ms Lewes on this issue before becoming distressed and agitated.

[73] I was able to meet Ms [LO] briefly prior to the hearing. She expressed her view to me, concretely, that she wished to go ahead with the termination. During the course of the brief discussion, I raised with her that Mr [DB] had expressed a wish for her to continue with the pregnancy. She responded that she could only speak to Mr [DB] for a few minutes at a time and expressed fear about his future wishes, whether they were to return to his former partner. I asked her whether there was anyone else in her whanau she wanted to speak to. Her response was firm. She said she did not want her whanau to be involved and said, *"it's my body, it's my choice"*. Ms [LO] was anxious about having to wait for a decision and she expressed a wish to leave [the mental health and assessment treatment service].

Past and present wishes and feelings

[74] The evidence establishes that Ms [LO] had sought advice on her pregnancy and wish for termination. Social workers met with Ms [LO] on three separate

occasions regarding her pregnancy. On 15 July 2021 at [the first location] Social Detox Facility there was a discussion about pregnancy options available to Ms [LO], where Ms [LO] expressed a wish for a termination and the procedure. At a meeting with Ms [LO] on 19 July 2021, the social workers formed the view that Ms [LO] was requesting a termination and understood that the procedure would be under general anaesthetic in [the second location].

[75] Since Ms [LO]'s admission to hospital under the Mental Health Act on 21 July 2021 in [the second location], she has expressed inconsistent views about her pregnancy. At times she has expressed a very strong wish for a termination of the pregnancy; at other times she has expressed a wish to maintain the pregnancy.

[76] Ms Lewes submitted that Ms [LO] had expressed clear views wishing to have a termination of pregnancy when she was able to in July and prior to the deterioration in her mental health. At that time, Ms [LO] had the ability to communicate choice, and demonstrated an understanding of the consequences. For example, she was able to understand that her personal circumstances were unstable and that she would have considerable difficulty in caring for a child. She referred to being homeless, experiencing violence, and had made a choice to continue with alcohol use. At that time, she demonstrated an appreciation of the situation and its consequences. She appeared to have the ability to follow logical sequence of thought in order to reach decisions.

[77] I heard evidence from the social workers, [the first social worker and another social worker]. From their evidence, I am satisfied that on 15 July Ms [LO] had a lengthy discussion with the social workers and her emphasis was on a termination. The process was explained to her, including the procedure and the length of stay in hospital. She was able to ask advice about general anaesthetic and where it would occur. The social worker's evidence is that Ms [LO] was very aware of the issues.

[78] On 19 July, the social workers did not have concerns about her mental capacity and their view was that Ms [LO] understood what they were saying to her. They explained the two-day procedure carefully and the consequences and risks, including medical risks of the procedure. She expressed a wish to continue with the termination.

[79] Ms [LO]'s present views are ambivalent and difficult to place weight on. However, her past views were not ambivalent, they were clear. In light of the evidence of the maternity social workers, Dr [DT] and the wider information from Ms [LO]'s mother and Mr [DB], through Mr Yeoman, I am satisfied that weight should be given to Ms [LO]'s past views regarding the termination.

Views of others interested in Ms [LO]'s welfare.

[80] Since her admission to [the mental health and assessment treatment service], there have been several discussions with Ms [LO]'s mother. Ms [LO]'s mother confirmed to Dr [EL] that Ms [LO] had a termination of pregnancy when she was approximately 18. Her grandmother had died at around that time and Ms [LO] had deteriorated into mental health difficulties. She voiced some concern about a termination and the impact that might have on Ms [LO]'s mental health. She did not have a good understanding of what Ms [LO] might now wish for regarding the pregnancy. She reported that the whānau had discussed the matter and that if Ms [LO] continued with the pregnancy, her brother in Australia would be willing to raise the child. Ms [LO]'s mother expressed support for her daughter and whatever her wish was regarding the pregnancy.

[81] Ms Lewes for Ms [LO], endeavoured to speak with Ms [LO]'s mother, but was unable to. Ms [LO] mother had advised that she did not want to participate in the hearing.

[82] I was satisfied that Ms [LO]'s mother is aware of the proceedings, although she has not been served, through many discussions she has had with the health professionals.

[83] Mr Yeoman obtained Mr [DB]'s views and represented those at the hearing. Mr Yeoman made Mr [DB] aware of the nature of the documents filed by the applicant, the purpose of the application and the documents filed. He also explained in general terms the contents of the medial report of Dr [EL] and the report of Mr [AC] and Dr [MM], the gynaecologists.

[84] Mr Yeoman confirmed that Mr [DB] was well aware of the nature of the proceeding and had been in regular telephone contact with Ms [LO]. He advised Mr Yeoman that Ms [LO] told him on Sunday, 1 August, that she was adamant that she wanted the pregnancy terminated. Mr [DB] was not happy with that view but was prepared to support Ms [LO] in her choice and confirmed that he would support whatever Ms [LO] decided to do.

[85] Mr [DB]'s preference would be for Ms [LO] to continue with the pregnancy and that he would support her, but he reiterated he would abide by Ms [LO]'s wishes in relation to termination of the pregnancy. Mr [DB] did not want the Court to make any decision but preferred that decision to be his and Ms [LO]'s alone.

[86] Mr Yeoman confirmed that those were Mr [DB]'s views at the time of the hearing and that he did not wish to be served in a formal way with the proceedings.

[87] It is important to take into account Mr [DB]'s views and the views of Ms [LO]'s mother and her whānau to the limited extent available. It appears that Mr [DB] has been consistent in wanting Ms [LO] to continue with the pregnancy. The times that she has expressed a wish to continue with the pregnancy appear to correlate with times she was staying with Mr [DB] before the assault on 15 July and subsequently when she has spoken to Mr [DB] by telephone. She is susceptible to Mr [DB]'s influence and this is likely to be contributing to her ambivalence.

[88] Mr [DB]'s views are relevant because he is the person who Ms [LO] would wish is consulted. His views are to be respected and heard, but it is Ms [LO]'s welfare that is the central consideration.

[89] Ms [LO]'s mother is concerned for her daughter and wants her to be able to regain her mental health, but with regards to the pregnancy she has acknowledged that Ms [LO]'s circumstances are unsettled and her mental health such that she would likely have difficulty caring for a child. The whānau have discussed the possibility of the child being cared for by a maternal uncle, Ms [LO]'s brother, and that suggestion has been put forward. Ms [LO] has firmly rejected that outcome.

[90] It is not clear whether Ms [LO] has the mental capacity at present to weigh up the implication of pregnancy continuing and her not being able to care for the child, but the child being placed with her brother in Australia. She has rejected that possibility in concrete terms.

[91] Whilst it may be objectively reasonable to consider the pregnancy continuing and the child being placed within the wider whānau, that is not the Court's task. The Court's task is to consider Ms [LO]'s point of view. It is her wishes and feelings, her beliefs and values and the things that are important to her in respect of this decision, that should be taken into account. They are the components in making a choice which is right for her as an individual human being[11].

[92] It is important to note that Ms [LO] had a termination of pregnancy when she was younger and has a daughter who is now cared for by her mother. She has experienced both a termination and bearing a child; the child being cared for by another family member. Her mother stated that she becomes very stressed when she is unwell, that she is not able to care for her daughter and that creates a conflict between Ms [LO] and her mother. It is reasonable to infer that these experiences are contributing to the wishes that Ms [LO] is expressing now.

Least restrictive intervention.

[93] The options available to the Court include waiting until Ms [LO] has regained mental capacity to make a decision regarding the continuation or termination of pregnancy. This is unlikely to occur quickly and any termination following that would necessarily involve an induction of labour.

[94] I heard evidence from Mr [AC] and Dr [MM] regarding the procedure up to 20 weeks and the possible procedures following 20 weeks. I also heard from Dr [MM] regarding the supports that would be available to Ms [LO] for the procedures.

[95] It is not necessary for me to go into the medical information in any depth. I am satisfied that the explanations given by Mr [AC] and Dr [MM] were thorough and

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[11] Drawing on the expression of the subjective test in *Aintree University Hospital NHS Foundation Trust v James* (2013) UKSC p 67; [2014] AC 591 at 45.

respectful towards Ms [LO]'s ethical and medical needs. They noted that even if the Court's consent was granted for a procedure up to 20 weeks, the procedure would not be provided if Ms [LO] expressed objection. It would only be provided if it was medically and ethically recommended by Mr [AC] and Dr [MM].

[96] Mr [AC] confirmed that it is a medical and ethical decision at the time as to whether the procedure would be provided.

[97] I clarified with the [maternity social worker] that she had discussed risks with Ms [LO] and she was confident that Ms [LO] understood the explanation given.

[98] Both doctors advised that a procedure after 20 weeks would be extremely difficult for Ms [LO] and they had doubt that it would be possible.

[99] I am satisfied that the least restrictive intervention for Ms [LO] would be a procedure under general anaesthetic prior to 20 weeks.

[100] Given the urgency, I considered in all the circumstances that the welfare of Ms [LO] requires the Court to give consent under s 10(1)(f) to termination of the pregnancy. As Miller J said in *X v Y*[12], the intervention under s 10 of the Act is directed to secure the welfare of the person in respect of whom the decision is made. The factors drawn from s 4 of the MCA are a helpful framework to guide the inquiry of what is in this person's best interests in respect of this decision. [13]

[101] Applying the statutory objective of the least restrictive intervention in the life of this person, I find the Court should give consent for this medical procedure. I am mindful of the safeguard that the consultants would not proceed unless they were satisfied that it was clinically and ethically appropriate.

Orders and Directions

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[12] Paragraph [41] above.
[13] See paragraph [45] above.

[102] In addition to the order under s 10(1)(f) of the Act that was made on 3 August 2021, and the direction that the order not be suspended in the event of an appeal, I make the following directions:

(1) Leave is reserved to counsel to apply for any further directions arising out of this decision.

(2) Lawyer for the subject person's appointment is continued for her to meet with Ms [LO] and explain this decision to her.

(3) Mr Yeoman's brief as lawyer to assist is continued to explain the outcome to Mr [DB].

(4) I trust that Dr [CP] will arrange for Ms [LO]'s mother to be advised.

(5) Lawyer for the subject person's costs and lawyer to assist's costs are to be met from the Consolidated Fund.

[103] I record my appreciation to counsel for their assistance and submissions in this difficult and sad case for all concerned. I particularly thank Ms Reuvecamp for her legal submissions prepared under time constrains.

[104] I record my appreciation to all the doctors who gave evidence, for the quality of the medical notes that were made available, and to the maternity social workers who gave evidence. They, and all the clinicians demonstrated great respect and concern for Ms [LO]'s welfare and wellbeing.

[105] I am grateful to the District Inspector, Ms Gray for her attendance at the hearing and her helpful assistance.

M N E O'Dwyer
Family Court Judge