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Case No. 1232356

IN THE COURT OF PROTECTION

Royal Courts of Justice

Date: Tuesday, 21st May 2013

Before:

MR JUSTICE HOLMAN

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Re SB

(A patient; capacity to consent to termination)

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MR M. MYLONAS QC appeared on behalf of the applicant NHS Trust

MR M. HORNE appeared on behalf of the patient

MR S. CHAWATAMA appeared on behalf of the Second Respondent, being the patient's husband

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J U D G M E N T

MR JUSTICE HOLMAN:

1. This is the most ex tempore of judgments. I am very clear about the decision which I have reached in this case and the essential reasons for it. Nevertheless, having regard to the importance of the issues, I would, if time had permitted, have given myself the time to prepare a carefully crafted written judgment. Time does not permit, for reasons that are well-known to everyone in the court room and will soon become apparent. In the event, I am compelled to begin this judgment shortly before eight o'clock in the evening, immediately after the end of the evidence and submissions, and after I and everyone involved in this case has already had a very long day indeed in court.

2. I wish to begin by expressing my sincere thanks to the advocates and their instructing solicitors and to everyone in the court room, and that includes the

family members, the doctors, the nursing staff and escorts who have attended today, the interpreter, and indeed the journalists who have attended throughout this hearing. Everyone has approached this difficult case with the utmost professionalism and concern, and I am sincerely grateful to them all. I would particularly like to record the dignity and sensitivity with which the patient's mother gave her evidence and addressed me.

3. With those preliminaries, I now wish briefly to state certain propositions which are extremely important to this case. First, this has been a hearing in the Court of Protection in which, despite the intimate issues involved, I have sat robed and in public for every moment of the hearing, and representatives of the press and media have been able to be present throughout. There is a reporting restriction order, designed to protect absolutely the confidentiality of the identity and whereabouts of the patient, her family and all the treating staff. Subject to that, everything in this case is in, or is able to be in, the public domain. I have also asked that redacted copies of, at any rate the principal, statements and written evidence should be made available as soon as practicably possible to the representatives of the press here today and they can freely report and quote from them. So nothing at all in this case is secret apart from identity. Everything else is public and open.

4. Second, the central issue in this case relates to termination of a pregnancy in the twenty-third week of its term. I am well aware that there is currently considerable public debate, not only around the appropriateness of elective or semi-elective abortions at all, but particularly around the provision in section 1(1)(a) of the Abortion Act 1967 which, in the circumstances there described, permits abortion if the pregnancy has not exceeded its twenty-fourth week. It is important to stress that the present case clearly falls to be considered and resolved within the framework of the law as it is, and not any alternative law that some people argue or campaign for.

5. Third, this case has nothing whatsoever to do with a quite separate issue that sometimes arises in the Court of Protection, of termination of a pregnancy without the actual consent of the mother concerned. The entire reason why these proceedings have been issued and why we are here today is because the mother concerned is herself very strongly indeed requesting a termination and giving her consent to it. The issue relates to her capacity. But if a termination does take place, it will only take place because she personally has strongly requested it and consents to it right up to the moment when the procedure begins.

6. Fourth, there is no question in this case, or indeed in any case, of a court, by order, requiring any doctor to perform an abortion or termination. An abortion will only happen in this case if, as section 1 of the Abortion Act 1967 requires, two registered medical practitioners are of the opinion, formed in good faith, that the pregnancy has not exceeded its twenty-fourth week and that the

continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman. Further, it will only happen if a doctor or doctors, in the exercise of their own professional judgment, voluntarily decide to perform the abortion that the mother is so strongly requesting them to do.

7. Fifth, the protection which the law affords to the foetus is the protection of the Abortion Act 1967 and other legislation, such as sections 58 and 59 of the Offences Against The Person Act 1861. But, subject to that, the foetus has no independent rights which fall to be weighed or considered by me at all in these proceedings. Some people may consider that the law should be otherwise. But the law is currently as I have just stated it, and that is the law which I must apply.

8. Sixth, the father of the expected child, who is present and represented, has a full right to participate in these proceedings and to express views about the various issues that arise. But he has no independent right, as father, to prevent the abortion if the mother does have capacity and remains determined to have it and the doctors remain willing and lawfully able to perform it.

9. Seventh, the first issue that arises in these proceedings relates to the capacity of the mother to make a decision to request, and then to give her consent to, the proposed abortion. Section 1(2) of the Mental Capacity Act 2005 is very clear and provides as follows: "A person must be assumed to have capacity unless it is established that he lacks capacity." Accordingly, unless it is established, on a balance of probability, that the mother does not have capacity to make the decision that she undoubtedly has made, her autonomy as an adult to request and consent to the proposed abortion procedure is preserved.

10. Eighth, that autonomy includes the autonomy to make a decision which may be unwise or with which others, including but not limited to her husband, her mother, her treating doctors or indeed I myself, might disagree. Section 1(4) of the Mental Capacity Act 2005 very clearly provides that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision."

11. Ninth, if, but only if, the patient lacks the required capacity, then the court not only may, but must, decide what is in the patient's overall best interests, taking account of both the short and long term and all relevant factors and circumstances. However, any consideration of the best interests of the patient, and indeed any power or right of the court to trespass into consideration of her best interests, only arises if it has first been determined that she herself lacks capacity in relation to the decision and subject matter in point.

12. Tenth, and finally, I wish to stress that this case could not be more fact

specific. I endeavour to resolve it by a correct application of the law as enacted in the Mental Capacity Act 2005, but I wish to make very clear that, precisely because the case is so fact specific and also because I am giving this highly ex tempore judgment already now at 8:05 pm, I certainly do not seek or intend to create any precedent or to indicate any general proposition of the law or construction of the Mental Capacity Act 2005.

13. The essential factual background can be fairly shortly stated, for the headline facts and dates are not in dispute.

14. These proceedings concern a lady who is now aged 37. She is one of the three children of her mother, who has been present in court throughout the hearing and is present now, and her father, to whom her mother has been married for many years. The patient is clearly a lady of considerable intelligence. She is well educated, including having a degree, and she has worked at a relatively high level in demanding work in the field of Information Technology. It is of peripheral relevance that her mother is English and her father is Libyan. It is through her father that she herself is Muslim. She has travelled much during her adult life, and indeed her own mother has tended to live part of the year in England and part of the year in Italy, where her mother has a home and where the mother's other two children live.

15. It is a fact that, now several times in the past 8 years or so, the patient has presented with symptoms which have been diagnosed as those of bi-polar disorder. She has been detained under compulsory or similar powers at various times in Italy, in France and here in England. She herself denies illness, but there is very clear psychiatric evidence in this case that it is often a feature of her type of illness that patients do deny it. I wish to make crystal clear that I accept unreservedly, on the evidence that I have read and the relatively short oral evidence that I have heard, that this lady has suffered bi-polar disorder now for at least 8 years and continues to do so. At times that disorder has been controlled by medication. At times it has not, and she has suffered both remissions and relapses.

16. About two years ago, whilst in Italy, the patient met the gentleman who is now her husband. He is Egyptian and also of the Muslim faith. It is clear that a relationship did develop between them. It is clear that even before they married there was a sexual element to that relationship, for during 2011 the patient became pregnant. Some of her evidence today hinted at a doubt as to the paternity of that conceived child; but she certainly has not suggested that the man whom she later married could not have been the father.

17. At that time, she was taking prescribed drugs for her mental state. She underwent a termination of pregnancy in Italy at about 19 weeks' term. The method, she says, was labour induced by medication. She says that she had the

termination at least in part because she was concerned about the effect on the foetus of the high level of medication that she had been taking. She gave some further evidence earlier today around the circumstances of that termination, but it does not seem to me very material to what I have to decide. It is not in doubt that she did, in January 2012, have that termination. She was asked very clearly today, in part by myself, whether she now regrets it. She was very clear indeed that she does not regret the fact of that termination, although she regrets that she became pregnant at that time. She says that she feels that it was for the best that she had the termination. She rejected a suggestion that it was contrary to the Muslim faith to have had the termination in the circumstances in which she did so.

18. Time moved on. They actually married in April 2012. In May 2012 she returned to live here in England. The gentleman, now her husband, followed in July 2012. They began to live together in rented accommodation. She was working in the IT field. He was working as a washer of cars.

19. She became pregnant again during December 2012. It is her own evidence today that she herself positively wanted to become pregnant and wanted to have a baby. She has said, today, that her husband did not particularly want to have a baby. He, she says, was indifferent to her being pregnant. The husband has made, to my mind, a wise, appropriate and caring decision not to give oral evidence at this hearing and, indeed, to instruct his most able counsel, Mr Sydney Chawatama, not to cross examine his wife, the patient. His version of events is rather different, but at all events, the important point at this stage of the narrative is the patient's own evidence that she herself did want a baby at the time that she conceived last December.

20. There is evidence, which I completely accept, that for the first stage of this pregnancy she acted in the caring and conscientious way of any mother who is expecting a wanted baby. She meticulously attended scans and other antenatal appointments. It is the evidence of her husband and of her mother and from other sources, all of which I accept, that until about the month of April 2013, that is, about 5 - 6 weeks ago, the patient showed every sign of wanting to keep this baby and of desiring to be a loving and caring mother to the baby.

21. Perhaps out of that very desire, it seems that the patient ceased taking her previously prescribed medication. At all events and for whatever reason, there were many changes during the month of April 2013. Her mother and husband observed and reported various signs that appeared to them to indicate that she was again becoming unwell. She herself has frankly said that there came a time when she brandished a knife in the direction of her husband; albeit that she says that he first brandished one at her. She has also said that there was an occasion when she put her hands around his throat as if to strangle him. There was also undoubtedly a total reversal in her attitude towards the baby that she was, and is

carrying. On 17 April 2013 she voluntarily and on her own initiative attended a clinic in a town not far from where she lives, where she sought an abortion. The clinic agreed that she should have one. For reasons which are a little unclear, but do not seem to be in issue or doubt, they arranged an appointment for the abortion actually to take place a few days later at another town which is several hundred miles away from where she lives. She says that the only reason why she did not keep that appointment was that it was simply too far for her to travel and that she (being no longer working) did not have sufficient funds with which to do so. She investigated alternative places where an abortion might be performed, and another appointment was made for a clinic rather nearer to her home, although still some distance away.

22. She says that the reason why she did not keep that second appointment was that she ascertained that the method of termination that would be used there was surgical evacuation of the foetus, and she would have much preferred induced labour by medication as she had had on the previous occasion in Italy. So she says, and this does not seem to be gainsaid, that it was for that reason that she did not keep that particular appointment. She has said that she was so determined at that stage to have a termination that she then ordered online forms of medication designed, or believed by her, to procure a miscarriage. She was, however, detained before it arrived.

23. The patient is adamant that throughout the period from about the middle of April to date she has been determined to achieve an abortion if she can. However, events then took a significant turn, for at the beginning of May 2013, that is, just under three weeks ago, she was compulsorily detained under section 2 of the Mental Health Act 1983. She remains compulsorily detained. Despite that, she has maintained her wish to have an abortion and has made contact with, and indeed had a consultation with, a doctor employed by a well known body, who is present in court. As I understand it, the doctor has fully explained to her the proposed procedure, and any physical and other risks to her, and has satisfied himself that she understands them. Further, I understand, although it will remain entirely a matter for him and a colleague, that that doctor is currently minded to certify as required by the provisions of section 1(1)(a) of the Abortion Act 1967.

Because the duration of her pregnancy is already approaching the 24th week, and because of the interposition of other factors, including a bank holiday weekend and the non-availability of the doctor who is proposed to perform the abortion, it is currently proposed to start the two day procedure tomorrow, Wednesday 22 May 2013. It may be that because everybody will have been delayed here in London (far away from where the patient lives and is detained) so late tonight, the procedure may not be able to commence tomorrow, but only on Thursday. But at all events, it is for that reason that time is so pressing and, as I have described, we have been constrained to sit so late and I have been constrained now to give this judgment so late today.

24. The hospital where the patient is detained have of course been well aware for an appreciable period of time now of her desire for a termination, and indeed they must have facilitated the assessment of her by the doctor that took place last week. The hospital believe, as I will more fully describe, that she lacks capacity to make her own decision to have a termination. They do not necessarily say that she should not have a termination, but they do say that as she, in their view, lacks capacity to make the decision, the decision must be made by the Court of Protection, applying the test of best interests as fully elaborated in section 4 of the Mental Capacity Act 2005.

25. So it was that last week, on 15 May 2013, the hospital issued the present proceedings in the Court of Protection in which they seek "a determination by the court and the associated declarations under s.16 MCA 2005, as to: (1) whether [the patient] lacks capacity to make decisions about the desired termination of her pregnancy; (2) if she lacks capacity, whether it is in [the patient's] best interests to undergo an abortion procedure."

26. There was a first hearing for directions last week in front of Mr Justice Bodey at which arrangements were made for this hearing to take place this week.

27. Rule 141 of the Court of Protection Rules 2007 provides that "Subject to rule 147, P (if a party to proceedings) must have a litigation friend." It was pursuant to that rule that last week the Official Solicitor was invited to act as litigation friend of this lady, who undoubtedly falls within the definition of P where it appears in rule 6; for P means "any person…who lacks or, so far as consistent with the context, is alleged to lack capacity to make a decision or decisions in relation to any matter which is the subject of an application to the court."

28. However, the patient herself had already herself approached a local firm of solicitors in anticipation of the hospital launching the proceedings which in due course they did launch. So she already had her own solicitor and already had her own public funding certificate. That solicitor was subsequently retained by the Official Solicitor to conduct the case on behalf of the Official Solicitor. The Official Solicitor then appropriately obtained an urgent, but comprehensive, report upon the patient, by an independently instructed consultant psychiatrist, Dr Shubulade Smith, who is a consultant psychiatrist at the Maudsley Hospital here in London and practises also from a clinic in Chelsea. Dr Smith's report became available around lunchtime yesterday, the first day of this hearing. One of the questions that Dr Smith had been asked to address was whether the patient has capacity to litigate these proceedings. She clearly answered yes, and gave reasons why. This led to discussion about continued involvement of the Official Solicitor. Rule 147 makes provision "where P ceases to be a person who lacks capacity to conduct proceedings himself but continues to lack capacity in relation

to the matter or matters to which the application relates." On the basis of the report of Dr Smith, that is the situation in this case.

29. I asked Mr Michael Horne, who at that stage was receiving his instructions from the Official Solicitor, whether the actual solicitor considered that the patient has capacity directly to instruct him. The answer was yes. I gave further consideration yesterday afternoon, in light of that report of Dr Smith, to whether it might indeed be possible for the patient herself to attend the remainder of this hearing. I had already read that she strongly desired to do so. As a result, and cutting a longer story short, she has indeed attended today. I express my sincere appreciation to her treating psychiatrist and his team for enabling her to do so. I am deeply conscious that they had some hours of travel to be here, and some hours of travel still lie ahead. So it was that she has attended throughout the day, and my assessment of this case has been enormously illuminated by her attendance and by the considerable oral evidence which she has given.

30. Applications were made by the Official Solicitor, who was personally present, and also by Mr Horne on behalf of the patient, that the appointment of the Official Solicitor as litigation friend should be brought to an end, and I granted that application. I had and have no doubt whatsoever that this lady has ample capacity and autonomy directly to instruct her own lawyers to effectively protect and pursue her own position and interests in the case.

31. I will now refer to the relevant provisions of the Mental Capacity Act 2005.

Section 1 provides as follows:

"1 (1) ....

(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) ….

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

……"

Section 2 provides as follows:

"2(1) For the purposes of this Act, 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 a disturbance in the functioning of, the mind or brain.

(2) It does not matter whether the impairment or disturbance is permanent

or temporary.

(3) ….

(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

……"

Section 3 provides as follows:

"3 (1) For the purposes of section 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) ….
(c) to use or weigh that information as part of the process of making the decision, or
(d) …..

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of –

(a) deciding one way or another, or
(b) failing to make the decision."

32. The decision and matter in point is as to the termination of this pregnancy. It is the very clear evidence of the treating consultant psychiatrist, Dr T, that in his opinion this lady lacks the capacity to make that decision about that matter. Indeed he said during the course of his oral evidence "I am 100% clear that she does not have capacity to take the decision." He said that the reason why she lacks capacity is because she has certain current persecutory or paranoid beliefs as a result of the bi-polar illness which he diagnoses in her. The overall position of the hospital and the applicant NHS trust is perfectly and aptly summarised by their leading counsel, Mr Michael Mylonas QC, as that "she is not thinking straight."

33. The professional opinion of the treating psychiatrist, Dr T, is also reflected and equally strongly stated by the independently instructed psychiatrist, Dr Smith, for although Dr Smith considers that the patient has litigation capacity, she also considers that she does not have the capacity to make the decision whether or not to undergo a termination of pregnancy. Her opinion is very fully elaborated in a section on internal pages 22 – 26 of her report dated 20 May 2013, which are too long to read out but which are already available in

redacted form to the Press and to anyone with a proper interest in this case to read.

34. Dr Smith said in the course of her oral evidence that the basis of the patient's decision is based upon flawed evidence and paranoid beliefs. Dr Smith is absolutely clear, and it cannot be in doubt, that the patient perfectly understands what is involved in the termination. She perfectly understands the procedure and what would be involved. She has previously undergone a termination, albeit that was induced by medication whereas the presently proposed termination would now be surgical. She perfectly understands the finality of the event. She perfectly understands any risks to her from undergoing a termination, which have been fully explained to her by the doctor whom I have mentioned. The reason why the psychiatrists and indeed the patient's mother and husband consider that she is "not thinking straight" is because there has been this apparent marked change of attitude between her apparent pleasure at being pregnant in the early stages of the pregnancy, and her more recent desire to seek termination since April 2013. They all note an association between that change in position and the patient ceasing to take her medication and displaying a relapse in her illness, coupled with what are said to be paranoid ideas about her husband and mother in the last six or eight weeks. Thus Dr Smith said "there is a strong temporal relationship between the patient stopping medication, developing paranoid ideas about her husband or mother and deciding to opt for a termination of her pregnancy."

35. It is undoubtedly the case that in numerous accounts to psychiatrists and others, including her solicitor, and indeed in her oral evidence to me here in the court room today, the patient has described and emphasised her perception that her husband has not been supportive of her and would not be supportive of her as a parent; and her perception also that her mother, and indeed also her father, do not and will not support her. Her husband and her mother strongly assert otherwise, and it is the observation of the treating psychiatrists that the husband in particular has appeared to be an attentive and caring husband. So they say that her often expressed view and beliefs that her husband is no longer supportive of her display paranoia. Dr T, the treating psychiatrist, stated "her beliefs regarding her husband, her mother and social services have been informed by paranoid beliefs." The evidence of Dr Smith is to similar effect. So it is said that the patient is only making this decision to seek a termination because of skewed thought processes and paranoid beliefs as a result of her illness; and from that, it is said, it therefore follows that she lacks capacity to make this important decision.

36. In most cases that come before the Court of Protection, at any rate in my experience, the assessment of capacity by one or more psychiatrists is regarded as determinative. But those are generally cases in which the patient himself or herself is not positively and strongly asserting, and actually giving evidence, that

he or she has the required capacity. In the present case, as I now reveal, I have reached a different overall conclusion as to capacity from that of the psychiatrists, Dr T and Dr Smith, and indeed the husband and the mother.

37. I wish to make crystal clear that I do not in any way whatsoever question or reject the evidence of either Dr T or Dr Smith insofar as it is evidence within their professional domain. I unreservedly accept that the patient is currently mentally unwell, and I accept their diagnoses. I unreservedly accept, therefore, that she does currently suffer "an impairment of, or a disturbance in the functioning of, the mind or brain." That, however, is the beginning not the end of the enquiry; for the relevant test and requirement under section 2 of the Mental Capacity Act 2005, as I have already quoted, is that because of such an impairment or disturbance the person "at the material time … is unable to make a decision for himself."

38. Once the issue is before a court, the overall assessment of capacity is a matter for the judgment of the court. Where I very respectfully differ from, and disagree with, the engaged psychiatrists is as to, what I might call, the level of the bar as to capacity. The relevant question under section 2 is whether she is "unable" to make a decision. There is absolutely no doubt whatsoever that this lady has, many weeks ago, made a decision. She persists in it, and she very, very strongly urges it upon me today. So there is no doubt that she has a capacity to "make" a decision and she has made one.

39. However, section 2 of course has to be read by application of section 3(1). What is said in the present case is that, because of her illness, the patient is unable to "understand the information relevant to [her] decision", namely the information which the psychiatrists, it is said, keep urging upon her, that contrary to her beliefs, her husband is caring and supportive and would be a caring and supportive husband and father after a live birth. They make a similar point in relation to the patient's mother. They say that, because of her illness, she is unable to "use or weigh" that information in relation to her husband and her mother as part of the process of making the decision. They say, further, that she is not processing information "about the reasonably foreseeable consequences" of a decision to terminate, as section 3 (4) requires. In particular, the psychiatrists, and more especially the husband and the mother, express their great concern that when she, as she will, recovers from her present relapse, she will bitterly regret a termination. In that regard, it is important to emphasise her evidence, which I accept, that she has not experienced a sense of regret about her previous termination. She was very clear that she regrets that she became pregnant that time, but not the termination.

40. The other parties say that everything is different now. First, she is now married to her husband; and second, she demonstrated by her actions in the early stage of pregnancy, her desire and commitment to carry the baby as a healthy

baby. Of course, assessment of whether her expressed views about her husband, in particular, are indeed delusional and paranoid, would require greater evidence and some detailed analysis as to the true state of their relationship. She has said today, at some length, that she found that her husband became increasingly colder in the relationship. She has said that she would sometimes wait days to have 15 minutes of his time, to have a discussion or any real communication. She has said, brutal as it sounds, that she no longer loves him and indeed never really loved him. As far as she is concerned, there is no future in the relationship. The husband has a very, very different view of that; but clearly I might have been here for a very considerable period of time if I were to try and unravel, as if this were a divorce hearing, the true state of their relationship.

41. What weighs most significantly with me is that, even if the patient has some skewed thoughts and paranoid or delusional views with regard to her husband and his attitude towards her and his behaviour, she gives many other reasons for desiring a termination. It is something of a paradox in this case that Dr T said in his oral evidence "I am quite clear that she is not making a rational decision. She did not show evidence to me that she was weighing what was going on – if she had said simply that I do not want this baby, I would have considered it more capacitous." His view derives from examination of the rationality of the reasons she has actually given. It appears that if she had simply said, very subjectively and emotionally, that she did not want the baby, then he would have accepted that she had capacity to make that decision.

42. During the course of her evidence today the patient has identified a considerable number of discrete reasons for her desire for a termination. They certainly include that she perceives that she receives no support from her family and that they will not function as a family. She says that she does not see a future in the relationship with her husband; it is not stable nor productive; he does not have the same ambitions as she has, or for a child. Let us assume that all of those reasons are influenced by delusion or paranoia. She gives many other reasons for her desire for a termination. She refers again and again to her current position that she is a compulsorily detained patient to which she objects. It is perfectly true, as Mr Chawatama emphasised in his eloquent submissions, that many detained patients who become pregnant choose to carry their babies to term. The view of this particular patient is that "in the situation that I am in, the idea of me having a baby is crazy." That situation includes the fact that she is currently compulsorily detained. She says "I am extremely unhappy where I am. Imagine being unhappy and being pregnant." That seems to me to be a perfectly understandable position for a detained patient to take, even though it is not one that all detained patients would take. She referred to the fact that staff at the hospital have frequently said to her "why not give it up for adoption?" Her reaction is "why should I have a child just to give it up?" She said she is very worried about her ability to bring up a child. Since it is so strongly said that she has for 8 years suffered from a lifelong, relapsing bi-polar disorder, it is entirely

rational that she has that worry.

43. She has said, not only today, but on a number of other recent occasions, that she feels suicidal at the prospect of having to carry this child to term. She says that if there is no termination she will seek to kill herself or the baby. It may be that those suicidal thoughts are in some way bound up with her illness. But if, indeed, she does feel them (and I have no reason to suppose that she expresses them simply to threaten or blackmail me or others) then it seems to me to be entirely rational for her to consider and decide that it is preferable for her to seek and undergo a termination before being driven to attempting suicide.

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