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Case No: TBA

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/03/2021

Before:

THE HONOURABLE MR JUSTICE MACDONALD

- -

Between:

East Lancashire Hospitals NHS Trust	**Applicant**
- and -	
GH	**Respondent**

- -
- -

Mr Mungo Wenban-Smith (instructed by **East Lancashire Hospitals NHS Trust**) for the **Applicant**
The Official Solicitor acting as litigation friend for the **Respondent**

Hearing dates: 2 March 2021

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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. Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email. The date and time for hand-down is deemed to be at 10.30am on 5 March 2021.

MR JUSTICE MACDONALD

This judgment was delivered in private. The Judge has given permission for this anonymised version of the judgment (and any of the facts and matters contained in it) to be published on condition always that the names and the addresses of the parties and the children must not be published. For the avoidance of doubt, the strict prohibition on publishing the names and addresses of the parties and the children will continue to apply where that information has been obtained by using the contents of this judgment to discover information already in the public domain. All persons, including representatives of the media, must ensure that these conditions are strictly complied with. Failure to do so will be a contempt of court.

Mr Justice MacDonald:

INTRODUCTION

1. At 11.45pm last night I concluded an out of hours hearing that had commenced at 10.00pm with respect to GH, a 26-year-old woman who suffers from anxiety, depression and acute agoraphobia and who had gone into labour at home nearly 72 hours earlier but who had thereafter suffered an obstructed labour. Within this context, it became apparent that GH required urgent in-patient obstetric treatment and a possible emergency caesarean section. GH was, however, refusing to agree to that course of action.

2. At the conclusion of that hearing I declared that, by reason of the operation of her acute agoraphobia and anxiety, GH lacked capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section and that it was in her best interests to be conveyed from her home to hospital by ambulance and for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's pregnancy and delivery, as outlined in the Obstetric Management Plan. I now set out the reasons for that decision.

3. The application is brought by East Lancashire Hospitals NHS Trust, represented by Mr Mungo Wenban-Smith of counsel. GH is represented in these proceedings at short notice by the Official Solicitor, Ms Sarah Castle. The court is extremely grateful to Ms Castle for attending the out of hours hearing to act as litigation friend to GH, testing the evidence of the Trust by way of cross-examination and making, by way of closing submissions, a considered recommendation to the court regarding GH's best interests.

4. During the course of the telephone hearing last night, I heard evidence on oath from Ms Yates, a Specialist Perinatal Community Mental Health Midwife, who undertook the capacity assessment of GH, and Dr Sarah Davies, Consultant Obstetrician, who was at that point the consultant responsible for GH's obstetric care.

5. As Mr Wenban-Smith fairly acknowledged in his opening, in *An NHS Trust and Anor v FG (By Her Litigation Friend, the Official Solicitor)* [2014] EWCOP 30 Keehan J made clear the heavy burden on Trusts to engage in early and thorough planning in cases of this nature in order to prevent the need for urgent applications to the out of hours judge. However, I accept Mr Wenban-Smith's submission that this case is distinguished by the fact that up until late yesterday afternoon GH was assessed to have capacity with respect to decisions concerning the management of her pregnancy and birth and indeed had agreed to admission to hospital in the event that admission was required during the course of her labour. It was only during the latter part of the day yesterday that it became clear that GH's anxiety and agoraphobia had become the dominant feature in her decision making and that a subsequent capacity assessment revealed that she lacked capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. Within this context, and as the Official Solicitor pointed out, there were options that might have been considered in order to endeavour to avoid the need for an urgent hearing following that assessment, I was satisfied that this case met the criteria for the urgent out of hours service. I make clear however, that nothing said in this judgment should detract from

what should be the ordinary approach in cases of this nature as set out by Keehan J in *An NHS Trust and Anor v FG (By Her Litigation Friend, the Official Solicitor)*.

BACKGROUND

6. GH is 26 years old. She has had one previous, uncomplicated, pregnancy followed by a normal hospital birth in 2017. GH suffers from severe anxiety, depression and debilitating agoraphobia. Those difficulties appear to have had their genesis in a particularly traumatic incident suffered by GH some years ago, the details of which it is not necessary to recount. It is however, not without significance in the context of GH's current difficulties that yesterday was the anniversary of that deeply upsetting event. As a result of her agoraphobia, anxiety and depression, GH finds it difficult to leave her local area and has not done this since the birth of her last child. She considers her home to be her "safe space". Prior to yesterday however, GH's mental health has been stable during her current pregnancy and is managed with Sertraline, Propranolol and Mirtazapine.

7. By reason of GH's agoraphobia, she has been unable to attend any antenatal care outside the home during her current pregnancy. Within this context, GH declined all routine antenatal ultrasound scans and growth scans. This means that as at this hearing, those responsible for the medical care of GH and her unborn baby are unable to determine:

    i) Whether there are any concerns regarding the placental site, for example undetected placenta praevia or an undetected low placenta.

    ii) Whether there are any foetal abnormalities.

    iii) Whether there are any issues with foetal growth.

    Within this context, GH was advised that the risks associated with a home birth were high, extending to a threat to the life of both GH and her unborn child. The evidence before the court makes clear that although midwives are trained to deal with emergency situations that arise during home births, where risks are already apparent then immediate access to obstetric and neonatal care is desirable and in-patient admission is therefore indicated. Within the foregoing context, GH was informed that she did not meet the criteria for a home birth.

8. The evidence before the court further indicates that the risks arising out of GH's incomplete participation in antenatal care are exacerbated by the fact that GH has a raised body mass index (hereafter BMI). In particular, the risks associated with GH's raised BMI in the intrapartum period are:

    i) A delay in the first or second stage of labour.

    ii) An increased risk of elevated blood pressure leading to pre-eclampsia/eclampsia.

    iii) Difficulty in assessing foetal size and risk of larger baby which could lead to shoulder dystocia.

    iv) Risk of haemorrhage.

v) Risk of venous thromboembolism.

vi) Difficulty in auscultating the foetal heart.

9. GH has been throughout her pregnancy well supported by her partner and is close to her family. I pause to note that GH's partner and her family strongly support GH's admission to hospital this evening and support the application being made by the Trust. There are no concerns regarding GH's ability to parent her first child or her unborn child. It is plain from the evidence before the court that GH is looking forward to the birth of her second child and wishes that birth to proceed safely.

10. Within this context, whilst GH had not fully engaged with a programme of ante natal care and whilst GH had decided to have a home birth, she had in fact agreed to be admitted to hospital should this be required. At the time she gave that agreement there were no concerns regarding GH's capacity to make decisions concerning her admission to hospital should this be clinically indicated during the course of her labour.

11. As I have noted, GH's waters broke at 2.00am on 28 February 2021 and she went into labour. At 3.45am yesterday morning, 2 March 2021, GH was diagnosed as having failed to progress in the first stage of labour and was advised of the risk of prolonged ruptured membranes and the need for her to be admitted to hospital. GH declined to be admitted. By 7.20am yesterday the midwife was concerned that GH's labour was obstructed, a further recommendation was made for GH to attend hospital, which recommendation was again declined by GH. A further assessment was undertaken at 4.30pm yesterday with no change in the clinical picture. GH was advised that the risks to the baby at that point included significant infection, hypoxia, brain damage, birth injury and still birth. GH was further advised that the risks to her at that point comprised those of sepsis and septic shock, uterine rupture, injury to the pelvic organs, significant risk of postpartum haemorrhage and possible trauma. Again, GH declined admission to hospital.

12. Within the foregoing context a multidisciplinary meeting concluded that a capacity assessment of GH should be undertaken to determine whether she retained capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. That capacity assessment is before the court, completed by Ms Yates late yesterday afternoon at GH's family home. It concludes that GH at present lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section.

13. I heard oral evidence from Ms Yates who described in clear and cogent terms the assessment she had undertaken and the conclusions that she had drawn from that assessment with respect to the question of GH's capacity to make the decisions in issue. Ms Yates considered that GH's agoraphobia, anxiety and depression satisfied the diagnostic element of the capacity test under the Mental Capacity Act 2005. With respect to the functional element of the test for capacity, during the course of her oral evidence Ms Yates confirmed her assessment that GH currently lacks the ability to use and weigh information relevant to the decision in issue. In particular, Ms Yates confirmed that whilst GH was able to recall and articulate some of the risks attendant on not being admitted to hospital, she was fixated on the idea that those risks would not come to pass with respect to her and could be avoided provided she was permitted to remain in her "safe space", which action would, with the support of her partner, by itself

enable her body to successfully deliver the baby. Within this context, Ms Yates considered that the demands of GH's agoraphobia and anxiety prevented her from properly evaluating the information concerning risk as a key element of deciding whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. The Official Solicitor did not take issue with the assessment of Ms Yates that GH lacks capacity on the decision in issue.

14. As I have noted, with respect to the question of best interests, I heard oral evidence from Dr Sarah Davies, Consultant Obstetrician, regarding the risks and benefits to GH of remaining at home during the course of her labour and birth and the risks and benefits of her being admitted to hospital for obstetric and postnatal care.

15. Dr Davies considered that it was now essential that GH be admitted to hospital in circumstances where the midwives at the family home were clear that GH's labour had become obstructed. Whilst GH remained stable at the current time, Dr Davies was clear that should GH's condition or the condition of the baby deteriorate (which Dr Davies confirmed in oral evidence could happen very quickly) the facilities of the hospital would be required as a matter of urgency but with no guarantee, absent a pre-arranged transfer, that an ambulance could respond immediately in such circumstances.

16. In particular, in circumstances where GH's waters broke over 72 hours ago Dr Davies considered that GH was at risk of deteriorating quite rapidly to a situation of infection and concurrent sepsis, which would be a significant risk to GH and which her unborn baby would not tolerate. Further, Dr Davies considered that in circumstances where the risks of obstructed labour include uterine rupture that would lead to significant haemorrhage. It is further clear from the documentary evidence before the court that in any event a uterine birth in the context of blocked labour now carries with it considerable risks, particularly if attempted at home, which risks comprise increased chance of uterine trauma and uterine tone following the delivery of the placenta with the attendant risk of significant postpartum bleeding, which could only be effectively treated with transfusions that could only be administered in hospital. In the event such haemorrhage could not be controlled there is a risk the mother could collapse, suffer a cardiac arrest, hypoxic brain injury or die. Dr Davies considered that additional risks at this point included disseminated vascular coagulation, acute renal failure and the need for a hysterectomy. Dr Davies was clear that the longer the delay in achieving the admission to hospital of GH the greater these risks.

17. In response to cross-examination by the Official Solicitor, Dr Davies conceded that it would be a challenge to get GH into the ambulance in order to transfer her to hospital were the court to determine this to be in her best interests. Dr Davies confirmed that the Trust had access to support from mental health professionals experienced in using reasonable force to transport patients. Dr Davies agreed when asked by the court that it would be important for her to provide advice to those professionals regarding particular steps that will need to be taken in order to ensure that reasonable force is assessed properly by reference to GH's pregnancy and current obstetric condition. Dr Davies further agreed with the Official Solicitor that, subject to advice from the Consultant Anaesthetist on call, it may be possible to provide GH with mild sedation in order to lower her anxiety with respect to the journey to and the admission to hospital.

18. At the conclusion of the evidence, and by way of closing submissions, the Official Solicitor, having considered the documentation before the court and the oral evidence

heard by the court, accepted the assessment of Ms Yates that GH lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. The Official Solicitor further recommended to the court that, subject to ensuring all possible steps are taken to reduce GH's anxiety and ensure her dignity, it is in GH's best interests to be conveyed from her home to hospital by ambulance and for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's pregnancy and delivery, as outlined in the Obstetric Management Plan.

LAW

19. The law that the court must apply in this difficult situation is well settled. Pursuant to the Mental Capacity Act 2005 s 15(1) the court may make declarations as to whether a person has or lacks capacity to make a decision specified in the declaration, may make declarations as to whether a person has or lacks capacity to make decisions on such matters as are described in the declaration and may make declarations as to the lawfulness of any act done, or yet to be done in relation to that person. Within this context, 'act' includes an omission or course of conduct (Mental Capacity Act 2005 s. 15(2)).

20. The law that I must apply to the facts in this case in reaching my decision as to capacity is set out in the Mental Capacity Act 2005 ss. 1 to 3. The sections of the Act relevant to my decision provide as follows:

> **1 The principles**
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> …/
>
> **2 People who lack capacity**
>
> (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) A lack of capacity cannot be established merely by reference to—
>
> (a) a person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(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.

…/

3 Inability to make decisions

(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) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(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.

21. In *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80 I summarised the cardinal principles that flow from these sections of the statute as follows:

i) A person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s 1(2)). The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s 2(4) and see *KK v STC and Others* [2012] EWHC 2136 (COP) at [18]);

ii) Determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by

sections 1 to 3 of the Act (see *PC v City of York Council* [2014] 2 WLR 1 at [35]). Thus, capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally;

iii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s 1(3));

iv) A person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise (see *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP) at [7]). The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see *R v Cooper* [2009] 1 WLR 1786 at [13] and *York City Council v C* [2014] 2 WLR 1 at [53] and [54]);

v) Pursuant to s 2(1) of the 2005 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 (the so called 'diagnostic test'). It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s 2(2)). It is important to note that the question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable to make the decision by reason thereof (see *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP) at [38]);

vi) Pursuant to s 3(1) of the 2005 Act a person is "unable to make a decision for himself" if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means (the so called 'functional test'). An inability to undertake any one of these four aspects of the decision making process set out in s 3(1) of the 2005 Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see *RT and LT v A Local Authority* [2010] EWHC 1910 (Fam) at [40]). The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s 3(4)(a));

vii) For a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s 3(1) of the Act and the diagnostic element of 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s 2(1) of the Act, i.e. for a person to lack capacity the former must result from the latter (*York City Council v C* [2014] 2 WLR 1 at [58] and [59]);

viii) The threshold for demonstrating capacity is not an unduly high one (see *CC v KK & STCC* [2012] EWHC 2136 (COP) at [69]).

22. The Mental Capacity Act 2005 s 4(1) provides as follows in respect of determining the question of best interests:

> **4 Best interests**
>
> (1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—
>
> (a) the person's age or appearance, or
>
> (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
>
> (2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
>
> (3) He must consider—
>
> (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
>
> (b) if it appears likely that he will, when that is likely to be.
>
> (4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
>
> (5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
>
> (6) He must consider, so far as is reasonably ascertainable—
>
> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
>
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so.
>
> (7) He must take into account, if it is practicable and appropriate to consult them, the views of—
>
> (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
>
> (b) anyone engaged in caring for the person or interested in his welfare,

> (c) any donee of a lasting power of attorney granted by the person, and
>
> (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
>
> (8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—
>
> (a) are exercisable under a lasting power of attorney, or
>
> (b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
>
> (9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.
>
> (10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
>
> (11) "Relevant circumstances" are those—
>
> (a) of which the person making the determination is aware, and
>
> (b) which it would be reasonable to regard as relevant.

23. In order to determine the question of best interests the court must consider all the circumstances of the case (Mental Capacity Act 2005 s 4(2)). The assessment of best interests under the Mental Capacity Act 2005 s. 4 is thus an assessment wide in compass and not confined to an assessment only of the best medical interests of the patient. Beyond this description however, it has been observed that it is undesirable, and probably impossible, to set bounds on what matters will be relevant to a welfare determination (*Re S (Adult Patient: Sterilisation)* [2001] Fam 15 at 30). In *Aintree University Hospitals NHS Foundation Trust v James & Ors* [2014] AC 591, and noting that the purpose of the best interests test is to consider matters from the patient's point of view, Baroness Hale observed at [39] that:

> "The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be."

24. In considering all of the circumstances of the case in order to reach a best interests determination, the Act requires the court to consider a number of specific matters:

    i) Whether it is likely that the person will at some time have capacity in relation to the matter in question and, if it appears likely that they will, when that is likely to be (Mental Capacity Act 2005 s. 4(3)). The MCA Code of Practice at para 3.14 provides that where a person's capacity is likely to improve in the foreseeable future then, if practical and appropriate, the person should be helped to make the relevant decision by waiting until their capacity improves. The Code of Practice at para 4.27 provides that an assessment must only examine a person's capacity to make a particular decision when it needs to be made and, accordingly, it may be possible to put off the decision until the person has capacity to make it. However, para 5.26 of the Code of Practice recognises that in emergency situations, such as when urgent medical treatment is needs, it may not be possible to see if the person may regain capacity so that they can decide for themselves whether or not to have the urgent treatment;

    ii) The person's past and present wishes and feelings (and, in particular, any relevant written statement made by them when they had capacity) (Mental Capacity Act 2005 s 4(6)(a));

    iii) The beliefs and values that would be likely to influence their decision if they had capacity (Mental Capacity Act 2005 s 4(6)(b));

    iv) The other factors that they would be likely to consider if they were able to do so (Mental Capacity Act 2005 s 4(6)(c));

    v) If practicable and appropriate, the views of, inter alia, anyone named by the person as some to be consulted on the matter in question, anyone engaged in caring for the person or interested in his or her welfare as to what would be in the person's best interests and in particular as to the matters set out in s 4(6) of the 2005 Act (Mental Capacity Act 2005 s 4(7)).

25. The court must also, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any decision affecting him or her (Mental Capacity Act 2005 s. 4(4)).

26. In assessing whether it is a patient's best interests to receive treatment that will or may prolong their life, the fundamental principle of the sanctity of human life will weigh heavily in the balance. Art 2 of the European Convention on Human Rights imposes a positive obligation to give life-sustaining treatment where responsible medical opinion is of the view that such treatment is in the patient's best interests, although that obligation is not absolute. As Munby J (as he then was) observed in *R (Burke) v GMC* [2004] EWHC 1879 (Admin) in a passage approved by the Court of Appeal:

> "There is a very strong presumption in favour of taking all steps to prolong life, and save in exceptional circumstances, or where the patient is dying, the best interests of the patient will normally require such steps to be taken. In case of doubt, that doubt falls to be resolved in favour of the preservation of life. But the obligation is not absolute. Important as the sanctity of life is, it may have to take second place to human dignity…"

27. Pursuant to the Mental Capacity Act 2005 s 4(1) the decision as to what is in a person's best interests must not be taken merely on the basis of the person's age or appearance nor on the basis of the person's condition, an aspect of their behaviour that might lead others to make unjustified assumptions about what might be in the person's best interests.

28. Within this context it is also important to remember that, by reason of the inalienable and universal character of human rights, a person who lacks capacity has the same human rights as a person who does not lack capacity (see *P v Cheshire West* [2014] UKSC). In addition to rights under Art 2 of the ECHR, as articulated above, GH benefits from rights under Art 3 (right not to be subjected to torture or to inhuman or degrading treatment or punishment) and Art 8 (right to respect for family and private life) under the Convention. The assessment of GH's best interests must take account of these rights.

DISCUSSION

29. As I set out at the beginning of this judgment, at the conclusion of the out of hours hearing I indicated my decision that GH lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. I further indicated my decision that it is in GH's best interests (a) to be conveyed from her home to hospital by ambulance, (b) for staff employed by the applicant and/or any other NHS Trust responsible for GH's clinical care or transportation to the hospital to use reasonable and proportionate measures, including those which constitute a deprivation of GH's liberty, and (c) for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's pregnancy and delivery, as outlined in the Obstetric Management Plan, including:

    i) A formal examination and diagnostic assessment;

    ii) Monitoring both the condition of GH and the foetus;

    iii) The taking of blood samples for testing;

    iv) The insertion of needles for the purpose of intravenous infusions;

    v) The administration of anaesthesia including general anaesthesia;

    vi) Delivery by caesarean section;

    vii) Pre-, peri- and post-operative medical care associated with such treatment.

    My reasons for reaching these conclusions on the evidence before the court are as follows.

Capacity

30. I am satisfied that GH's agoraphobia, anxiety and depression fulfil the so called 'diagnostic' element of the test for capacity. I am further satisfied that the so called 'functional' element of the test for capacity is made out in GH's case. Having regard to the evidence before the court, and in particular the evidence of Ms Yates, I am clear

that GH's current agoraphobia and anxiety is preventing her from using or weighing information in deciding whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section.

31. Despite clearly and carefully presented information that unless she is now admitted to hospital both her and her baby are at increasing risk of serious injury or even death, GH has chosen, without acknowledging and considering the reality of those risks, to stay in what she considers her "safe space", which she considers will allow her to give birth in a manner safe for both herself and her unborn child. Within this context, this is not a case in which GH has acknowledged the risk of serious injury or death, weighed that risk and then rejected that risk it in favour of an unwise course of action but rather a case in which GH simply does not acknowledge the risk of serious injury or death or accept that the risk of serious injury or death is relevant to her as long as she remains in her "safe space". I am satisfied that this demonstrates that GH's agoraphobia and anxiety has overwhelmed her ability to use and weigh the information required to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. Within this context, I am further satisfied GH's inability to use and weight information is clearly the result of an impairment of, or a disturbance in the functioning of, GH's mind or brain.

32. I am also satisfied that in her current circumstances there is no evidence before the court that GH is likely to regain capacity to make the decision regarding admission to hospital before it becomes necessary for her safety and the safety of her unborn child for that admission to take place.

Best Interests

33. In circumstances where I am satisfied that GH lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section, this court has jurisdiction to determine what course is in GH's best interests and to make declarations accordingly. On the evidence before the court, I am satisfied that it is in GH's best interests to be conveyed from her home to hospital by ambulance, with use of reasonable force if necessary, and for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's pregnancy and delivery, as outlined in the Obstetric Management Plan.

34. First, I have given significant weight to the fact that, at a time when all involved accept that GH had capacity, she had indicated that whilst she wished for a home birth, she agreed to be admitted to hospital should that be required. I am satisfied that this is cogent evidence regarding her wishes and feelings at a time when she had capacity with respect to the decision in issue. Further, I have also weighed in the balance in assessing GH's best interests the fact that she was clearly looking forward to the birth of the child and wished for the birth to go smoothly and safely. If GH had retained capacity with respect to the decision in issue, I am satisfied that it is likely she would have remained in agreement with being admitted to hospital should that admission have become necessary during the course of her labour, which it now has.

35. I have of course borne in mind carefully the risks attendant on admission to hospital, particular in circumstances where one of the options contemplated is a caesarean section under a general anaesthetic. A caesarean section carries with it the risks

associated with a general anaesthetic and an increased risk of bleeding. The transportation of GH to hospital will also inevitably increase her levels of anxiety at a time when her body is already stressed by her pregnancy and obstructed labour, particularly if it is necessary to use reasonable force to facilitate the transfer.

36. However, set against these risks are what I am satisfied is the greater risk to GH's health (and the health of her of her unborn baby) of not being now admitted as an inpatient for obstetric and postnatal care. The documentary evidence before the court and the evidence of Dr Davies makes abundantly clear the fact that a uterine birth now carries with it considerable risks in any event, particularly if attempted at home, which risk comprise increased chance of uterine trauma and uterine tone following the delivery of the placenta with the risk of a hysterectomy being required. As I have noted, other risks include disseminated vascular coagulation, acute renal failure and the need for admission to ISU for organ support. Were GH to suffer significant post-partum bleeding she would require multiple transfusions which can only be effectively delivered in hospital. In the event the haemorrhage cannot be controlled there is a risk the mother could collapse, suffer a cardiac arrest, hypoxic brain injury or die. The longer the delay the greater the risk. The risks present in this case are further exacerbated by the uncertainties caused by the impact of GH's condition on the course of her antenatal care, with medics having no clear picture of the position of GH's placenta, whether her unborn child has any foetal abnormality or the extent to which there are issues in respect of foetal growth.

37. I have also borne in mind that GH's partner and family, who are close to her, all take the view that GH should now be admitted to hospital in order to have safe obstetric care and a safe birth of her second child. Within this context, GH's family are supportive of the application made by the Trust and of the relief sought in that application.

38. It is important for me to consider the position from GH's point of view. In this regard, I am once again assisted by fact of GH's consent to admission when she had capacity to consent to that course and before she was overborne by her agoraphobia and anxiety. As I have stated, for the reasons I have given I am satisfied that this would remain her position if she had capacity in light of the fact this this view was taken by her as recently as a few days ago. I am further satisfied that GH would also take counsel of relatives and family who seek for her to go to hospital and would likely place weight on that counsel, particularly in circumstances where it is plain that GH was desirous of a safe birth for her second child. Within this context, I have of course also borne in mind that, having heard the evidence in this case, the considered recommendation of the Official Solicitor, as litigation friend for GH, that it is in GH's best interests now to be admitted to hospital for obstetric and postnatal care.

39. In all the circumstances of the case, and for the reasons I have given, I am satisfied that it is in GH's best interests to grant the order sought by the Trust. During the course of the hearing, the Official Solicitor rightly drew the attention of the court to additional steps that can be taken to ensure that this course of action is carried out as sensitively and with as little distress for GH as possible. In particular, I endorse the Official Solicitors view that the use of mild sedation should be explored with the assistance of advice from the on-call anaesthetist. I further endorse the suggestion that in determining what constitutes reasonable physical restraint, should this be necessary, the views of Dr Davies in this regard will be important to ensure that such restraint is appropriate for a woman in GH's position.

CONCLUSION

40. As I noted in *Cambridge University Hospitals NHS Foundation Trust v BF* [2016] COPLR 411, it is a very grave step indeed to declare lawful medical treatment that a patient has stated she does not wish to undergo. It is a graver step still compel, possibly by means of the use of sedation and reasonable force if further gentle persuasion fails, the removal of a person from their home to ensure their attendance at hospital for such medical treatment. Parliament has conferred upon the court jurisdiction to make a declaration of such gravity only where it is satisfied that the patient lacks the capacity to decide whether to undergo the treatment in question and where it is satisfied that such treatment is in that patient's best interests.

41. In this case I am satisfied that the Trust has discharged the heavy burden resting upon it in demonstrating that GH lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section and that the course of action proposed by the Trust is in GH's best interests. Within this context, I make the order in the terms appended to this judgment.

42. That is my judgment.

POSTSCRIPT

43. Ahead of this judgment being formally handed down, the court was informed that GH had given birth to a healthy baby boy. In the event, following the out of hours hearing and the decision of the court, GH's labour began to progress quickly and she delivered her son at home before it was possible to execute the arrangements authorised by the court regarding her transport to hospital for obstetric and postnatal treatment.

APPENDIX

IN THE COURT OF PROTECTION **CASE NO: TBA**
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
AND IN THE MATTER OF GH
BETWEEN:

EAST LANCASHIRE HOSPITALS NHS TRUST

Applicant

-and-

GH
(By her litigation friend, the Official Solicitor)

Respondent

ORDER

BEFORE Mr Justice MacDonald by telephone sitting as a nominated judge of the Court of Protection at the Royal Courts of Justice, The Strand, London on 2 March 2021.

UPON hearing counsel (Mr Wenban-Smith) for the applicant (the "NHS Trust") and the Official Solicitor, Ms Castle, in person for the proposed respondent ("GH") acting by her litigation friend

AND UPON the court reading:

(a) GH's Birth Care Plan;
(b) GH's medical records for the period 10 pm on 1 March 2021 to 5.15 pm on 2 March 2021;
(c) GH's Obstetric Management Plan; and
(d) The capacity assessment dated 2 March 2021.

AND UPON the court hearing oral evidence from Dr S. Davies, consultant obstetrician, and Ms C. Yates, specialist mental health midwife

AND UPON the applicant agreeing to issue this application by 4 pm on 3 March 2021

AND UPON the applicant agreeing to pay half the Official Solicitor's costs of the application

IT IS DECLARED AND ORDERED PURSUANT TO SECTIONS 15 AND 16 OF THE MENTAL CAPACITY ACT 2005 THAT:

1. GH lacks capacity:
    a. To conduct these proceedings; and
    b. To make decisions generally about her care and treatment in connection with her ongoing pregnancy, including to attend the [hospital] as an emergency admission.

2. It is in her best interests for GH to be conveyed from her home to the [hospital] by Ambulance and for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's present pregnancy and delivery, as outlined in the attached Obstetric Management Plan, including if in their professional opinion it is necessary and in her best interests:

a. A formal examination and diagnostic assessment;
b. Monitoring both the condition of GH and the foetus;
c. The taking of blood samples for testing;
d. The insertion of needles for the purpose of intravenous infusions;
e. The administration of anaesthesia including general anaesthesia;
f. Delivery by caesarean section;
g. Pre-, peri- and post-operative medical care associated with such treatment.

3. It is in GH's best interests for staff employed by the applicant and/or any other NHS Trust responsible for GH's clinical care or transportation to the [hospital] to use reasonable and proportionate measures, including those which constitute a deprivation of GH's liberty:
    a. To convey GH from her home to the [hospital];
    b. To achieve the interventions referred to in paragraph 2 above; and/or
    c. To ensure that she does not leave the [hospital] during the course of such interventions and/or post-operatively until it is clinically appropriate for GH to be discharged from the [hospital] after those interventions

    PROVIDED THAT:
    d. Anaesthesia and sedation may be used as far as necessary as prescribed by a consultant anaesthetist in consultation with a consultant obstetrician and is to be administered by a registered medical practitioner or registered nurse as appropriate;
    e. Such physical restraint or force that may be used to convey GH to the [hospital], to administer such treatment and/or to prevent GH from leaving the [hospital] shall be the minimum necessary reasonable force; and
    f. All reasonable steps are taken to minimise distress to GH and to maintain her greatest dignity.

4. Any deprivation of GH's liberty and/or interference with GH's rights under ECHR Article 8 occasioned in the giving effect to the orders and declarations set out above is authorised by the court as being necessary, proportionate and in GH's best interests.

IT IS FURTHER ORDERED THAT:

5. The applicant has permission to bring these proceedings.

6. Having consented thereto, the Official Solicitor is appointed as litigation friend to GH.

7. There be no order as to costs, save that the applicant shall pay half the costs of the Official Solicitor of this application, to be subject to detailed assessment if not agreed.

8. This order shall have effect notwithstanding that it does not bear the seal of the court.

9. A copy of this order shall be placed on GH's medical records and a copy shall be served on any NHS Trust involved in the conveyance and/or obstetric care of GH.

10. Liberty to apply in relation to the terms of implementation of this order.

By the Court
Dated 2 March 2021