



Neutral Citation Number: [2024] EWCOP 7

Case No: 14198302

**COURT OF PROTECTION**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 14/02/2024

**Before:**

**MS JUSTICE HENKE**

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**Between:**

**A Hospital Trust**

**Applicant**

**- and -**

**(1) CP**

**Respondents**

**(by her litigation friend, the Official Solicitor)**

**(2) A Mental Health Trust**

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**Conrad Hallin** (instructed by **Capsticks LLP**) for the **Applicant and Second Respondent**  
**Ian Brownhill** (instructed by the **Official Solicitor**) for the **First Respondent**

Hearing date: 12 February 2024  
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**Approved Judgment**

This judgment was handed down remotely at 2pm on 20 February 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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**MS JUSTICE HENKE**

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 must be strictly preserved. There is a transparency order in relation to this case made by Mrs Justice Theis on 30 January 2024. All persons, including representatives of the media, must ensure that the terms of the transparency order are strictly complied with. Failure to do so will be a contempt of court.

**Henke J:**

**My Decision in Summary**

1. Having considered all the evidence placed before me: -
  - a. CP's parents are not joined as parties to the application;
  - b. Pursuant to section 15 of the Mental Capacity Act 2005 ("the MCA"), I declare that CP lacks the capacity to:
    - i. Conduct these proceedings; and
    - ii. Make decisions regarding her obstetric care, anaesthesia and ancillary care and treatment; and
  - c. Pursuant to section 16 of the MCA, I declare that it is lawful and in CP's best interests to receive the care and treatment within the filed care plan which has been amended and which is now agreed between the parties and endorsed by the court.
2. This court's decision was communicated to the parties at the close of submissions on the afternoon of Monday 12 February 2024.
3. This judgment was handed down electronically at noon on 14 February 2024 for editorial corrections, and the perfected and anonymised version was approved on 19 February 2024. The perfected judgment was handed down remotely at 2pm on 20 February 2024 by circulation to the parties' representatives by email and release to the National Archives.

**My Decision in Full**

**Introduction and Brief Background**

4. The application before me concerns CP. CP has schizophrenia, most likely of a hebephrenic or disorganised type. CP is currently detained under section 3 of the Mental Health Act 1983 ("the MHA"). The second Respondent is the provider of mental health services at the hospital where CP is currently detained. CP has been detained at that hospital since August 2023. CP is approximately 36 weeks pregnant. Her estimated due date is 29 February 2024.
5. The application before me is made by the Hospital Trust. The applicant is an acute Trust providing obstetric care to CP. The application is for declarations and orders to allow a planned caesarean section to take place on 14 February 2024.
6. The application before me was issued on 18 January 2024. On 30 January 2024, Mrs Justice Theis considered the application bundle. She granted the applicant permission to bring these proceedings; declared herself satisfied that there is reason to believe for the purposes of s.48 of the MCA that CP lacks the capacity to (i) conduct these proceedings and (ii) make decisions about her obstetric care and support, and made the directions agreed between the parties. Those directions included setting the application down for hearing. It is the hearing of the application that is before me.

**This Hearing and the Evidence Before Me**

7. In order to determine the application before me I have read:
  - a. Two sworn witness statements from Dr B, a Consultant Psychiatrist working for the Mental Health Trust. He has been CP's Responsible Clinician since November 2023. His evidence was unchallenged.
  - b. Two sworn statements from Ms M. Ms M is a Consultant Midwife and Clinical Lead in Perinatal Mental Health at the Applicant Trust. She has nearly 10 years' experience of looking after pregnant women with perinatal mental health concerns.
  - c. Two sworn statements from Mr N, Consultant Obstetrician. His evidence was unchallenged.
  - d. A sworn statement from Dr Z, consultant anaesthetist. He was not able to give evidence before me.
  - e. Statement from a solicitor appointed by the Official Solicitor to act for CP. That solicitor visited CP as recently as 8 February 2024. She has exhibited her attendance note to the statement. The conversation with CP on that date illustrates the observations made by the clinicians. During the conversation CP confirmed that she wanted to have a prearranged Caesarean section and she wanted a spinal block.
8. In addition, I heard oral evidence from Ms M and Dr X. Ms M gave brief oral evidence during which she confirmed that during the ante-natal procedures she had built a good rapport with CP. She would be part of the team monitoring both CP's mental and physical health during delivery. Dr X gave oral evidence in Dr Z's stead. I am grateful to Dr X for reading himself into the case at relatively short notice and for the focused and cogent evidence he gave. From that evidence it was clear that he was not simply following his colleagues' opinion but that he had formed his own professional view which built upon that already before the court.
9. Before the hearing began, I met with CP who attended on the link with the support and assistance of a representative of her solicitors. In court was her own counsel and the Official Solicitor's representative who very kindly kept a note of my conversation with CP. That note was then circulated to all parties before the hearing began. Having met CP, I can report that she was as described by her clinicians. CP is clearly a bright woman. She was able to tell me that she wanted a pre-arranged Caesarean and a spinal block. She told me that she wanted a spinal block because she wanted to be present for the birth. That seemed to me to be a good reason and a reasonable one. She was content with the operation taking place on 14 February 2024 but wanted to move to the acute hospital before then. Her reasoning appeared to me to be dominated by her needs. She wanted to leave her current hospital because she found its regime of confinement in her words "traumatic". She was not allowed out. She failed to tell me that she had previously absconded when escorted for a cigarette break. I was left with the impression, not just by what she said but how she said it, that the motivation to move to the acute hospital sooner than planned may well have been the plans in place there to enable her to smoke outside the hospital and vape within it. As a result of CP's firm wish to move sooner than 14 February, her counsel made enquiries of the acute Trust. The plan could not be put into place sooner than already arranged. Thus, what CP wanted was not achievable and it was not pursued on her behalf.

10. As part of the hearing, I also spoke to CP's parents who each confirmed their views were as recorded in the substance of this judgment.

### **The Issues to be Determined**

11. At the close of evidence, I was told that there was no longer any issue between the parties. The draft order which has kindly been sent to me on behalf of the Applicants was agreed. The agreed order is endorsed by me. It is accordingly attached to this judgment. However, given the serious nature of the issues and given that CP and her baby may in due course want to know why the plan was endorsed, I have proceeded to give judgment on the central issues before me.

12. Those issues are:

- a. Should CP's parents be made parties to these proceedings?
- b. Does CP have the capacity to make decisions about her obstetric care and treatment, including a pre-arranged caesarean section?
- c. If not, what orders should the Court make in respect of her treatment?
- d. If the court decided that a pre-arranged Caesarean section is in CP's best interests, is it in her best interest to have a spinal block or a general anaesthetic?

### **My Findings of Fact**

13. CP is now 30 years old. When circumstances allow, she is a heavy smoker. She has misused alcohol and illicit drugs. She is an intelligent woman. She is highly educated. Her first known meeting with mental health services was in January 2021. At that time, she was 27 years old and was said to be presenting with symptoms of possible schizophrenia. Notes from that time record that CP herself had been worried since 2017 that she might be schizophrenic, but she had not liked to voice her concerns for fear of stigmatisation. They also record her speaking about her troubled childhood which she says was traumatic. CP was discharged from mental health services in the Autumn of 2021. She had no contact with them again until March 2022 when she referred herself. By 11 May 2022 she was in crisis. She was exhibiting disinhibited and self-neglecting behaviours which put herself at risk. On 13 May 2022, CP was detained under s.2 of the MHA. On 20 June 2022, she was discharged for home treatment. The planned home treatment was interrupted when CP absconded from the hospital to which she had been taken for treatment for a physical injury. Shortly after this episode she was made homeless. By the end of December 2022, CP had travelled to Amsterdam where she settled for a while. Whilst in Amsterdam, her behaviour remained erratic and reckless. It is reported that whilst in Amsterdam she was drinking two bottles of wine a day. In February 2023, CP was admitted to intensive care in Amsterdam. She absconded from there during a cigarette break. CP was located and thereafter detained on a closed ward in Amsterdam until 29 March 2023. On detention her urine screen was positive for cocaine and THC.

14. From 2017 until her detention in hospital in May 2022, CP was estranged from her parents. Thereafter CP has had intermittent contact with her father. There is evidence of her father taking steps to minimise the risks to which CP was exposing herself in Amsterdam. On 29

March 2023, CP flew home with her father from Holland. On return to England, CP had a base with her parents and input from the community mental health team. Her behaviours, however, continued to be erratic. She stayed with a man whose identity caused her father and professionals concern that she may be being exploited, and she was observed to be drinking alcohol excessively and regularly. To date, CP remains in contact with her father who visits her regularly. She has no current contact with her mother or her younger sister. She has stated that she does not want either of her parents at the baby's birth.

15. On 22 August 2023, CP was assessed following the execution of a s.135 warrant. She was found in a state of self-neglect surrounded by empty wine bottles and cigarette butts. She was initially admitted to hospital under s.2 of the MHA. Whilst so detained she absconded more than once. On 14 September 2023, CP was detained under s.3 of the MHA. Since then, CP's behaviours have included repeated claims that she is claustrophobic on the ward and needs to have coffee and a cigarette. For CP her need to smoke has been a pre-occupation throughout her detention. CP has made several attempts to abscond, one of which has been successful. Despite changes in medication, she remains acutely unwell with auditory hallucinations.
16. The evidence before me is that CP appears uninterested in her pregnancy and is more interested in having her immediate needs and wants met. I am told by Dr B that CP appears focused on her needs and in particular on her need to smoke and to have a cigarette. Ms M describes her as being detached and showing no interest in her baby during her antenatal care. Mr N tells the court that when he discussed her pregnancy with her, she was uninterested.
17. Since 18 October 2023, all of CP's antenatal care has been conducted where she is detained to minimise attempts to abscond. However, even when detained in her mental health hospital CP has managed to abscond and did so on 30 October 2023 by eluding two members of staff when being escorted in the grounds for a cigarette break. She was missing for 4 weeks. She was returned to hospital on 23 November 2023. In the meantime, her mental health had deteriorated.
18. CP's view about her pregnancy has changed overtime. In November and early December 2023, the evidence was that CP wanted an emergency abortion. That was not an achievable option. CP's view then changed to wanting to go to a mother and baby unit after the birth. CP's interest in a mother and baby unit appears to be linked to the possibility of a more relaxed environment in which she may be allowed to smoke.
19. In a capacity assessment conducted on 11 December 2023, CP expressed a wish for a natural birth. More recently she has expressed a wish for a pre-arranged C-section. That appears to be a reactive stance precipitated by Braxton Hicks with which she is not coping. It is an agreed fact that CP does not tolerate pain well.
20. In terms of CP's mental health, she has been prescribed haloperidol since 11 December 2023. That medication has elicited a partial response. Her emotions are more settled, and her self-care has improved. There are mild improvements in her mental health, but she continues to respond to unseen stimuli. Her schizophrenia continues to impair her ability to order her thoughts and make decisions. She has displayed a pattern of behaviour which has not really changed over the last 18 months even when apparently treated with antipsychotic medication. She has displayed self-destructive and risky behaviours even on

haloperidol. Dr C's evidence to this court, which I accept, is that it is unlikely that any anti-psychotic medication will improve her executive functioning.

### **Should CP's Parents be Made Parties to the Proceedings?**

21. CP's parents attended the hearing on the CVP link. They had made an informal application to be joined as parties before the hearing began. The Applicants and those representing CP expressed themselves to be neutral in relation to the application. When I spoke to CP, CP herself was opposed to their joinder. Her reasoning was brief. It was that she was shocked by their application, there was a history between her and her parents and, in essence, that she could see no need for them to be joined.
22. Counsel for the Applicant and Counsel for CP both very kindly referred me to COP r.9.15(1) which states that *any person with sufficient interests may apply to the court to be joined as a party*. I accept that both of CP's parents are people to whom s.4(7) of the MCA would apply. They clearly have the sufficient interest to open the CoPR 9.15(1) gateway. Having done so, the application is properly made, but I consider that it does not follow that they must be joined. The court must apply a further test. That test is found in rule 9.13(2) of the COP Rules 2017 which provides: "*The Court may order a person to be joined as a party if it considers that it is desirable to do so for the purpose of dealing with the application*" (my emphasis added). The court has a broad discretion whether or not to join a party with sufficient interest. It must be desirable for them to be joined. Desirability in this context means that their joinder would enable the court to better deal with the substantive application. The overriding objective in COP r.1.1 is also engaged.
23. Applying the relevant law to the facts of this case, I concluded that joining CP's parents would not enable me to better deal with this case. They each told me that they simply wished to observe the proceedings. They had not put any formal written evidence before this court, nor did they seek to do so. They did not want to give oral evidence, nor did they wish to challenge any of the evidence before me. Their view that CP is not good at handling pain and would find a natural delivery a very difficult experience had been expressed to the clinicians who had reflected that in their written evidence before me. They reaffirmed that view when they spoke to me. They had nothing to add. CP, on the other hand, was opposed to their joinder. Whilst her reasons were brief and not fully informed, I weighed them in the balance. I also factored in the fractured relationship between CP and her parents. Standing back and looking at all the factors in this case I am obliged to consider and in particular factoring in the matters I have articulate in this paragraph, I considered that joining CP's parents would add nothing to this hearing. In those circumstances CP's parents remained observers to the proceedings. As such they were able to witness first-hand that the issues concerning their daughter were dealt with thoroughly and properly without having to enter the fray. That was, in reality, what they wished to achieve.

### **Does CP Have the Capacity to Make Decisions About Her Obstetric Care and Treatment, Including a Pre-Arranged Caesarean Section?**

#### Capacity: Legal Framework

24. I have been provided with a legal framework in relation to capacity which is agreed by Counsel. Having read it, I adopt it. That which follows is based upon it.

25. Firstly, I am reminded that an adult of sound mind is entitled to make decisions about his or her medical treatment, even if those decisions lead to harm or death - Lord Brandon in Re F (Mental Patient: Sterilisation) [1990] 2 AC 1.
26. One of the circumstances in which adults can have treatment imposed upon them without their consent is if the person lacks capacity under the MCA.
27. A person must be assumed to have capacity unless it is established that they lack capacity – s.1(2) MCA.
28. The burden of proof lies on the person asserting a lack of capacity and the standard of proof is the balance of probabilities – s.2(4) MCA and CC v KK [2012] EWHC 2136 (COP).
29. Determination of capacity is always ‘decision specific’, having regard to the clear structure provided by ss.1-3 of the MCA - City of York Council v C [2014] Fam. 10.
30. Determination is also time specific. Pursuant to s.2(1) MCA, 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 s.2(2) MCA. Where there may be fluctuation, capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made.
31. 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 – s.1(3) MCA. A person is not to be treated as unable to make a decision merely because they make a decision that is unwise – s.1(4) MCA and Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP). The importance of respecting autonomy, even where a person makes unwise decisions, has been recognised, e.g., in Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80.
32. Pursuant to s.3(1) MCA a person is ‘unable to make a decision for himself’ if he is unable to: (a) understand the information relevant to decision; (b) retain that information; (c) use or weigh that information as part of the process of making the decision; or (d) communicate his decision whether by talking, using sign language or any other means. An inability to undertake any one of these four aspects of the decision-making process set out in s.3(1) MCA is 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. The inability to make a decision must be caused by (‘because of’) the mental disorder satisfying the definition of s.2 MCA.
33. The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another – s.3(4)(a) MCA.
34. Within the context of s.3(1)(c) MCA, it is not necessary for a person to use and weigh every detail of the respective options available to them in order to demonstrate capacity, merely the salient factors - CC v KK (above).

My Analysis and Decision in Relation to Capacity

35. Dr B and Ms M have participated in two capacity assessments in relation to CP's capacity to make decisions about her obstetric treatment. The first on 11 December 2023 and the second on 5-6 February 2024. I accept those assessments.
36. I find that CP is suffering from a disorder of her mind, namely schizophrenia. She presents with a disorganised or hebephrenic subtype. Her current presentation remains characterised by auditory hallucinations and clear disorganisation of thoughts and behaviours. I accept Ms M's evidence that CP's intelligence is such that she is able to mask the probable continuous nature of her auditory hallucinations. CP's self-care remains poor. She experiences marked anhedonia and lacks motivation. She cannot plan for her future or the future of her baby.
37. I find that although CP is undoubtedly an intelligent woman, her capacity to make informed decisions is impacted by her disordered thinking. Her mentally disorder is such that she is unable to adequately weigh up the benefits and detriments of each obstetric treatment option, including which type of anaesthesia. She is detached from her pregnancy and the decision-making surrounding the imminent birth of her baby. CP's risk taking and impulsivity impacts on her decisions making including her decisions about her obstetric treatment. Her decision making is short term and responsive to her immediate needs rather than considered and long term. Whilst there has been improvement in her mental health since being prescribed haloperidol, the improvement is relatively mild and has not improved her decision-making capacity. There is unlikely to be a change in her capacity which will affect her capacity to make decisions about her obstetric care. Sadly, she has been experiencing symptoms consistent with schizophrenia since early/mid 2021. Even when adequately and appropriately medicated, the improvement is mild and not substantive.
38. Accordingly, I find on the evidence before me and on the balance of probabilities that CP cannot use or weigh the information that she has as part of the process of making decisions about her obstetric care, anaesthesia and ancillary care and treatment. CP is unable to make a decision for herself in relation to obstetric care, anaesthesia and ancillary care and treatment because of an impairment or disturbance in the functioning of her mind or brain.
39. Accordingly, and pursuant to s.15 MCA, I declare that CP lacks the capacity to make decisions with regard to her obstetric care, anaesthesia and ancillary care and treatment.

### **What Orders Should the Court Make in Respect of CP's Obstetric Treatment?**

#### Best Interests: Legal Framework

40. It is agreed that the following principles apply to a best interest's determination.
41. Where a person is unable to make a decision for themselves due to a lack of mental capacity there is an obligation for a decision maker (here the Court) to act or make decisions in the person's best interest – s.1(5) MCA.
42. When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence their decision if they had capacity, and to the other factors that they would be likely to consider if they were able to do so – s.4(6) MCA.



43. Account must be taken of the views of anyone engaged in caring for the person or interested in their welfare – s.4(7) MCA.
44. The provisions of ss.15-17 MCA give the court power to make decisions about personal welfare and to make declarations and orders in respect of a person who lacks capacity. Section 15 deals with declarations, including declarations as to the lawfulness or otherwise of any act which has been or is to be done. Section 16 enables the court, by making an order, to make personal welfare decisions for a person without capacity, and, by s.17, the court's power in this regard extends to giving or refusing consent to the carrying out or continuation of a treatment by a person providing health care.
45. Section 16(3) MCA provides that the court's powers under section 16 are subject to the provisions of the MCA and, in particular, to s.1 and to s.4. The court's decision about any matter concerning personal welfare is therefore determined by the person's best interests.
46. The starting point when considering best interests where life is potentially at stake is a strong presumption that it is in a person's best interests to stay alive, but this is not an absolute, and there are cases where it will not be in a person's interests to receive life sustaining treatment - *Aintree v James* [2013] UKSC 6. The principle of the right to life can be 'simply stated but of the most profound importance. It needs no further elucidation. It carries very great weight in any balancing exercise' - *W v M* [2011] EWHC 2443 (Fam). It is argued that this principle has potential application in this case given the unintended but nevertheless real life-threatening consequences for a patient of their non-compliance or aggression, if they are not appropriately managed.
47. Whether or not a person has the capacity to make decisions for themselves, he or she is entitled to the protection of the European Convention on Human Rights. In the present context, the potentially relevant rights are found in Article 2 (the right to life), Article 5 (right to liberty and security) and Article 8 (the right to respect for a private and family life).
48. Section 4 MCA requires a focus on the wishes and feelings of CP. In *Aintree* (above), Baroness Hale, giving the judgment of the court, stated:

*'[39] 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 towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be' ...*

*'[45] Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what*

*we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being'.*

49. The weight to be attributed to CP's wishes and feelings will differ depend on such matters as how clearly the wishes and feelings are evidenced, how frequently they are (or were previously) expressed, how consistent CP's views are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views).
50. In M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group [2015] EWCOP 76, Hayden J said:

*'[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. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them. Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment'.*

#### Natural Birth or Pre-Arranged C-Section?

51. I remind myself that I should only endorse the plan placed before this court if I consider that plan to be in CP's best interests. In that regard I have very properly been taken by Counsel to s.4 MCA. According to s.4(2) MCA, I must consider all the relevant circumstances of the case before coming to a decision.
52. I factor in CP's parents expressed view that CP is not good at handling pain and would find a natural delivery a very difficult experience. According to them, she becomes distressed when she has a headache.
53. I place in the balance CP's views as stated now and previously. CP has previously expressed a wish for a natural birth. However, to use Ms M's phrase, CP has only ever voiced the choice. She has never given reasons for her choice. Mr N's unchallenged evidence is that

when he spoke to her about a natural delivery, CP was unable to say why or expand on her choice or tell him what it would look like. That resonates with Ms M's evidence, which I accept, that in discussion with CP, CP showed no real understanding of the natural birth process, its likely duration or the pain associated with it.

54. Of late, CP has changed her mind. Recently, she has articulated a clear wish to have a planned Caesarean section. On 5 February 2024, CP told Ms M that she wanted a pre-arranged Caesarean section before 16 February 2024 because she could not cope with the pain of the Braxton Hicks longer than that. CP accepts that that operation has been arranged for 14 February 2024 and has told me today that that is what she wants. I accept the evidence before me from the clinicians that CP's decision is likely to be based on the discomfort she feels. It seems to me that it is not unnatural nor is it out with normal human experience for a first-time mother experiencing the realities of the process of labour to change her mind from wanting a natural birth to wanting a Caesarean section as quickly as possible. It is also not unnatural nor unreasonable to begin to experience pain and change your mind. I consider that a desire to avoid pain is a significant motivating factor for CP.
55. I accept Ms M and Mr N's evidence that CP would be unlikely to be able to cope with a normal labour of 12-16 hours duration. CP would find it traumatic and require medical intervention. The process is likely to impact negatively on CP's mental health. There is a real likelihood that medical intervention would be required in crisis and that CP would need to be restrained. I accept Ms M's evidence in this regard.
56. I also accept Ms M's evidence that there is a real risk that when taking the natural birth route that CP, like any other woman, may go into spontaneous labour. If that were to occur, she would not necessarily have the package of support around her that a planned process permits. There would be a risk of an emergency caesarean section and that simply because of its urgency is likely to be traumatic. There are also physical risks of CP not cooperating with a natural labour and the management that is needed to prevent vaginal tears and lacerations such as instrument use to facilitate delivery or interventions to prevent potential haemorrhages. Without management these are grave risks. The risks cannot be managed without the patient's cooperation. CP has a history of non-cooperation with staff.
57. Ms M's evidence is that prearranged caesarean section enables pain to be managed and the patient to be sufficiently immobilised. Because the procedure is pre-arranged, CP can have a hand-picked and experienced obstetric and mental health team around her to manage the risks and respond to her physical and mental health needs.
58. Dr B sets out the comparative impact of the two options from his perspective, namely their likely impact on her mental health. Natural birth would be painful. CP does not tolerate pain well and is likely to find it difficult to manage. She is likely to find the experience highly stressful. Natural birth will require CP to cooperate, and CP is in Dr G's opinion unlikely to follow commands; indeed, she has a history in other settings of not doing so. Failing to comply will lead to restraint and interventions performed in an emergency. Without adequate anxiolytics (especially during transfer to the acute hospital), CP is likely to try to abscond. Any such attempt would illicit a response which is likely to include restraint. Again, that is likely to increase CP's stress and anxiety. A pre-arranged C-section would have the benefit of being organised and relatively calm. CP will have her anxiolytic medication and trained staff familiar to her around her on transfer, during birth and afterwards. The process is likely to be less painful and thus less traumatic for her. This of

itself reduces the risk of non-cooperation with the delivery of her baby and reduces the risks to herself, her baby and her medical treating team of non-cooperative and risk-taking behaviours during labour.

59. In his statements to this court, Mr N very fairly sets out the advantages and disadvantages of vaginal birth and the advantages and disadvantages of a prearranged caesarean birth. The advantage of vaginal delivery is that it has the best clinical outcome for a medically low risk of primigravida. Recovery time is quicker than after a caesarean, there is no uterine or abdominal scar, there are less use of lines and thus less likelihood of wounds and infections. However, it is likely that CP will not tolerate the prolonged pain of labour over a protracted time. There is a risk she will not recognise that she is in labour, and she may delay summoning help. There is a risk she will abscond. She is unlikely to cooperate with the management of the birth and with the professionals managing it. CP has a history of non-cooperation. Calming, anxiety reducing anxiolytic medication would not be conducive to a natural birth. She may attempt to abscond and if she did, she would be restrained. All of which would have a deleterious effect on her mental health. In relation to a pre-arranged caesarean section, Mr N's evidence, accepted by all before the court, is that the procedure will take 1-2 hours. There is less risk of CP becoming distressed or moving during the procedure although despite anaesthetic she may feel movement within her abdomen. Restraint is less likely to be necessary but even if it is, it is likely to be for a shorter period than during vaginal delivery. Because this procedure will be pre-arranged there will be a seamless plan in place to transfer CP from the hospital where she is detained to the acute hospital for a procedure which will be conducted by a specialist team made up of familiar faces. Every caesarean section comes with risks, there will be intravenous, catheter, and drains which there is a risk she will move. There will be wound sites and thus an increased risk of infections. As the anaesthetic wears off there will be a risk of absconding which can be mitigated by supervision but cannot be eliminated.
60. I further factor in that the treating clinicians all consider that a pre-arranged caesarean is in CP's best interests.
61. Standing back and looking at the evidence as a whole, looking at the advantages and disadvantages of each option and having factored in all the matters I have set out above, I have decided that a planned caesarean section is in CP's best interests.

#### Type of Anaesthesia- Spinal Block or General Anaesthetic

62. A caesarean requires an anaesthesia. Logically, the next issue for me to decide is which form of anaesthesia should be used- spinal block or general anaesthetic.
63. When making that decision I factor in CP's wish to have a spinal block. Whilst she does not have capacity, her stated reason that she wishes to be present at her baby's birth is reasonable and totally natural. It is weighty.
64. I also factor in that the unanimous opinion of the clinicians in this case is that a spinal block is the least restrictive approach with fewer potential complications.
65. On the basis of the evidence before me, I make a balance sheet of the advantages and disadvantages of both options. I note Mr N's accepted evidence is that recovery from a spinal block is quicker than general anaesthetic. There is a lower risk of chest infection and

a lower risk of aspiration. A spinal block is less likely to cause sickness and vomiting. It will be quicker to return to eating and drinking following the procedure. A spinal block also has the benefit of providing good pain relief immediately after surgery meaning there is less need for post-operative pain relief and the risk of associated side-effects. However, a spinal block does require CP to keep very still when the needle is inserted into the subarachnoid space or there is a risk of a dural tap and/or permanent headaches and nerve damage. CP may experience a short sharp scratch when the injections is given. CP may find the feeling of loss of sensation in her legs bewildering. The feeling is likely to be that of pins and needles but sometimes it is a short sharp shooting pain of momentary duration measured in milliseconds. There is also a risk that the anaesthetic could be administered in the wrong place, making the spinal not effective enough to perform the Caesarean section. Tests can be performed, including a cold spay, to ensure it is effective. Other complications include bleeding potentially around the spinal column, difficulty urinating, stop in blood pressure, infection of the spine and seizures are a rare risk if the spinal block cannot be administered or is not effective, then it is agreed in the circumstances of the care plan placed before me that it will be in CP's best interests to use general anaesthetic.

66. General anaesthetic has a number of benefits, not least CP will not be able to move at all. She will have no awareness of the procedure and will not become distressed or agitated during it. She will not need to be restrained when under the anaesthetic. However, there are risks. There is a greater risk of aspiration, failed intubation and chest infections. In oral evidence Dr X explained that in CP's case, you had to factor in that she is a smoker. That leads to an increase in post-operative chest infection. There is an increased possibility she will need to go to HDU, although it is not inevitable. There is an increased risk of lung infection. She will have taken medication to calm and keep her calm when being transferred to the acute hospital and to the operating theatre. There is a risk because you do not know her metabolism and the individual effect of the sedatives on her. There is thus an increased risk that she will not be able to be managed on the maternity unit. In the longer terms, there are increased risks of lung scarring and poor respiratory recovery. Whilst the expectation is a good recovery, these are risks which need to be factored in.
67. I place in the balance that CP does not tolerate pain well and that a spinal block is likely to provide the better pain free transition into recovery than a general anaesthetic. I consider that the risks as the effects of the anaesthetic wears off are likely to include CP seeking to abscond when she cannot walk properly but those risks can be managed by appropriate supervision. CP is likely to regain mobility faster after a spinal block than a general anaesthetic. A speedier recovery will be concordant with CP's wish to move to the mother and baby unit and into an environment where she can smoke as quickly as possible.
68. Thus, having surveyed the evidential canvas, taken into account all the factors set out above and having weighed in the balance the advantages and disadvantages of the two anaesthetic options, I consider that the spinal block is in CP's best interests and accordingly I endorse that part of the care plan.
69. I am confident that the care plan that has been placed before the court for CP will be managed by experienced professionals with knowledge of CP's case and her physical and mental health needs. They will monitor her physical and mental health throughout delivery, and they have the skill and the empathy to make the decision to use general anaesthetic if it becomes necessary. For the avoidance of doubt, I thus endorse the entirety of the care plan placed before me and which is attached to this judgement.

70. That concludes my judgment.