



Neutral Citation Number: [2021] EWCOP 17

Case No: COP1371563T

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/03/2021

Before :

THE HON. MR JUSTICE COHEN

Between :

X NHS FOUNDATION TRUST [1]

Applicant

Y NHS FOUNDATION TRUST [2]

- and -

MS A

Respondent

(by her litigation friend, the Official Solicitor)

Ms E Sutton (instructed by **DAC Beachcroft LLP**) for the **Applicant Trusts**

Mr M Horne QC (instructed by **Official Solicitor**) for the **Respondent**

Hearing dates: 26 February 2021

Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....
THE HON. MR JUSTICE COHEN

This judgment was delivered in public. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family and the identity of the treating Doctors and Trusts must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

The Hon. Mr Justice Cohen:

1. This application relates to Ms A, a woman in her 30s, who is 38 weeks pregnant, and who suffers from paranoid schizophrenia. The application dated 15 February 2021 relates to serious medical treatment in the form of obstetric care. The first applicant, X NHS Foundation Trust is responsible for providing Ms A's obstetric care, and the second applicant, Y NHS Foundation Trust, is responsible for providing Ms A's mental health care. The applicants are represented by Miss Sutton.
2. Ms A is the respondent to this application and proceeds by her litigation friend, the Official Solicitor, who is represented by Mr Horne QC. Ms A's diagnosis was made some 15 years ago, and is a recurring condition, and the severity of its symptoms are variable and can, to a greater or lesser extent, be controlled by medication. It is not necessary for me to go into the distant chronology in any detail.
3. Ms A's diagnosis of paranoid schizophrenia is a mental disorder under section 2 of the Mental Capacity Act 2005 ("MCA"). Ms A has been in hospital on at least 5 occasions in 2007, 2011, on two occasions in 2015 and now. The admissions in 2007 and 2011 were respectively after the birth of her two children. It is not clear to me from the records, but it may be that they occurred after she ceased taking medication. There have been other referrals to mental health services not requiring hospitalisation.
4. In September 2019, Ms A stopped taking medication as she was well and wanted to try for another child. Various concerns about her mental health and functioning were raised in 2020, particularly in the last few months of the year. In early 2021, at her appointment with Dr B, her consultant obstetrician, she formed the view that Ms A lacked capacity with regard to her mental health care and treatment as she was demonstrating no insight into her previous illness. Ms A stated then, as now, that she was hoping for a normal vaginal birth at home.
5. I shall turn now to the chronology over the last month. On 18 January 2021 Ms A separately contacted the community and specialist midwife stating that she had been in a car accident a few days previously and was suffering from various symptoms. She was advised to attend the maternity triage at once, but declined, saying that she had an obstetric appointment the next day. On 19 January 2021, she did not attend her appointment or scan and declined to make contact with maternity health services. On the following day, Dr A, her consultant psychiatrist, rang Ms A, but Ms A politely said she was not going to see or speak to mental health services again and ended the call.
6. On 21 January 2021, in the very early hours of the morning, Ms A contacted an emergency duty team about one of her children. Her behaviour was inappropriate and she didn't seem concerned about the time of her call. On the same day, 21 January 2021, Ms A did not attend a scan that morning, and social services were informed. They went to carry out a welfare check, but Ms A refused to allow them access to the house. The following day, on 22 January 2021, it was decided that a Mental Health Act 1983 ("MHA") assessment should be undertaken at Ms A's home, a warrant was needed, and an assessment was made. It was concluded that Ms A was experiencing a relapse of her paranoid schizophrenia characterised by paranoid thinking, formal thought disorder, and a lack of insight. She was detained under section 2 MHA for a period of assessment.

7. On 26 January 2021, Ms A saw Dr A and Dr B. Both clinicians concluded that Ms A lacked capacity to make a decision regarding her mental health and obstetric care and it was apparent to them that she was suffering the severe relapse to which I have referred. She declined any treatment for her mental health, and said that she wanted to go home and have her baby at home. On 30 January 2021 she was given her first depot injection. On 7 February 2021 she had her second depot injection. Two days later, on 9 February 2021, there was still no improvement in her presentation.
8. On 10 February 2021, when Ms A's detention under section 2 was subject to the review of the First Tier Tribunal to which she was entitled, the detention was upheld. She stated very clearly that she would not take medication or engage with mental health services if she had a choice and that she wanted to have her baby at home. She denied any history of mental illness. On 11 February 2021, Ms A was detained for treatment under section 3 MHA. It was noted by then that there had been a slight improvement since she had started treatment. I will return later to matters relating to her mental health, but it is appropriate at this stage to refer to her pregnancy.
9. On 11 February 2021, Ms A had a scan which showed the baby was growing normally but the fetus was in the breech position meaning that the bottom was presenting with the legs and head pointing up the birth canal and the fetus appeared to be engaged in the pelvis. This meant that unless corrected that the risks in a vaginal delivery were significantly greater, and potentially fatal. Dr B and Ms A discussed the external cephalic version ("ECV") procedure, where the obstetrician would attempt to turn the baby by spinning the fetus in the uterus. The chances of that being successful are greatly enhanced if an injection is given which relaxes the uterus. This was to be attempted a week later on 18 February 2021, but when Dr B met with Ms A on that day and Dr B explained the very small risks attached to the process, Ms A became very anxious and distressed and declined the procedure. She was not able to weigh up the small chance of complications of the ECV and the benefits if successful when compared with the potential risks attached to a vaginal breech birth.
10. On 24 February 2021 the midwife reported to Dr B that Ms A would now like to undergo the ECV. Dr B had an appointment with Ms A the following day, on 25 February 2021. That is only yesterday. At this appointment, it was apparent to Dr B that Ms A had either misunderstood or misremembered what Dr A had told her regarding the options in relation to the delivery, and that a planned caesarean section, which is what she strongly advised, was a far safer process than an emergency caesarean section which is what might well be required in the event of a vaginal breech birth. Ms A declined to have an injection for the ECV. Dr B did her best but she could not shift the fetus' position. It is now too late to have any realistic chance of successfully carrying out an ECV as the baby continues to grow. Accordingly there are now only two options: a vaginal breech birth or planned caesarean section.
11. Also on 24 February 2021, Ms A was seen by the Official Solicitors' agent. The Official Solicitor has been appointed to act as Ms A's litigation friend, and I am grateful to her for taking on this role. I have a long and extremely helpful attendance note of the visit to Ms A that day. It was carried out just a day before the appointment with Dr B to which I have referred. She was asked by the Official Solicitor's agent what Ms A would do if she had the ECV procedure and the baby doesn't turn. She said "I'm trying to avoid thinking about it and answering". She said her last 2 pregnancies went to full term and she had vaginal births for both. She said "What I

am saying is that it should be about how it can be prevented from going down that route. No one is listening to what I am saying and trying to prevent me from needing a caesarean. I'm really trying not to get to that point but no one else is".

12. Later when, pressed about the caesarean section, she said she would not be happy and doesn't want to have it under any circumstances. When asked what she would say if there were signs of distress during labour from the baby, and the medical team said that they needed to move to an emergency caesarean section, Ms A said she didn't like thinking of the worst scenario, and didn't like to say anything about that. Her position was summarised helpfully in the Official Solicitor's agent's note in these terms:
 - i) You don't agree that you are unwell;
 - ii) You think you do have capacity to decide yourself how to give birth;
 - iii) It is important to have a vaginal birth;
 - iv) You don't feel like you have been listened to;
 - v) You don't feel like everything has been done to exhaust the option of a vaginal birth;
 - vi) You think that, for you, the cons of a C-section outweigh the pros.
13. Dr A saw Ms A this morning and she feels, as Dr B does, that Ms A is unable to make a decision for herself. It is not that she is unable to understand the information, but that she is unable to retain that information and is unable to use or weigh the information as part of the process of making the decision. Those factors are set out at section 3(1)(a)-(c) of the MCA. I am in no doubt that section 3(1)(d) does not apply, as Ms A is well able to communicate her views.
14. The doctors advise that there will be little improvement in Ms A's presentation between now and next Thursday which is the optimal time for the caesarean section, and she is unable to have another depot injection between now and that date. She refuses to take oral medication, but even if she did, it would not make a difference between now and the proposed caesarean section date. The doctors will of course keep Ms A's capacity under review, despite there not being any anticipated significant change.
15. There is no doubt that Ms A's functioning has improved since her admission, but she is still unable to weigh the risks of what she wants, namely a vaginal birth at home. There is no doubt that a birth at home would be very risky, and in any event, she would not be allowed to return home as she is detained under section 3 MHA. The only issue therefore, is whether there should be a vaginal breach birth or a planned caesarean section in hospital.
16. Ms A's reasons for her opposition to a caesarean section and preferring a vaginal breech birth are set out in the evidence of the Official Solicitor from the meeting with the Official Solicitor's agent. I can summarise them rather than read them all out, and basically they relate to the discomfort that she would feel, or anticipates she would

feel, as a result of the caesarean section. The benefits she mentions are simply that she perceives it as being, in a way, the “easy option”. It’s quicker and depending on the circumstances, the baby might be safer.

17. What Ms A cannot properly appreciate are the risks that her preferred course exposes the fetus to. The chances of requiring an emergency caesarean section with a breech baby are at 40%, which I am told is the statistic provided by the Royal College of Obstetrics and Gynaecologists. That is a very high risk. Also, emergency caesarean sections are very stressful. By their nature they are rushed, unplanned and risky to both mother and child. No one should question how frightening and distressing an emergency caesarean section would be, and it is to be avoided if at all possible.
18. There is no doubt that in her more rational moments, Ms A wants the best for her child. It is why she came off medication in 2019. At a different point of her interview with the Official Solicitor’s agent she says that “I would just like us to be healthy and well and return home safely”. She stated that the single most important thing to her is “for me and baby to be healthy, well and safe”. And indeed, it was in this sense, her being able to put the fetus first, that she presented until her relapse at the end of 2020. I am in no doubt that if she regained capacity, that it would be her wish to have a safe delivery of her child.
19. In all the circumstances, I am in no doubt that (a) she does not have capacity to conduct these proceedings and make decisions regarding her obstetric care and treatment and (b) that she is not able to retain and weigh up the information, including the risk that the course of action that she wishes presents both to herself and the fetus, and also the increased risks engaged by an emergency caesarean section rather than a planned caesarean section.
20. As Dr B put it, the risks of fetal mortality for vaginal breach may be low, but the stakes are very high. Nothing could be worse for Ms A’s health than if a vaginal breech birth went wrong and if she or the fetus was harmed. Dr B was clear in her evidence that whilst she very much wanted to respect Ms A’s wish for a vaginal birth, and that she would have (ordinarily) supported a breech birth having regard to Ms A’s obstetric history, having regard to all of the circumstances of this case, she was unable to support this, and considered a planned caesarean section was in Ms A’s best interests.
21. I do not want Ms A to think that I have not given considerable thought to her expressed views. They are of great significance. As Mr Justice Hayden said in *M v N* [2015] EWCOP 9 [at paragraph 28] “...where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P’s ‘best interests’. Respecting individual autonomy does not always require P’s wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not”.
22. To apply that to another case, Mr Justice Munby (as he then was) in *Re M, ITW v Z* [2009] EWHC 2525 held, at paragraph 35(iii)(e), that when considering the weight and importance to be attached to P’s wishes and feelings the court should consider “crucially, the extent to which P’s wishes and feelings, if given effect to, can properly be accommodated within the court’s overall assessment of what is in her best

interests". I am in no doubt that the views expressed by Ms A are not in her best interests, and it is the test of her best interests which I must apply.

23. At the conclusion of the oral evidence of Dr A and Dr B, the Official Solicitor, who acts on Ms A's behalf, was strongly supportive of the application made by the Health Trusts that Ms A should be transferred to the maternity unit of the hospital for an elective caesarean section. That conclusion was reached after weighing up all of the risks and benefits, and no one has closed their eyes to the risks which are attached to any surgical procedure including the risks of anaesthetics. These are well known, but in my judgment, and in that of the Official Solicitor, they are far out weighted by the risks of not having an elective caesarean section.
24. Of course, as already mentioned, Ms A's capacity will continue to be assessed over the next week, and of course if she regains capacity then her wishes will be respected. I can only deal with how she is now, and how it appears likely she will remain.
25. I will make the declarations and orders as sought by the Health Trusts, namely that Ms A lacks the capacity to conduct these proceedings, and to make decisions regarding the birth (mode of delivery) of her child, her obstetric care and post-operative management and, notwithstanding Ms A's lack of capacity, that it is lawful, as being in Ms A's best interests, for her to be transferred from Hospital A to the maternity unit at Hospital B for an elective caesarean section.
26. I also declare that it is lawful, being in Ms A's best interests, for the staff of Hospital A or B, by their employees or agents, to use reasonable and proportionate measures in accordance with the care plan, including those which involve physical or medical restraint, to facilitate her transfer between either Hospital A or B and Hospital C (the latter if applicable). Finally, I also declare that in the event that Ms A goes into labour or requires emergency obstetric care before her elective caesarean section on Thursday 4 March 2021, and if necessary, clinicians may treat Ms A, including by way of an emergency caesarean section, if it is considered clinically necessary to do so in order to prevent harm to Ms A, and if it is considered a proportionate response.
27. There are also consequential orders, as set out in the draft order, which I also make. That is my ruling.