Neutral Citation Number: [2019] EWCOP 23

Case No: COP13441755

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/06/2019

Before :

MR JUSTICE WILLIAMS

- -

Between :

NHS Trust	**Applicant**
- and -	
JP	**Respondent**
(by her litigation friend, the Official Solicitor)	

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- -

Katharine Scott for the **Applicant**
Debra Powell QC (instructed by **The Offical Solicitor**) for the **Respondent**

Hearing dates: 18th June 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MR JUSTICE WILLIAMS

This judgment was delivered in private. 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. 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.

Mr Justice Williams :

1. I am concerned with the welfare of a young woman JP, who is now 25. She is the subject of an application brought by the NHS Trust for declarations whether it is in JP's best interests to:

   i) Deliver her baby via a Caesarean section under general anaesthetic

   ii) To be transferred to hospital from her home in accordance with the transfer plan by 24th June

   iii) Not inform her of the outcome of these proceedings.

   The application arises because the NHS Trust maintains that JP does not have capacity to make decisions about her obstetric care and the delivery of her baby. The Trust are represented by Miss Scott, counsel.

2. The application was made on 31 May 2019 and Mr Justice Francis made an order on paper by consent on 6 June 2019. He timetabled the application for a hearing on 18 June 2019.

3. JP is the respondent to the application and is represented by her litigation friend The Official Solicitor, Mr Justice Francis having made declarations pursuant to section 15 and 48 of the Mental Capacity Act 2005 that there is reason to believe that JP lacked capacity to conduct the proceedings. The Official Solicitor is represented by Miss Powell, QC.

4. JP's family and the father of the baby are not respondents to the application and have not participated in these proceedings.

5. Both the Trust and Official Solicitor agree that JP lacks capacity to conduct the proceedings or to make decisions about her obstetric care and the delivery of her baby, and that it is in her best interests for the treatment to be undertaken and for the care plan to be implemented.

6. I have had the benefit of detailed position statements on behalf of the applicant NHS Trust and on behalf of the Official Solicitor. I have had the benefit of brief submissions in support of those documents and I also heard from Dr Press, a consultant anaesthetist, and Dr Sullivan, the consultant obstetrician and gynaecologist. I have been able to read various statements and reports, from her treating clinicians, and notes from meetings by the Official Solicitor. Over the course of the hearing on 18 June it became clear that the evidence as to the nature of the condition that was said to amount to the impairment of, or a disturbance in the functioning of, the mind or brain of JP lacked clarity. It emerged from the oral evidence of the consultant gynaecologist that JP was under the care of a consultant psychiatrist in the learning disabilities team who would be able to shed light on the issue. In some situations, although unsatisfactory, this would not have represented much of a difficulty and a short delay although undesirable would have had limited impact on the ground. However given that JP was close to 36 weeks pregnant and might go into labour at any moment time was of the essence. On that basis, I indicated that were the consultant psychiatrist to confirm that JP had a learning disability, the totality of the

evidence would lead me to conclude that she lacked capacity and that subject to certain amendments to the care plan it would be in her best interests for the care plan to be implemented. Time proved to be of the essence because by the morning of the 19th, I was informed that JP had indeed been taken to hospital and was believed to be in the early stages of labour. By this stage the consultant psychiatrist had indeed confirmed that JP had a mild to moderate learning disability which affected her cognitive ability. I therefore made the orders with judgment to follow.

7. I am not sure why the application was not made until 31 May by which time JP was roughly 33 weeks pregnant. The listing of the final hearing on a date between the 36th and 37th weeks of her pregnancy introduced unnecessary pressure into the process. Unless it is unavoidable because of late awareness of a pregnancy, I see no reason why it should not be possible for these applications to be issued and heard before they become time critical.

Background

8. This is set out in the position statement of the applicant and the witness statement of JP's consultant obstetrician and gynaecologist.

9. JP is 25 years old. I know little about her childhood, adolescence or the early years of her adulthood. In February 2019 the community midwife saw JP who was pregnant. She was in a relationship but at that time was living at her home with her mother and spending time at her boyfriend's family home. On 27 February she was seen in clinic and scanned which showed that she was 20 weeks +3 weeks pregnant. Her due date is 14 July 2019.

10. As will emerge from my review of the evidence later in this judgment, over the ensuing 4 months the community midwifery team, the Trust clinicians, a learning disabilities team, and local authority adult and children's social workers have been involved with JP and her pregnancy.

11. By May she had moved out of her mother's home into a supported living placement. Over the ensuing months those around JP have been seeking to support her through the pregnancy and to reach a decision as to how the delivery was to be managed. The team at the applicant Trust eventually concluded that the only safe way to manage the labour for JP was for her to have a caesarean section under general anaesthetic. This is contrary to JP's wishes; she had expressed a wish to have a natural birth. However as the Trust considered JP lacked capacity to make a decision for herself this application was issued.

The Legal Framework.

12. The Mental Capacity Act 2005 sets out the statutory scheme in respect of individuals aged over 16 who lack capacity. Section 15 gives the court the power to make Declarations as to whether a person lacks capacity to make a specified decision and the lawfulness or otherwise of any act done or to be done in relation to that person. Section 16 gives the court the power to make an order and make the decision on a person's behalf. Section 48 gives the court a discretion to make an order on an interim

basis and in particular if it is in the person's best interests to make the order without delay.

13. JP is clearly habitually resident in England and Wales and so this court has jurisdiction under the MCA.

14. Section 1 of the MCA set outs '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*

(5) an act done, or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

(6) before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the persons rights and freedom of action.

15. Section 2(1) of the Act provides that a person lacks capacity 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.*'

16. It does not matter whether the impairment or disturbance is permanent or temporary. The determination of whether a person lacks capacity to make that 'specific' decision is to be made on the balance of probabilities. Section 2 thus imposes what has been termed a 'diagnostic threshold'. 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]).

17. Section 3 sets out various criteria by which the court should determine whether a person is unable to make a decision.

(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

18. 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]).

19. Section 4 of the Act deals with '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 done 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.

20. The courts have emphasised in a variety of contexts that 'best interests' (or welfare) can be a very broad concept.

i) *Re G* (*Education*: *Religious Upbringing*) [2012] EWCA Civ 1233, 2013 1 FLR 677. Best interests must be taken in its widest sense and its evaluation will change according to developments in society. It need not be confined to the short-term but should look at the medium to long term and can take account of anything that might affect the best interests.

ii) In *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591

> *[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*

iii) *An NHS Trust v MB & Anor* [2006] EWHC 507 (Fam), Holman J:

> *That test is the best interests of the patient at this particular time. Is it in THIS patient's best interests to receive this treatment? Best interests are used in the widest sense and include every kind of consideration capable of impacting on the decision. In particular they must include the nature of the medical*

treatment in question, what it involves and its prospects of success and the short, medium and longer-term outcome, best interests goes far beyond the purely medical interests. They must also include non-exhaustively medical, emotional, social, psychological, sensory (pleasure, pain and suffering) and instinctive (the human instinct to survive) considerations.

21. It is a fact of the proposed care plan that it will involve an element of deception of JP. In NHS Trust-v-K and Ors [2012] EWCOP 2922; Re AB [2016] EWCOP 66; Re P [2018] EWCOP 10 and NHS Trust (1) and (2) -v-FG [2014] EWCOP 30 the court has confirmed that deception can be compliant with the individuals Article 8 rights provided the best interests exercise has been carried out. It seems to me that if it is in JP's best interests for deception or misrepresentation to take place then the court would be obliged to authorise that. The question of the level of deception would no doubt feed into the evaluation of whether the best interests of JP were met by the plan which involved that deception; the greater the deception the more it might potentially weigh against JP's best interest and vice versa but as a matter of principle seems to me that deception cannot be a bar to authorisation of a procedure. To hold otherwise would be to supplant the best interests of JP by some other principle, perhaps of public policy, that the court should not condone white lies.

22. Ultimately the lodestar is the best interests of the patient evaluated by reference to the provisions of the MCA 2005.

Capacity

23. The evidence as to JP's capacity to make the decision herself caused me some concern. The COP 3 'assessment of capacity' was completed by Dr O'Sullivan, the consultant obstetrician and gynaecologist. The diagnosis that was contained in the COP 3 at paragraph 7.1 was '*Microcephaly (behavioural disorder)*'. The COP 3 stated that JP was unable to make a decision in relation to care in labour and delivery for her baby and care before and after childbirth because she is unable to understand relevant information namely she does not understand the possibility of any complications or difficulty with childbirth for either herself or the baby. The COP 3 stated that she was unable to retain that information, that she was unable to use or weigh that information and that she was unable to communicate her decision by any means at all because she refuses or is unable to discuss the possibility of any complications in childbirth or the potential need for any interventions, even in the simplest format. The COP 3 confirms that the opinion is based on her own experience of JP, that JP has said she does not want a Ceasarean and that there is no prospect that JP might regain or require capacity because '*microcephaly is a condition that will not resolve. Her behaviour problems are of long duration and the stress of childbirth is likely to worsen not lessen them.*'

24. In her statement Dr Sullivan said '*JP has significant learning difficulties from microcephaly. JP also has behavioural problems*.' She said in evidence that she understood the diagnosis of microcephaly came from JP's GP records which the community midwife had access to. The statement also referred to her contacting the learning disability team to get their opinion on whether JP lacked capacity regarding her own medical treatment and care. It does not appear that a clear answer was received from them; at least if it was it is not recorded in her statement. However in her evidence Dr Sullivan referred to the fact that JP was under the care of a consultant

psychiatrist in the learning disabilities team, Dr Gomez. She gave evidence to the effect that Dr Gomez must have accepted that JP had a learning disability or he would not have accepted her as a patient under his team's care. No evidence had been filed from Dr Gomez. Dr Sullivan said that she is the lead consultant obstetrician and gynaecologist for women with mental health or learning disability and she has extensive experience of expectant mothers with learning disabilities. She said she was satisfied that JP had a learning disability and that from her discussions with her that she lacked capacity because in particular she was unable to comprehend the risks associated with vaginal delivery either to herself or to her unborn child. Being unable to comprehend the risks meant that she was unable to take an informed decision on the means by which she delivered her child. She was clear in her opinion that JP's lack of engagement in the decision-making process arose from her learning disability rather than from her simply being obstructive. She said that her lack of engagement was '*due to the combination of her limited intellect being exacerbated by her stress level and the behaviour that this brings about'.* When the complexities of childbirth are discussed she immediately disengages and becomes distressed and aggressive and thus cannot retain, weigh or communicate information or a decision.

25. Both the Trust and the Official Solicitor invited me to determine the issue of capacity on the basis of Dr Sullivan's evidence supported by some of the hospital notes including a record of a multidisciplinary team meeting that had been held on 2 May 2019. Ms Powell submitted that the microcephaly condition was in effect a red herring and that the critical issue for the purposes of the Mental Capacity Act was whether the learning disability that Dr Sullivan said JP demonstrated was sufficient to meet the section 2 MCA diagnostic criteria of '*an impairment of or a disturbance in the functioning of the mind or brain*'. I declined to do so. I consider that where an applicant Trust asserts that a patient is suffering from a condition such as microcephaly leading to a significant learning difficulty that appropriate evidence demonstrating the condition (microcephaly) and its consequences (learning disability or significant learning difficulties) is placed before the court. Whilst I would not rule out the possibility of a consultant obstetrician and gynaecologist, particularly one with the expertise of Dr Sullivan, providing the only evidence of a learning disability, it seems to me far from satisfactory in matters of such profound importance to JP for the evidence of the impairment or disturbance in the functioning of the mind or brain to come from a clinician other than a consultant psychiatrist or psychologist, particularly where it is known that JP is known to a psychiatric team. Where such evidence is likely to be available because JP is and has been under the care of a learning disabilities team for some 2 ½ years the first port of call for such information ought to be from that specialist team, preferably the lead consultant.

26. I adjourned the final decision in order to enable the Trust and the Official Solicitor to liaise with Dr Gomez to see whether he was able to file a statement which shed further light on JP's condition and its consequences.

27. The outcome of that was that Dr Gerald Gomez, a consultant psychiatrist for women with learning disabilities filed a witness statement dated 19 June 2019. His team have had involvement with JP since 27 January 2017 although Dr Gomez did not see JP himself until 5 March 2019. At this time he diagnosed JP as having a learning disability in accordance with the ICD 10 criteria. The level of the learning disability is mild to moderate. Dr Gomez observes that he had to use very simple language to JP

as she found it hard to understand normal or complex sentences. He concludes her condition is lifelong and affects her ability to make cognitive decisions. On making enquiries with JP's GP it was confirmed that she was on their learning disability register and they confirmed that JP was diagnosed with microcephaly when she was 2 years old. Dr Gomez confirms that psychological support will be provided to JP at the hospital as soon as the baby is born. He, the community nurse, and health facilitator will be there to conduct a psychiatric assessment and they will visit JP as often as is needed whilst she remains in hospital and thereafter will visit her at home when she returns to her residential unit. A consultant psychologist is also available to attend upon JP in the community. His proposed support has now been incorporated into the care plan.

28. I am satisfied on the basis of the medical evidence set out above that JP currently lacks capacity both to conduct these proceedings and to take a decision for herself on the issue of her medical treatment relating to her ante-natal care and the delivery. In particular she is unable to make a decision for herself because she does not understand the information relevant to the decision and is unable to use or weigh that information as part of the process of making the decision. The evidence from the health visitor and Dr Sullivan make it clear that many attempts have been made to convey information in a way tailored to JP's learning disability about the process of delivery and the risks attendant upon it and the options available but because of her learning disability JP has been unable to understand that information or to use or weigh it. This inability to make a decision for herself is caused by the impairment or disturbance of the functioning of her mind or brain arising from her diagnosed learning disability. The evidence of the efforts made by the health visitor, learning disability support and Dr Sullivan make clear there is no means by which she could currently be enabled to make a decision. The lack of capacity is likely to be permanent but will certainly endure until after the baby is born

The evidence as to best interests

29. I have read the witness statements of the various clinicians who have been involved in JP's anti-natal care and who will be involved in the delivery of JP's baby. The following I hope summarises the principle points of their evidence.

Dr Sullivan, consultant obstetrician and gynaecologist.

30. Dr Sullivan filed a statement dated 7 June 2019. She gave oral evidence by telephone.

    i) The Trust became aware of JP on 4 February 2019. Her due date is 14 July 2019. At a visit by the community midwife and the learning disability nurse on 13 February JP engaged for a short period of time that became emotional, agitated and defensive and made threats against her neighbours and her mother.

    ii) On 27 February 2019 Dr Sullivan saw JP at her clinic. She was accompanied by several individuals but would not talk to Dr Sullivan at all, hiding behind her boyfriend and hitting her head on an x-ray box. After further efforts JP was

able to return to the room and agreed to let Dr Sullivan take her blood. However when the equipment was obtained she then refused.

iii) Dr Sullivan contacted the learning disability team to obtain confirmation of whether JP lacked capacity.

iv) Between then and the next meeting between JP and Dr Sullivan on 24 April 2019 a number of meetings were held by Trust staff with JP. Concern was expressed that JP understood some basic information about her pregnancy but not the complexities of the same, including methods of childbirth.

v) On 24 April JP return to the antenatal clinic. Support workers managed to apply local anaesthetic cream to her arm so that she could have her blood taken without pain however JP became distressed and ripped the dressing off and rubbed the cream over her face and hair. As a result Dr Verdi an experienced anaesthetist had to attend and along with two support workers and the midwife he was able to take blood. JP was very distressed during this process.

vi) JP has been visited by a specialist midwife for women with learning disabilities and with the learning disabilities nurse. JP said she would like to push the baby out. The staff tried to explain the complexities of vaginal birth but JP did not appear to engage in the conversation.

vii) On 8 May JP was brought to the hospital's maternity triage department as she was complaining of abdominal pain. She was shouting and agitated upon arrival. She was not cooperating with staff. She allowed a short period of monitoring for the unborn child of about 20 minutes but then became distressed and began pulling the fetal monitoring wires off. She allowed a physical internal examination.

viii) On 14 May the learning disabilities midwife and the specialist nurse for learning disabilities undertook another joint visit to JP. She failed to engage and was verbally abusive.

ix) On 22 May JP attended the Trust for a scan. She was aggressive and rude. She allowed the scan to take place and appeared to be happy to see her unborn child. She would not engage in any conversation with Dr Sullivan now including over labour, burying her head in her hands, banging her hat on the table and shouting and swearing at staff. She calmed down but when Dr Sullivan attempted to speak about childbirth she again disengaged and when a caesarean section was mentioned she said she did not want to be cut open. She appeared to understand the simple outline but could not understand or explain anything beyond that. She said that as it was her baby she would do what she wanted.

x) As a result of the totality of the concerns on 24 May a team comprised of Dr Allan, the midwife, the senior midwife manager, the security manager and Dr Sullivan concluded that a planned caesarean would be in JP's best interests. JP's support worker at her residential unit agreed with this conclusion.

xi) Dr Sullivan sets out the various benefits and burdens of the forms of delivery that could be adopted for JP. She deals with induction, vaginal delivery and planned ceasarean section.

xii) Dr Sullivan is clear that an induced delivery or a natural vaginal delivery whilst having the benefits of being the least restrictive and in accordance with JP's expressed preference (amongst others) carries with it very considerable risks. Dr Sullivan considers that it is highly unlikely that JP would have a successful vaginal delivery and that to attempt it would be highly risky. The evidence suggests that JP's response to pain and distress would be to run, hide or become aggressive. If she were to seek to leave the hospital the consequences could be very serious in terms of her health; infections or haemorrhages. The process of natural childbirth would involve some degree of pain and discomfort which would be difficult to manage particularly as JP is averse to needles. An epidural would not be possible given the need for a high degree of cooperation. Gas and air has to be administered in a methodical way and in any event does not provide complete pain relief. She does not consider that JP would be able to agree to normal maternal observations to monitor her health and that of the unborn child. In the absence of such monitoring the onset of complications could not be detected placing the health of JP and the baby at risk. Likewise abdominal and vaginal examinations, and foetal monitoring. Further treatment such as intravenous antibiotics would also likely be impossible. In the event of complications JP would be likely unable to make decisions leading to delay which would place her health and that of the baby at risk. There would be an increased risk of JP requiring an emergency ceasarean section and a risk of her needing a general anaesthetic as a result of a vaginal birth.

xiii) A planned ceasarean section would allow a hand-picked team of staff to be in attendance who would be able to minimise the risk of complications arising from a caesarean section carried out under general anaesthetic. All of the risks of an induced or natural vaginal delivery would be overcome. First-time mums have a 1 in 5 chance of requiring a caesarean section in any event. Dr Sullivan acknowledges caesarean deliveries carry with them surgical risks to JP together with associated risks related to the administration of anaesthetics along with the risk of future complications. She notes that of course a caesarean would be against JP's expressed wishes and that there would be a greater need for post-operative care.

xiv) Dr Sullivan had discussed the proposal with the senior manager at JP's residential unit and she agreed that it was in JP's best interest to proceed this way.

31. Ms Homer, a specialist midwife within the vulnerable women's team has also provided a statement dated 7 June 2019. She has had direct dealings with JP on a number of occasions.

i) When she met her on 4 March 2019 together with the learning disability nurse they were unable to engage JP in a discussion about her pregnancy.

ii) At a meeting on 19 March when she was accompanied by JP support worker JP would not engage in the discussion about the birth process. She complained about the baby kicking her saying 'the bitch keeps kicking me'. She seemed happy to hear the heartbeat of the baby.

iii) She attended an initial pre-birth child protection case conference on 8 April 2019. JP was present. She did not engage during the meeting.

iv) At a meeting on 9 April when she attended to discuss emergency situations again JP did not engage in the discussion. Her boyfriend did.

v) On 24 April JP attended the antenatal clinic. She was present during the incident when JP became anxious and distressed about the taking of blood and smeared cream all over her clothes, face, and hair. Although they were able to distract her to enable the consultant anaesthetist to take blood JP still screamed with pain and it was very distressing for everybody. She called the anaesthetist a 'bastard' and said she would sue him. What should have taken 5 minutes took over an hour.

vi) On 26 April a joint visit was conducted to discuss labour options and pain relief but JP was disengaged throughout.

vii) On 8 May she saw JP when she attended the maternity triage Ward by ambulance. She would not engage with anyone although she and the residential unit worker convinced JP to allow monitoring for 15 to 20 minutes. She became agitated and pulled off the monitoring belts and walked off. She returned and allowed an examination internally.

viii) On 14 May they visited JP at her home in order to discuss giving birth. JP completely disengaged and became quite abusive. She said she would do things her way.

ix) She is quite clear that JP could not cope with the pain distress and duration of vaginal delivery.

<u>Dr Allan, consultant anaesthetist</u>

32. He has filed a witness statement dated 6 June.

i) He has met with JP on 22 May. She would not speak with him or make eye contact with him. When he was introduced to her she turned around and started punching the chair. She would not engage in any way with him and demanded to go home.

ii) If she was in that sort of mood when she went into labour it was clear she would need more than persuasion or coercion to get her to cooperate for any medical procedure.

iii) Caesarean section can be undertaken either by regional or general anaesthetic. Regional would not be safe for JP as it would require her full cooperation in order to administer an epidural type injection into her spine. This requires the patient to cooperate in particular to remain still. As JP does not like needles

and has shown she can become extremely distressed and agitated this does not appear to be a realistic option and the problems would outweigh the advantages.

iv) A gas induced general anaesthetic should be used. Intravenous access will probably not be tolerated by JP due to her dislike of needles. As she is unlikely to like a gas being delivered through a face mask some degree of physical and chemical restraint will be required. Hospital security staff are trained in providing physical restraint if necessary. The chemical restraint would be in the form of midazolam which would be covertly provided in a drink upon her arrival at hospital.

v) Gas induced general anaesthesia has an increased risk of aspiration of the stomach contents but is the only realistic option.

vi) After midazolam has been administered JP will be assessed to determine whether she was sufficiently cooperative to allow intravenous access and intravenous general anaesthetic. If not, she would be taken to theatre in a wheelchair and the gas induced general anaesthetic face mask would then be applied immediately to reduce any distress stop once the general anaesthetic took effect intravenous access would be gained and anaesthetic continued using the IV route during the Caesarean section.

vii) The risks of general anaesthetic will be present for JP. She will be monitored throughout and some of the risks appear no greater than for the general population. For JP there is a significantly increased risk of aspiration or pneumonia, seemingly arising from the gas induced general anaesthesia rather than in intravenous. There is some increased risk of dental damage.

viii) At the conclusion of the Caesarean section JP would be given a spinal anaesthetic to provide a high degree of pain relief which would assist in her dealing with the pain and post-operative distress. Spinal anaesthesia itself carries risks but these are very rare and for JP are no higher than the general population. Thereafter she would be given strong analgesic medication through a patch which would work as the spinal wore off and would continue to take effect for 3 days. She could also have other painkillers.

ix) He is of the view that the risks of general anaesthetic administered for a planned Caesarean section outweigh the potential risks that JP could be exposed to buy an emergency caesarean section. He agrees with the opinion of Dr Sullivan that JP could not cope with the pain distress and duration of a vaginal delivery.

Dr Press, consultant anaesthetist

33. Dr Press filed a statement dated 14 June. In particular he deals with issues relating to the process that would be adopted in order to secure JP's attendance at hospital. He gave evidence by telephone.

i) He was clear that it would be far preferable for the process of anaesthetising JP for the Caesarean section to be carried out in the hospital environment where

any complications could be managed immediately. Anaesthetising JP out of the hospital environment was very much something to be done as a last resort.

ii) He highlighted that sedating or anaesthetising JP for the purposes of getting her to hospital is exceptional. He said that he has experience of administering at anaesthetics outside of the hospital environment as a result of his work with the air ambulance. He has done it on numerous occasions. He has administered anaesthetics to pregnant women outside the hospital environment where they had been injured. He said that the outcome for the patient and the baby was dictated by their injuries rather than by the anaesthetic.

iii) His evidence was that administering a general anaesthetic to a pregnant woman was to be avoided where ever possible. The risks of pre- hospital sedation or anaesthesia to JP are very high. However the risks range from the minor to potentially fatal. At the lower end the administration of midazolam can marginally affect CO_2 and oxygen levels although that would potentially affect the unborn child more than the mother. It also affects the drive to breathe and the cough or gag reflex thus resulting in a higher risk of aspiration. The use of ketamine can result in hyper salivation and laryngospasm which can cause the vocal cords to shut and block the airway causing difficulty breathing. The insertion of airways can then be complicated. 2 experienced anaesthetists would therefore be present to manage these risks.

iv) He put the risks of difficulty managing JP's airways at 1% and if that risk eventuated there would be a 10%-50% risk of a serious complication involving serious desaturation of oxygen leading to hypoxic brain damage or death. His range of risk was so broad because it is such a rare course to follow.

v) He also addressed the risks associated with restraint should JP not cooperate with the process. He said there were minimal risks to JP given her age and the fact that giving birth naturally is in itself a stressful process for the body.

34. On 6 June 2019 Lauren Crowe a solicitor instructed by the official solicitor attended at JP's home in order to speak to her about the case.

i) She spoke to the senior manager at the unit in order to gain some insight into how best to approach the matter with JP.

ii) CD was not aware of JP having any formal diagnosis of a mental health condition or learning disability. She expressed the view that from what she had learnt of the situation JP may have slipped through the net. She is provided with 10 hours of one-to-one care during the day and shared supported overnight. The staff believe that she is becoming more independent.

iii) CD reported that JP has expressed a desire to have a natural birth but the health professionals have been able to make little progress with her. The worker at her housing unit has managed to have some conversations with her. The staff have not been involved in discussions with the treating clinicians as to the implementation of any care plan for her.

iv) CD reported that JP can be very aggressive and abusive and has made threats to professionals herself and her unborn child. However she has a variety of interests including music and animals.

v) Miss Crowe was unable to engage with JP who remained in bed upstairs throughout her visit. Although attempts were made to engage with JP in particular over the role that the court might have JP was abusive and said that she could do as she wanted. In general she was rude and hostile to Miss Crowe.

vi) The worker at the unit to has a good relationship with JP reported that they had spoken about the birth. JP has expressed the view that she wishes to have a natural birth with the father the paternal grandmother and a member of the housing unit staff present. JP is ambivalent about the presence of her own mother. She wants gas and air, does not want Pethidine and is considering an epidural. Although the worker has herself had Caesareans and has spoken to JP about them, JP remains petrified. She often asks what labour is like but she has not engaged to any extent in any discussions about the realities of giving birth. She does not seem to have a high pain threshold and cries hysterically and says she is in agony when the baby moves. The worker does not think that JP would ever agree to a Caesarean section or go to hospital if she knew that were planned. After Miss Crowe had left the housing unit rang to say that JP had said she did not want a Caesarean.

The proposed treatment

35. The care plan for JP's proposed treatment has been the product of input by Dr Sullivan, Dr Press, Dr Alan, Dr James, and Lin Homer. It is a detailed document. As a result of discussions during the hearing it has been supplemented to make further provision for post-operative care in particular the provision of psychological or psychiatric support for JP. The essential elements of the proposed treatment are,

i) JP will be asked to attend hospital in order to conduct monitoring in respect of the baby. This will be a pretext for the carrying out of a planned caesarean section.

ii) If JP agrees to travel to hospital for the monitoring on arrival she will be provided with a sedative, oral midazolam, contained covertly in a drink. When that takes effect she will be taken to theatre where she will be provided with a gas administered general anaesthetic. This might involve some degree of physical restraint. If JP was cooperative a general anaesthetic by IV would be considered.

iii) If JP was not willing to travel to hospital for monitoring she would be given midazolam covertly in a drink at a residential unit. If she was then cooperative she would be transferred to the hospital. If she was not cooperative she would be given an intramuscular injection of ketamine. If necessary she might be physically restrained in order to achieve her transfer to hospital. If necessary a general anaesthetic would be administered at that time in order to effect her transfer.

iv) In theatre the Caesarean section would be performed by Dr Sullivan. Dr Sullivan would follow a particular surgical procedure in closing the abdomen to reduce the risk of JP interfering with the wound and sutures.

v) Following the Caesarean section, a spinal anaesthetic would be administered. She would have support from a worker from her residential unit and would have one to one care in the delivery suite from a midwife. She would then have a strong analgesic patch for 3 days. She would be discharged back to her residential unit within 1 to 2 days. If she sought to leave an urgent standard authorisation would be sought to deprive JP of her liberty.

36. The plan envisages that JP's baby would be removed from her after birth. The local authority have convened a pre-birth child protection case conference. It seems likely that, depending on the time of day the Caesarean section takes place, that either the local authority will immediately apply for an interim care order or EPO or that police protection powers will be used. Although the evidence as to JP's attitude to the baby is not unambiguously positive it seems probable that she will experience great distress as a result of having undergone an operation against her expressed wishes and the separation from her baby. She will therefore need looking after very sensitively in the aftermath of this dramatic intervention in her life. I invited the Trust and the Official Solicitor to consider what amendments would be needed to make provision for this in the care plan for JP and that I would not approve it without such provision being made. I do though recognise that the evidence as to JP's ambivalence also gives rise to the possibility that she may react differently and unexpectedly perhaps. The care package proposed by Dr Gomez has now been incorporated into the care plan.

Evaluation

37. It is clear both from Miss Homer and from Dr Sullivan who have had the most dealings with JP that objectively a vaginal delivery is likely to be profoundly distressing for JP and extremely risky in terms of her health. The level of pain that she experiences at the movement of the baby inside her and the distress it causes her, the level of pain that she experiences with the taking of blood, her aversion to needles, her inability to cooperate with relatively standard medical procedures all mean that a vaginal delivery will probably result in serious risks to JP's health. It is also likely to lead to risks to the baby. Given the evidence as to JP's response to relatively low-level pain and stress, her reaction to the far more challenging process of giving birth might result in her either seeking to flee from the hospital, or harming herself or refusing monitoring which might lead to serious complications including haemorrhaging. It is highly likely that any attempt at normal vaginal delivery would ultimately lead to the need for sedation and probably an emergency caesarean under general anaesthetic. That would be the worst of all possible outcomes.

38. The alternative of a planned caesarean under general anaesthetic is the least worst of all of the options that exist. Whilst the plan contemplates a degree of covert administration of medication and the misleading of JP those are justified by the benefits that they would bring if successful. Albeit JP may feel tricked after the event and will no doubt be both cross and suspicious in future the deceit is justified in order to maximise the chances of her getting through the process of delivering her baby healthily. It will also maximise the chance of the baby being delivered successfully.

39. The Official Solicitor agrees that the proposed plan is in JP's best interests.

40. It appears that it is the unanimous view both of the clinicians but also JP's support workers that the proposed plan is in her best interests.

41. In so far as it has been possible to discuss matters with JP it is clear that her wish is to give birth naturally. It is clear that she wishes to retain autonomy over what happens and her body. Those are very important factors.

42. Section 4(6) requires that in evaluating 'best interests' I consider past and present wishes, beliefs and values that would be likely to influence JP's decision if he or she had capacity and the other factors she would be likely to consider if she or she were able to do so. The evidence demonstrates that JP does not tolerate pain well and welcomes intervention which reduces pain. She appears to believe that gas and air will eliminate the pain of childbirth. Regrettably that is likely to be an erroneous belief. It is more likely that JP would experience considerable pain, discomfort and distress from the process of childbirth. This is in part a natural physical consequence but the emotional distress that she might experience will in my view be all the greater because she does not understand truly what will be happening to her. If she were able to understand the great physical and emotional toll that giving birth naturally can give rise to it seems likely that she would wish for an intervention that would minimise or eradicate that pain. Were she to have capacity I conclude that she would, along with many other expectant mothers, opt for an elective caesarean probably under general anaesthetic.

43. The following matters weigh against the approval of the proposed treatment plan:

    i) It is against JP's expressed wishes. She is likely to experience distress, distrust, anger, frustration at both the deception that may be necessary and the carrying out of a surgical procedure against her will in respect of such a profoundly important matter. This is likely to be all the greater because it is proposed that the baby will be removed from her care.

    ii) It appears likely to be against the expressed wishes of some family members close to her, including the putative father of the baby.

    iii) There are risks associated with the administration of general anaesthetic in the hospital environment.

    iv) There are far higher risks associated with the administration of anaesthetics outside the hospital environment if that became necessary.

44. Taking a broad approach to the factors which bear upon JP's best interests I am satisfied that it is in her best interests overall to approve the proposed treatment plan. The risks attendant upon an attempted vaginal delivery are so high that they plainly outweigh the risks linked to the proposed treatment plan. The other disadvantages to JP of approving the proposed treatment plan are not such as to outweigh the overall medical advantages to her of approving it. The reality is that this is a case where the proposed treatment plan is the least worst option. There is no ideal solution.

Conclusion

45. The evidence demonstrates that JP lacks capacity to make decisions as to her antenatal care and the delivery of her baby. That lack of capacity arises from a learning disability which renders JP unable to make a decision because she is unable to understand the information relevant to the decision and to use or weigh that information as part of a process of making a decision. The overall balance in the evaluation of JP's best interests is thus in favour of the proposed treatment plan provided it is supplemented to address the psychological or psychiatric consequences of giving birth in this way.

46. I therefore declare that it is in JP's best interests to undergo a planned caesarean and the proposed transfer and proposed postnatal care plan.

47. That is my judgment.

Post Script

48. As presaged in paragraph 6 of this judgment, before it was finalised I received the happy news that JP has indeed gone into labour, I believe on the 19 June, and had delivered her baby without the care plan I had authorised being implemented. Thus JP, against my evaluation of the probabilities, was able to give birth to her baby naturally. The capacity for individuals to confound judges' assessments is a reminder (to me at least) of the gap between probability and actuality.

49. I hope JP and the baby are well.