Neutral Citation Number: [2023] EWCOP 5

Case No: 14026236

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/02/2023

Before:

THE HONOURABLE MR JUSTICE MACDONALD

- -

Between:

North Bristol NHS Trust **Applicant**

- and -

R
(By her Litigation Friend, the Official Solicitor)
Respondent

- -
- -

Mr Vikram Sachdeva KC (instructed by **The Trust**) for the **Applicant**
Mr David Lawson (instructed by **The Official Solicitor**) for the **Respondent**

Hearing dates: 15 December 2022

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Approved Judgment

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

Mr Justice MacDonald:

INTRODUCTION

1. This is an application by North Bristol NHS Trust (hereafter "the Trust") for declarations that R lacks capacity to decide whether or not her unborn baby should be delivered pre-term by elective Caesarean section and that an elective Caesarean section at 34 weeks is in her best interests. R has been told of the hearing, but does not wish to participate. She is represented through the Official Solicitor by Mr David Lawson of counsel. The applicant Trust is represented by Mr Vikram Sachdeva of King's Counsel.

2. The Trust submits that R lacks capacity to make decisions concerning the delivery of her unborn child. The Trust further submits that, in circumstances where clinical observations suggest progressive placental dysfunction, if R's baby remains *in utero* to term there is a significant risk that the baby will die or suffer brain damage and that it is in R's best interests for an elective Caesarean to be performed in order to avoid the risk of R having to deliver a dead or severely damaged child and the adverse psychological impact consequent thereon. The application comes before this court in the urgent applications list having been issued on Thursday 12 December 2022. On 14 December 2022 I made a transparency order in the standard terms.

3. This case is unusual in that R has not expressed an objection to giving birth by way of Caesarean section. However, the medical team caring for R are concerned that there is a risk that she may ultimately refuse the Caesarean in the same way as she has intermittently refused foetal monitoring, resulting in her physical and/or mental heath being compromised through damage to, or the death of her baby. The evidence in respect of the prior question of R's capacity is, likewise, not straightforward. Although the most recent assessments provide clear evidence of incapacity there has been one capacity assessment, completed on 10 November 2022, that found R had capacity with respect to decisions concerning delivery of her unborn child.

4. In deciding this matter I have had the benefit of reading the court bundle and hearing oral evidence from Dr Naomi Jobson, Consultant Obstetrician, Dr Katherine Nickell, Consultant Anaesthetist and Dr Shilpa Zacharia, Consultant Psychiatrist. I have also had the benefit of the careful written and oral submissions of Mr Sachdeva and Mr Lawson. Given the urgency of the procedure planned by the Trust, at the end of the hearing I gave my decision with reasons to follow. I now set out my reasons for making the orders that I announced at the conclusion of the hearing.

BACKGROUND

5. R was born on 20 March 1990 and is now aged 32 years old. At present, R is a serving prisoner, following a conviction for an unspecified offence of violence. It is thought that R also has a conviction for being drunk and disorderly. She is a failed asylum seeker. R's mother, JM, resides in this jurisdiction but R has strenuously objected to contact being made with her mother and those wishes have been complied with. Neither the Trust nor the Official Solicitor sought to revisit this decision pursuant to s. 4(7) of the Mental Capacity Act 2005. During earlier involvement with medical services in 2011 with respect to the birth of her first child, R appears to have provided her mother's details as next of kin. The documents in the bundle suggest

that R may have been violent towards her mother, resulting in the police being called. Cardiff City Council, in whose area R resided for a time, has confirmed that it had no adult social services involvement with R. There have been consistent reports that R has been street homeless and further information from Cardiff City Council states that the mother has on occasion been located at the property of a registered sex offender. Beyond these sparse matters, very little else is known about the R's wider social circumstances.

6. The mother has two other children, both of whom were removed from her care prior to 2017, one to adoption and one to placement with her mother under a Special Guardianship Order. The medical records available in relation to R suggest that her first pregnancy in 2011 was unplanned and that R was unsure about keeping the baby. At that time, R appeared to be staying with an Aunt. The medical records available with respect to her pregnancy in 2011 do not suggest a concern on the part of doctors with regard to R's capacity as it related to mode of delivery. The records further evidence R discussing analgesia and electing an epidural after discussion of options for analgesia. R's first child was delivered normally following labour.

7. R's pregnancy in 2017 appears to have been reported to doctors as a "late booking" and is described in the medical notes as "unexpected". R is recorded as wishing to undergo a termination but not being certain how to go about that. The notes recording that fact, dated 30 March 2017, also record a concern about R's "affect" and potential mental health difficulties. On 10 April 2017, the medical records noted that R "Seems to have substantial MH disorder" and recorded a need to "discuss foster / adoption at this stage." Later in the notes for this pregnancy it is recorded that at this point R's first child was in the care of her mother and the unborn child was due to be made the subject of a Child Protection Plan on birth. R did not this time give her mother as next of kin. She was recorded as declining consent to peri-natal mental health treatment.

8. At the end of May 2017, R was noted as still needing a mental health referral, following a number of failed appointments. An entry for 24 May 2017 records that R had at that point consented to a psychiatric review. Whilst it would appear that R's mental health was worse in 2017 than in 2011, the medical notes that are available with respect to her 2017 pregnancy do not record concerns regarding R's capacity to make decisions with respect to mode of delivery. On 30 March 2017, R's notes record that R "has capacity" although it is not clear precisely to which decision or decisions that conclusion relates. There was at that time a further recommendation for a referral to the Perinatal Mental Health Team. During the course of her labour with the second child, R is recorded as having at points refused cardiotocography (CTG) to monitor foetal heartbeat. The second child was delivered normally following labour.

9. With respect to her current pregnancy, little is known about the circumstances in which R became pregnant. The prison has raised concerns as to the possibility of the pregnancy resulting from sexual exploitation and there is some suggestion in the papers that R has been involved in prostitution. However, there is no cogent evidence against which to evaluate these assertions. On 11 July 2022, R was asked by a Clinical Practitioner in prison whether she wished to continue with her pregnancy. The Clinical Practitioner recorded a concern that R may not understand her decision in this regard.

10. R was admitted to hospital on 4 November 2022 with a growth restricted baby but with normal liquor volume and dopplers. It was not felt that the baby's condition was at that point so concerning as to necessitate delivery for presumed foetal compromise, but R was administered steroids in preparation for a potential pre-term delivery. Whilst an in-patient on the ward R was the subject of regular scans and CTG to monitor foetal heartbeat, which R co-operated with approximately fifty percent of the time. The scans indicated continued foetal growth restriction and low liquor levels, supporting a diagnosis of placental insufficiency. During her oral evidence, Dr Jobson described the growth restriction as "undeniable". R was not proactively monitoring her baby, nor communicating whether the baby was moving.

11. R's psychiatric presentation has variously been described as "perplexing", "unusual" and "baffling". As I have noted, whilst pregnant with her second child, the medical notes suggest that R was labouring under significant mental health difficulties. With respect to the remainder of R's psychiatric history, it would appear that she was detained under the Mental Health Act 1983 at least twice in 2018. The information from Cardiff City Council records that R was invited for a screening assessment to ascertain whether she had a learning disability when aged 28, but failed to attend appointments on 18 April 2018 and 8 May 2018. However, the prison records indicate that in November 2018 a "risk assessment" was completed that indicated R did not meet the criteria for the Learning Disability team to work with her. The documents before the court also relate that when R's mother was involved in 2018, she suggested R had coped well at school and presented differently in early years, there being a dramatic change in R's ability and presentation in her later teenage years.

12. R may also have been detained under the Mental Health Act 1983 in August 2020. At that time, it would appear that R was prescribed with Aripiprazole, an anti-psychotic. This was recorded as not changing R's presentation and so was discontinued. Previous IQ tests have resulted in R demonstrating a full scale IQ of between 58 and 61.

13. Whilst in prison, R has been under psychiatric and peri-natal care. The clinicians responsible for R's care in prison did not consider that she presented with an acute mental illness and postulated that her presentation was, rather, due to cognitive impairment or was neurodevelopmental in nature. Within this context, they considered that R presented as having a learning difficulty. The prison regarded R's presentation as unusual and felt that her lack of engagement made it harder to reach a view on the genesis and nature of her difficulties:

> "Her presentation has, and continues to be unusual and baffling. She presents as perplexed, engagement is minimal with anyone who tries to engage with her and her answers to questions are mostly 'yes', 'no' or 'don't know'. There are times when [R] has become brittle and inexplicably irritable in her manner and this appears to be when being asked about certain things, or spending too much time with her."

14. The overall view of the prison mental health team with respect to R's capacity regarding her pregnancy and mode of delivery, expressed to the hospital before 4 November 2022, was that the mother probably lacked capacity to make decisions about the welfare of herself and her baby:

> "Throughout the pregnancy, [R] does not appear to have engaged with the unborn and has not engaged in any discussions about the pregnancy. At times she has denied being pregnant and we have queried whether she fully understands and is aware of the pregnancy, however it is very difficult to ascertain a firm view of this due to her lack of engagement with us… In view of [R] not engaging with any discussion about the pregnancy / unborn and seeming very disconnected, inconsistent engagement with the midwife and not self-reporting anything about the pregnancy (even when asked directly), our feeling is that [R] does not have capacity to make informed decisions around the well-being of herself and her baby. However, making a judgement on her capacity is obviously decision and time focused."

15. On 7 November 2022, the mother underwent a further capacity assessment undertaken in hospital. That capacity assessment concluded that R lacked capacity to make decisions in relation to her pregnancy and, in the event that one was required due to foetal compromise, in relation to delivery by way of Caesarean section. At this point, the growth trajectory of the baby caused clinicians to consider there was an increasing risk of foetal compromise. At a Best Interests Meeting on 8 November the treating clinicians considered that R should be provided with support by the Learning Disability Team to assist her in decision making with respect to mode of delivery.

16. On 10 November 2022, a further capacity assessment undertaken by Dr Q reached a different conclusion with respect to R's capacity to make decisions in relation to her pregnancy and, if necessary, a Caesarean section. Dr Q's original capacity assessment is recorded in the briefest of terms. It is not at all clear from that document what relevant information was conveyed and which questions Dr Q asked and which were posed by R. The assessment gives few details as to the basis it was considered the functional test under the Mental Capacity Act 2005 was not made out, with no formulation with regard to the diagnostic test under the 2005 Act. In his original report, Dr Q concluded that R had the "capacity to understand" that she is pregnant, that her baby needs monitoring and that, if the baby became unwell, she would need a Caesarean section. As noted by the Official Solicitor, the formulation "capacity to understand" used in Dr Q's original report is not, as an overall conclusion, readily amenable to interrogation by reference to the terms of the Mental Capacity Act 2005.

17. The court now has a further email from Dr Q dated 13 December 2022, obtained after the issue of proceedings and expanding on his conclusions. The analysis contained in that email is retrospective in nature and provided only after clarification was requested. Dr Q relates that information concerning Caesarean section was conveyed to R using easy to read leaflets R was noted by Dr Q to be able to state, in relation to a Caesarean section, there would be "a line in her tummy" and it would cause pain. When asked what would "come out of her tummy" the mother replied, "well, a new born baby of course". Dr Q further considered that the mother could answer "complex maths questions around money" and noted she used the words epidural and Caesarean even though simpler words had been used to convey those concepts to her. Within this context, Dr Q set out the following, as I have noted retrospective, conclusions in his email, which conclusion he states was also reached by the Learning Disability Liaison Nurse who accompanied him when assessing R:

> "In my opinion [R] has the ability and capacity to consent to caesarean section and she was able to retain and understand that information. She was

> able to ask relevant questions. She was able to make decisions weighing the benefits and risks involved with the procedure. She was able to understand the procedure and she asked relevant questions such as issues with pain, operative procedure leading to open abdomen and how it will be managed. She also asked if this procedure will be done by professionals and at the hospital. She was able to understand and retain information. She was able to weigh the benefits and risks of the procedure, she is currently in agreement for obstetricians to perform a caesarean section if required."

18. Dr Zacharia voiced concerns regarding the conclusions reached by Dr Q. In particular, she was concerned that R's presentation was so starkly different on 10 November 2022 to that experienced by *all* other professionals and clinicians who have dealt with her and/or assessed her capacity. By comparison to her own capacity assessment undertaken on 12 December 2022, Dr Zacharia told the court that she was simply unable to recognise the presentation of R described in the assessment of Dr Q, so far was it from her own experience and those of her treating team. In addition, Dr Zacharia also queried whether Dr Q was entitled to sign the assessment off as a Consultant Psychiatrist in circumstances where would not appear to have a completion certificate and is not a member of the Royal College. The email of 13 December 2022 is signed by Dr Q simply as a "locum consultant". In circumstances where I have not heard from Dr Q I make no further comment in respect of this latter reservation of Dr Zacharia's.

19. On 30 November 2022, a further brief capacity assessment was carried out on R with respect to her capacity to undergo CTG to monitor foetal heart beat. This concluded that R lacked capacity in relation to CTG in circumstances where she was assessed as being unable to give consistent responses, and was not able to retain information on this topic. In the context of the question of capacity with respect to mode of delivery, I note that during this capacity assessment R *denied* that she was, in fact, pregnant. On this occasion, R refused to comply with CTG and a foetal heart beat could not be confirmed.

20. A professionals meeting took place on 1 December 2022. It was noted at the meeting that in order to meet the formal criteria for a learning disability (as distinct from a learning difficulty) it would be necessary for R to be assessed by a standardised assessment and that this would be hard to do in circumstances where there was a lack of reliable information for R, including no reliable information concerning her early years. Within this context, the overall tenor of the meeting was that R did not present with a major mental illness, that trauma was likely part of her presentation and that R tended to present with a learning difficulty rather than a learning disability.

21. On 7 December 2022, following further concerns regarding the ability of R to understand and retain information concerning the mode of delivery of her baby, Dr Stephen O'Brien, a consultant obstetrician, undertook a further capacity assessment of R. Dr O'Brien concluded that R lacked capacity to make decisions concerning whether to undergo a Caesarean section. The Caesarean procedure was discussed with R with the aid of photographs and visual aids. R was not able to retain or repeat the information conveyed during the conversation with Dr O'Brien via speech, written communication or by way of reference to the pictures. R did not think that cutting open her stomach would cause her pain and was not able to identify what would come out of her "tummy". At the end of the exchange, R could not recall any aspect of

what had been discussed and explained with the aid of visual prompts. Dr O'Brien concluded that R was not able to understand the information given to her, retain the information in her mind or weigh the information as part of a decision making process about what she would want to happen. It was concluded that R lacked capacity to make a decision as to how and when her baby should be born.

22. A further capacity assessment has been provided this morning dated 12 December 2022, undertaken by Dr Zacharia. Dr Zacharia reports that when R is given information about a Caesarean section she could not repeat back a good part of what was said to her. On this occasion, R also denied having ever been in labour before. Dr Zacharia concluded that R is not able to understand the information and retain that information long enough to use or weigh that information as part of the process of making a decision.

23. On same day as Dr Zacharia undertook her capacity assessment, I note that of her own volition R told the representative from the Official Solicitor that she was due to have a Caesarean and when asked how she felt about it, said "It's alright, I don't mind" and later "It will go alright, if anything you know – yeah – see how it goes". R could not however, remember the earlier pictures used by clinicians to explain the Caesarean section that the representative was asking about and denied ever having had a natural birth. R did ask the midwife how they would "stitch it back up" and when the midwife replied "with a needle and special thread" R said "OK, we can do that – yeah definitely". At the end of the conversation the representative said to R "I will tell the judge what she has told me, and that she has told me that she is happy to have the Caesarean section, how does that sound?" and R replied "It sounds very well to me".

24. Having regard to the foregoing matters, in her evidence to this court Dr Zacharia was clear that whilst on occasion R may be able to understand the information conveyed to her regarding the decision at issue, she is often unable to retain that information and more often unable to demonstrate that she can weigh up information and communicate a decision.

25. Dr Zacharia conceded that the question of impairment for the purposes of s. 2(1) of the 2005 Act is more complex in this case. In her first statement to the court, Dr Zacharia concluded as follows with respect to the question of whether R suffers from an impairment of, or a disturbance in the functioning of, the mind or brain:

> "[11] There is no clear evidence that [R] has a severe or enduring mental health illness that impairs her capacity. However, after many assessments with multiple teams, it is felt that the most likely factors contributing to her ability to make a decision about her pregnancy would be neurodevelopmental cognitive impairment and past trauma. In terms of past trauma, we are not clear of all of [R]'s history but I understand she is a refugee. She is vulnerable and been in vulnerable positions. The circumstances of her pregnancy are also unknown. [R] appears to be detached from the situation and it is likely that the previous traumas [R] has suffered, and previous pregnancies experienced with babies taken away might contribute to her lack of engagement, detachment and ultimately capacity. There is no clear test to demonstrate this is what is impairing her capacity but in the absence of any mental health illness, I have come to the same conclusion as the prison mental health team, that [R] is possibly

> remaining detached from the situation at present, which amounts to cognitive impairment at the material time."

26. Dr Zacharia went somewhat further in respect of the question of the diagnostic test in her second statement. After a number of meetings with R, Dr Zacharia has concluded that R has a mild learning disability. She states as follows in this regard:

> "7. Learning disability is a diagnosis. After a number of meetings now, I have concluded that [R] has mild learning disability. Dr Q only met [R] once and, looking at the evidence in the round, I disagree with his assessment. I have also considered Dr Q's reflections on the assessment dated 13 December 2022 [Exhibit SZ1].
>
> 8. In my opinion there is more to [R's] presentation than trauma alone. Whilst she does not present with post traumatic stress disorder, she is unable to describe or discuss any experience in words. I suspect that inability to discuss past trauma is attributable to the learning disability. I have discussed this with her Prison Consultant Psychiatrist and her previous LD psychologist in Swansea during an MDT and we all came to the same conclusion."

27. Dr Zacharia expanded on her reasoning in oral evidence. She stated that having a good grasp of language does not exclude a diagnosis of learning disability. She conceded that she did not know as much about R's forensic history as she would wish, including the essential element of R's childhood history and that her presentation is "baffling and unusual". Dr Zacharia further conceded that this introduced significant diagnostic uncertainty and prevents a *formal* diagnosis of learning disability. However, Dr Zacharia maintained her view that, on the *totality* of the information available about R, the presence of a mild learning disability is the correct formulation in respect of R, which mild learning disability constitutes an impairment of the mind. Dr Zacharia further considered that trauma is likely also affecting R's functioning and plays a part in the disengagement and dissociation that she demonstrates.

28. A second best interests meeting took place on 8 December 2022. This decided that a Caesarean was required, probably on 14 December 2022 and in any event by 16 December 2022. With respect to the question of best interests, Dr Jobson was clear in her evidence that she now considers that *only* a Caesarean section is consistent with recommended safe obstetric practice in this case. Dr Jobson points to the NICE guidelines recommending Caesarean section to all women with foetal growth restriction and confirmed foetal compromise (see NICE guidance NG207 1.2.23). In this context, Dr Jobson noted that R has had continual deterioration in growth of her baby from 28 weeks and that her abdominal circumference now well below the 5th centile, indicating a growth restricted, oligohydramniotic pregnancy.

29. Dr Jobson acknowledged that in the context of these proceedings, it is the best interests of R, and not the best interests of the unborn child, that concern the court at this hearing. As to the balance of risks to R of the various modes of delivery (spontaneous labour, induced labour and Caesarean section) Dr Jobson provides in her statement an evaluation of the benefits of the various options available to R, albeit that as I have noted, Dr Jobson was clear in her view that only a Caesarean section is consistent with recommended safe obstetric practice in this case.

30. With respect to an elective Caesarean, Dr Jobson considers this is the best option for ensuring the birth of a healthy pre-term baby and is the most predictable option, being capable of being performed at a defined time and location for R and will not require pre-birth intimate examinations of R. As to risks that attach to an elective Caesarean section, the risks attached to the anaesthetic are at the same level for any pregnant woman, there will be discomfort from the wound for up to six weeks, a risk of bleeding at a slightly higher level of risk than that of a vaginal birth and a risk of further surgery, including hysterectomy, to control bleeding. In addition, there is a risk of infection, of thromboembolism, a tear in the uterus in future pregnancies and death (1 in 12,000 compared to 1 in 10,000 for vaginal birth).

31. With respect to awaiting a spontaneous birth, the benefits are a reduction (but not negation) of risks associated with anaesthetic and surgery and in the potential complications for future pregnancies. The risks in this case of awaiting spontaneous delivery are perineal injury and of still birth or brain injury to the baby and the associated traumatic impact on R in having to deliver a deceased foetus. In such circumstances there is a greater risk of inter-uterine infection if birth of the deceased foetus is delayed. There is also an increased risk of the need for an emergency Caesarean section, which itself caries an increased level of risk in relation to that procedure. In the context of her growth restricted, oligohydramniotic pregnancy Dr Jobson considers R to be at a much high risk of an emergency Caesarean section than other women were she to go into labour, either by induction or spontaneously.

32. Finally, with respect to the option of induced labour, Dr Jobson relates that the benefits are control over the timing of R's delivery with the associated ability to prepare her, less chance of brain damage to the foetus and of stillbirth, though at a higher risk than for an elective Caesarean section. There is also a reduced risk of the difficulties associated with the anaesthesia and surgery associated with a Caesarean section. Once again, there is also an increased risk of the need for an emergency Caesarean section, to which risk R is particularly susceptible in light of her growth-restricted, oligohydramniotic pregnancy. Having also been present at this assessment, in oral evidence Dr Jobson told the court that, with respect to the option of moving to a Caesarean section after labour had commenced and if required in an emergency, she considered it extremely unlikely that R would be able to make a capacitous decision about undergoing a Caesarean section in such circumstances.

33. As I have noted, Dr Jobson was careful to acknowledge that, in these proceedings, it is the best interests of R, and not the best interests of the unborn child. In this context, Dr Jobson further stated as follows in her written evidence regarding the benefits to R of an elective Caesarean section:

> "There is no evidence that surgery (Caesarean Section (CS)) is better for [R's] physical health. A vaginal delivery is "safer" for her physically as the indication for CS is for foetal wellbeing, not maternal complications. A CS in this case is in [R's] best interests because otherwise she may have to deliver a dead baby which would surely impact her mental health. Delivery of a stillborn baby can also be more difficult - lack of foetal tone requires a greater degree of maternal effort in the 2nd stage of labour (pushing stage), increasing the chance of requiring forceps for delivery. If the baby were healthy, we would be recommending a term vaginal delivery, an induction

> would be considered for her mental health only if it was felt control over timing of delivery was beneficial to her."

34. In her oral evidence, Dr Jobson expanded on her statement. She considered that whilst the risk of an elective Caesarean section must be weighed, should the baby die due to ongoing placental insufficiency before term, R would have to deliver a dead baby. Dr Jobson reiterated that this would be an extremely traumatic experience for R and a situation that would be "very bad for her". Dr Jobson considered that in this context, whilst a vaginal birth is the result of the best interests analysis if looked at from a purely physical perspective, having regard to both R's physical and emotional wellbeing, given the appreciable risk of the baby dying before labour occurs spontaneously or is induced and the consequent need for R to deliver a dead child, an elective Caesarean section is in R's best interests.

35. Within the foregoing context, Dr Jobson gave evidence that the treating team have sought to discuss an elective Caesarean with R (but not the other options in circumstances where they do not now constitute safe obstetric practice in R's circumstances having regard to the NICE guideline) on multiple occasions. So far as the treating team are aware, R has never said she does not want a Caesarean section. She has not expressed fear of surgery or comments about pain or scarring. In her statement, Dr Jobson summarises these exchanges as follows:

> "[An elective Caesarean] has been discussed with [R] on multiple occasions by different members of staff (myself, Stephen O'Brien, Sharon Cohen, other consultant obstetricians) as this has always been the most likely recommendation for her with this early growth restriction, and she has on some occasions verbalised an agreement to this course of action. She has also shown some preference for having a live, healthy baby. This has been deduced from her showing occasional interest in the baby such as asking for scan photos and wanting baby clothes. She has also spoken about going to see the baby from time to time. She has on occasion verbalised some understanding of what Caesarean section is (cutting open her tummy to deliver the baby) and that she would consent to this. However, her recent formal MCA assessment has clearly illustrated that we cannot determine [R]'s preferences with any certainty."

36. Dr Nickell, consultant anaesthetist, gave evidence that if a Caesarean section takes place a spinal anaesthesia should be used. This would involve an intrathecal injection of a local anaesthetic and opioid to provide neuraxial anaesthesia to enable an "awake Caesarean". In her statement, she describes the process as follows:

> "[11] If R agrees to Caesarean section on the day, my recommendation is to proceed with anaesthesia in line with her wishes, either spinal or general anaesthetic. Spinal anaesthetic would be preferable in terms of overall risk profile in term pregnancy, for post operative pain relief and in the context of R's Covid status. If R agrees to proceed with spinal anaesthesia and becomes distressed by administration of the spinal or the process of the Caesarean section, I suggest initially titrating a sedative agent to achieve conscious sedation. If this is not tolerated, I would proceed to general anaesthesia."

37. With respect to R's views concerning anaesthesia, when Dr Nickell spoke to R about spinal anaesthesia R did not appear to understand the simple explanation of spinal anaesthesia and was unable to repeat back any details to Dr Nickell. In relation to general anaesthesia, R did not appear to understand the initial explanation and could not repeat back to Dr Nickell any details of the process of general anaesthesia. In relation to the option of spinal anaesthesia she replied "Yes, definitely" at one point, although it is unclear to which of Dr Nickell's statements that response related. In relation to the option of general anaesthesia R said "No" when I asked if she had had a general anaesthetic before. She said "Yes" when I asked if she would prefer to be awake for her Caesarean section. During her oral evidence, Dr Nickell said of these exchanges that, "I would say she was assenting but would not say it was consent. She nodded her head but when asked her to repeat what we discussed, she said no I don't know."

38. As I have noted, the application was issued by the Trust on 12 December 2022. The Official Solicitor criticises the applicant for what she contends has been undue delay in making the application in circumstances where consideration was given to pre-term delivery almost immediately following R's admission on 4 November 2022, with an elective Caesarean being likely. The Trust refutes any suggestion of undue delay, pointing to the significant diagnostic uncertainty with respect to R's presentation and the evidence of Dr Q on 10 November 2022 that R had capacity with respect to decisions concerning her pregnancy. The Official Solicitor did not actively pursue the criticisms at the hearing.

LAW

39. The law that the court must apply in this difficult situation is well settled. A capacitous individual is entitled to decide whether or not to accept medical treatment. However, pursuant to the Mental Capacity Act 2005 s. 15(1), the court may make declarations as to whether a person has or lacks capacity to make a decision specified in the declaration, may make declarations as to whether a person has or lacks capacity to make decisions on such matters as are described in the declaration and may make declarations as to the lawfulness of any act done, or yet to be done in relation to that person. Within this context, 'act' includes an omission or course of conduct (Mental Capacity Act 2005 s. 15(2)).

Capacity

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

> **1 The principles**
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

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

…/

2 People who lack capacity

(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

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

(3) A lack of capacity cannot be established merely by reference to—

(a) a person's age or appearance, or

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

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

…/

3 Inability to make decisions

(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—

(a) to understand the information relevant to the decision,

(b) to retain that information,

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

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

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

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

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

(a) deciding one way or another, or

(b) failing to make the decision.

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

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

ii) Determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by ss 1 to 3 of the Act (see *PC v City of York Council* [2014] 2 WLR 1 at [35]). Thus, capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally;

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

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

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

vi) Pursuant to s. 3(1) of the 2005 Act a person is "unable to make a decision for himself" for the purposes of s.2(1) of the Act if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or

weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means.

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

viii) The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s. 3(4)(a));

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

42. With respect to the information relevant to the decision in this case, the Official Solicitor relies on the decision of Cobb J in *Re DD* [2014] EWCOP 11 to define what are described by Mr Lawson as the "pieces of information" relevant to the decision on mode of delivery. In *Re DD*, Cobb J considered that in relation to a decision concerning delivery, a prospective mother would need to be able to understand, retain and weigh the information relevant to (a) ante-natal care and monitoring, including blood tests to check for anaemia and diabetes; urine tests to check for infections; the benefits of discussion with health services about delivery options: (b) ante-natal monitoring of the foetus; the value of an ultra-sound imaging; (c) mode of delivery of the baby, including vaginal delivery, and caesarean section; (d) natural and/or induced labour; (e) anaesthesia and pain relief (f) place of delivery and the risks and benefits of each option; (g) the risk of complications, arising from conditions relevant to the mother or the baby; and (h) post-natal care of mother and baby. As recognised by Cobb J in *Re DD*, each case will be fact specific and there may be other relevant information that falls to be considered and weighed.

43. The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in *A Local Authority v JB* [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the Mental Capacity Act 2005, the court must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in *Re DD*, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so,

whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.

44. As can be seen from the background set out above, a difficulty in this case has been in identifying whether R is suffering from an impairment of, or a disturbance, in the functioning of the mind or brain. In particular, in circumstances where those who have assessed R are (with the possible exception of Dr Q) agreed that her presentation suggests that the functioning of her mind is impaired, but where they have not been able to arrive at any *formal* diagnosis for a presentation variously described as "unusual" and "baffling", this case has given rise to the question of whether a formal diagnosis in respect of R is necessary in order for the terms of s.2(1) of the 2005 Act to be satisfied.

45. On behalf of the Trust, Mr Sachdeva submitted that a formal diagnosis is not required for the purposes of s. 2(1) of the Act. On behalf of the Official Solicitor, and citing the decision of Williams J in *NHS Trust v JP* [2019] COPLR 298 at [25], in his Skeleton Argument Mr Lawson argued that, in identifying the impairment of the functioning of the mind or brain under s.2(1), the court *must identify* the underlying condition. During his oral submissions, Mr Lawson moderated his position on behalf of the Official Solicitor somewhat and did not seek to contend that a formal diagnosis is required for the purposes of s.2(1) of the Act. In any event, it is plain that the judgment of Williams J in *NHS Trust v JP* at [25] is not authority for the proposition that in identifying the impairment of the functioning of the mind or brain under s.2(1) the court must identify the underlying condition. All that Williams J is saying in that paragraph is that the evidence concerning the question of an impairment in the functioning of the mind or brain must come from a suitably qualified witness, Williams J having been faced in *NHS Trust v JP* with evidence concerning a learning disability being given by a consultant obstetrician and gynaecologist.

46. In *A Local Authority v JB* at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is *because of* an impairment of, or a disturbance, in the functioning of the mind or brain.

47. Once the case is before the court, the overall assessment of capacity under the single test is a matter for the judgment of the court (see *Re SB (A Patient: Capacity to Consent to Termination)* [2013] EWHC 1417 (COP) at [38]). In this context, the question of whether any inability of R to make a decision in relation to the matter in issue is *because of* an impairment of, or a disturbance in, the functioning of the mind or brain is a question of fact for the *court* to answer based on the evidence before it. In this context, the wording of s.2(1) itself does not require a formal diagnosis before

the court can be satisfied that whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain. The words "impairment of, or a disturbance in" are not further defined elsewhere in the Act. In these circumstances, there is no basis for interpreting the statutory language as requiring the words "impairment of, or disturbance in" to be tied to a specific diagnosis. Indeed, it would be undesirable to do so. To introduce such a requirement would constrain the application of the Act to an undesirable degree, having regard to the complexity of the mind and brain, to the range of factors that may act to impair their functioning and, most importantly, to the intricacies of the causal nexus between a lack of ability to take a decision and the impairment in question. In *PC v City of York Council* McFarlane LJ (as he then was) cautioned against using s.2(1) as a means "simply to collect the mental health element" of the test for capacity and thereby risk a loss or prominence of the requirement of a causative nexus created by the words "because of" in s.2(1). Reading s.2(1) as requiring a formal diagnosis would in my judgment significantly increase that risk.

48. In the foregoing circumstances, a formal diagnosis may constitute powerful evidence informing the answer to the second cardinal element of the single test of capacity, namely whether any inability of R to make a decision in relation to the matter in issue is *because of* an impairment of, or a disturbance, in the functioning of the mind or brain. However, I am satisfied that the court is not precluded from reaching a conclusion on that question in the absence of a formal diagnosis or, to address Mr Lawson's original proposition, in the absence of the court being able to formulate precisely the underlying condition or conditions. The question for the court remains whether, on the evidence available to it, the inability to make a decision in relation to the matter is because of an impairment of, or a disturbance in the functioning of, the mind or brain.

49. I am reinforced in this conclusion by the observations of the Vice President in *Pennine Acute Hospitals Trust v TM* [2021] COPLR 472 at [37] that "precise pathology is not required" in order to establish a causal link between an impairment of the mind or brain and the functional elements of s.3 of the 2005 Act:

> "It is clear therefore that there are a number of identified pathologies which separately or in combination are likely to explain the disturbance or functioning in TM's mind or brain. It might well have been possible to be more precise if TM had been able to cooperate with the MRI scan. It is a misunderstanding of section 3 MCA 2005 to read it as requiring the identification of a precise causal link when there are various, entirely viable causes. Insistence on identifying the precise pathology as necessary to establish the causal link is misconceived. Such an approach strikes me as inconsistent with the philosophy of the MCA 2005. What is clear, on the evidence, is that the Trust has established an impairment of mind or brain and that has, in light of the consequences I have identified, rebutted the presumption of capacity."

Best Interests

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

4 Best interests

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—

(a) the person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

(b) anyone engaged in caring for the person or interested in his welfare,

(c) any donee of a lasting power of attorney granted by the person, and

(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—

(a) are exercisable under a lasting power of attorney, or

(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) "Relevant circumstances" are those—

(a) of which the person making the determination is aware, and

(b) which it would be reasonable to regard as relevant.

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

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

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

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

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

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

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

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

53. The court must also, so far as reasonably practicable, permit and encourage R to participate, or to improve her ability to participate, as fully as possible in any decision affecting her (Mental Capacity Act 2005 s. 4(4)). As I have noted, R is aware of the hearing but did not wish to participate in it.

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

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

DISCUSSION

56. Having regard to the evidence before the court, I am satisfied that R lacks capacity to make decisions about the mode of delivery of her unborn baby. Further, I am satisfied that it is in R's best interests for this court to grant the order sought by the Trust declaring it lawful for the Trust to perform an elective Caesarean section on R. My reasons for so deciding are as follows.

Capacity

57. There are four questions for the court to answer when deciding if R has capacity. First, what is the "matter", i.e. what is the decision that R has to make. Second, what is the information relevant to that decision. Third, is R unable to make a decision on the matter. Fourth, if R is unable to make a decision on the matter, is that inability caused by a disturbance in the functioning of her mind or brain.

58. In this case, I am satisfied that the matter requiring decision by R is whether or not her baby should be delivered pre-term by means of an elective Caesarean section. In his Skeleton Argument on behalf of the Official Solicitor Mr Lawson formulated the matter for decision in considerably wider terms, namely "whether to carry her baby to the point of natural childbirth or to have the baby delivered earlier and, if so, whether to do so by induction or Caesarean section." In this context, in his Skeleton Argument on behalf of the Official Solicitor Mr Lawson complained that the clinicians had not put to R what he contended were all of the options. However, on the evidence available to the court from Dr Jobson it is clear that only an elective Caesarean section would now be consistent with recommended safe obstetric practice having regard to R's condition, the NICE guidelines recommending Caesarean section to all women with foetal growth restriction and confirmed foetal compromise (see NICE guidance NG207 1.2.23).

59. In this context, in circumstances where R has had continual deterioration in growth of her baby from 28 weeks and that her abdominal circumference now well below the 5th centile, indicating a growth restricted, oligohydramniotic pregnancy, the decision R is being asked to make is whether or not to undergo the procedure clinically indicated in those circumstances. This does *not* mean that the option of carrying the baby to term followed by labour either induced or natural is irrelevant. But in light of the fact that R's treating team can now offer for decision only one clinically safe course, it is relevant as information to be retained, understood, weighed or used when deciding the matter, rather than as part of the proper formulation of the matter to be decided.

60. Having identified what I consider to be the correct formulation of the matter requiring decision, I turn to the task of identifying the information relevant to the decision of whether or not her baby should be delivered pre-term by elective Caesarean section. This latter task must be undertaken by reference to the specific facts of this case.

61. Human decision making is not standardised and formulaic in nature in that we do not, at least consciously, break a decision down carefully into discrete component parts before taking that decision. In addition, decisions are always taken in a context, with the concomitant potential for a myriad of other factors, beyond the core elements of the decision, to influence the decision being taken. This has the potential to make the

task of creating a definitive account of the information relevant to a particular decision a challenging one. This difficulty can be addressed however, by acknowledging that in order to demonstrate capacity, a person is not required or expected to consider every last piece of information in order to make a decision about the matter, but rather to have the broad, general understanding of the kind that is expected from the population at large (see *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP) at [25]). Within this context, the Mental Capacity Act Code of Practice at [4.16] states relevant information includes "the nature of the decision", "the reason why the decision is needed" and "the likely effects of deciding one way or another, or making no decision at all".

62. In the foregoing context, in my judgment the information relevant to the decision on the matter in this case can usefully be derived from the questions that might reasonably be anticipated upon a member of the population at large being told that their doctor is recommending an elective Caesarean section and being asked whether or not they consent to that course. Namely, why do you want to do a Caesarean section, what are the alternatives, what will happen when it is done, is it safe for me, is it safe for my unborn child, how long will I take to recover and what will happen if I decide not to do it. Within this context, I am satisfied information relevant to the matter requiring decision by R in this case can be articulated as follows:

    i) The reason why an elective Caesarean section is being proposed, including that it is the clinically recommended option in R's circumstances.

    ii) What the procedure for an elective Caesarean involves, including where it will be performed and by whom; its duration, the extent of the incision; the levels of discomfort during and after the procedure; the availability of, effectiveness of and risks of anaesthesia and pain relief; and the length and completeness of recovery.

    iii) The benefits and risks (including the risk of complications arising out of the procedure) to R of an elective Caesarean section.

    iv) The benefits and risks to R's unborn child of an elective Caesarean section.

    v) The benefits and risks to R of choosing instead to carry the baby to term followed by natural or induced labour.

    vi) The benefits and risks to R's unborn baby of carrying the baby to term followed by natural or induced labour.

63. As will be noted, in respect of the information relevant to the decision, I consider that that relevant information *will* include some information concerning the impact on her unborn child of R taking or not taking a decision on the matter. R's unborn child has no separate legal identity until he or she is born. That position was confirmed in *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276, in which Sir George Baker held that a foetus cannot, in English law have a right of its own at least until it is born and has a separate existence from its mother, an approached affirmed by the ECtHR in *Paton v United Kingdom* (1981) 3 EHRR 408 in the context of Art 2 of the ECHR. But that legal position does not prevent the impact on the unborn child of taking or not taking a decision being information relevant to the matter requiring

decision. Indeed, I consider it a safe assumption that one of the foremost pieces of information a pregnant woman would consider relevant in deciding whether to undergo any medical procedure during pregnancy is that of the potential impact on her unborn child. On the evidence of Dr Jobson, in this case R has shown some preference for having a live, healthy baby, as inferred from her showing occasional interest in the baby by asking for scan photos, wanting baby clothes and speaking about going to see the baby from time to time.

64. I turn next to the third question, namely whether R is unable to make a decision on whether or not her baby should be delivered pre-term by elective Caesarean section. Pursuant to s.3(1) of the 2005 Act, this requires consideration of whether R is able to understand, retain and use or weigh that the relevant information I have identified above and to communicate her decision. At the conclusion of the evidence, both the Trust and the Official Solicitor submitted that R is not able to do so.

65. There is some difficulty in this case in establishing the extent to which the relevant information was conveyed to R. This stems from the relative brevity of each of the documents recording the outcome of the various capacity assessments that have been undertaken on R. During the course of her oral evidence, Dr Zacharia noted, "we are not good at writing capacity verbatim" and that, especially where professionals differ, it would be very helpful to have more detail. I agree with those sentiments. Given the number of capacity assessments that are required to be carried out on a daily basis in multiple arenas, it would obviously be too onerous to require a highly detailed analysis in the document in which the capacity decision is recorded. However, a careful and succinct account of the formulation of the matter to be decided and the formulation of the relevant information in respect of that matter, together with a careful and concise account of how the relevant information was conveyed and with what result, would seem to me to be the minimum that is required.

66. Notwithstanding these difficulties, what is clear on the evidence is that during the capacity assessment undertaken by Dr O'Brien on 7 December 2022, and following information being given to R about a Caesarean section in a manner designed to facilitate her decision making by way of photographs and simple visual aids, R was not able to retain that information. Indeed, at the end of the exchange, R could not recall *any* aspect of the information that had been conveyed to her regarding the Caesarean section.

67. Five days later, on 12 December 2022, and having conveyed the relevant information to R, Dr Zacharia reported that again R did not retain that information in that she could not repeat back any of the information that had been conveyed to her. It is also apparent from the account of the conversation between R and the representative of the Official Solicitor later on 12 December 2022 that R had virtually no recollection of the earlier information conveyed by her clinicians regarding the Caesarean section, albeit R did ask a question about the stitching of her wound. During this exchange occasion, R denied ever having been in labour, even though she had been twice in the past (during the capacity assessment with respect to CTG on 30 November 2022, R had even denied being pregnant). Dr Nickell encountered similar difficulties when seeking to discuss with R anaesthesia for the purposes of a Caesarean section. R did not appear to understand the simple explanation of spinal anaesthesia and was unable to repeat back any details to Dr Nickell. Likewise, in relation to general anaesthesia,

R did not appear to understand the initial explanation and could not repeat back to Dr Nickell any details of the process of general anaesthesia.

68. Having regard to the foregoing evidence, I accept the evidence of Dr Zacharia that whilst on occasion R may be able to understand in a limited way the information conveyed to her regarding the matter on which a decision is required (as demonstrated, for example, by R being able to verbalise to Dr Jobson that a Caesarean section is cutting open her tummy to deliver the baby), she is unable to retain that information for long enough to be able to use or weigh the information and communicate a decision and, in the circumstances, is unable to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section.

69. In the foregoing circumstances, I am satisfied that R is unable to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section. In these circumstances, I turn to the fourth and final question informing the decision as to capacity, namely whether R's inability to decide whether or not her baby should be delivered pre-term by elective Caesarean section is because of an impairment to the functioning of her mind or brain.

70. There is no dispute in this case that R labours under a learning *difficulty*. R has a full scale IQ of between 58 and 61. The evidence before the court, from both the mental health team and Dr Zacharia is that R's functioning is also adversely affected by past trauma, comprising the removal of her children following her past pregnancies, apparent family conflict with her mother and her history of homelessness and possible involvement in prostitution. Dr Zacharia considered that this may be leading R also to dissociate from her current situation to avoid further trauma. From the sparse history that is available, including medical notes from R's previous two pregnancies, R appears also to have suffered from what were described as significant mental health difficulties at least as early as 2017. In those records, there is reference to referrals being made in relation to assessment for learning disability, albeit it would appear those referrals did not lead to a diagnosis of such or intervention.

71. As I have noted, in circumstances where NICE guidelines specify that learning disability are defined by three core criteria, namely lower intellectual ability (usually defined as an IQ of less than 70), significant impairment of social or adaptive functioning and onset in childhood, a formal diagnosis of learning difficulty has not been made in respect of R. However, Dr Zacharia considers that having regard to the evidence that is available, her assessments of R and the multidisciplinary discussions that have taken place in respect of R's presentation, that on the balance of probabilities R has a learning disability. That evidence was not the subject of challenge. Dr Zacharia further considers that this that amounts to an impairment that disables R from being able to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section, by preventing her from retaining information long enough to use and weigh it to make a decision. Dr Zacharia also considered that, in circumstances where is an element of dissociation due to past trauma, R may also be at times choosing not to retain the information. In circumstances where a formal diagnosis is not required for the purposes of s.2(1) of the 2005 Act for the reasons I have explained, I am satisfied that Dr Zacharia's evidence demonstrates that R's inability to decide whether or not her baby should be delivered pre-term by elective Caesarean section is because of an impairment to the functioning of her mind or brain.

72. Having regard to the matters set out above I am satisfied that R lacks capacity to decide whether or not her baby should be delivered pre-term by elective Caesarean section in circumstances where she is unable to make that decision and that inability is by reason of an impairment in the functioning of her mind or brain.

73. I acknowledge that the court does have before it a capacity assessment from Dr Q that reached the opposite conclusion as at 10 November 2022. However, two further capacity assessments have been concluded since that date in relation to the matter in issue, on 7 December 2022 and 12 December 2022, which are more proximate in time to the decision of the court and conclude that R lacks capacity (and which are consistent with the capacity assessment undertaken on 7 November 2022 that came to the same conclusion). In addition, it is not clear from the contemporaneous record of the capacity assessment undertaken on 10 November 2022 that the correct test was considered, the assessment referring to "capacity to understand". Whilst the email of 13 December 2022 contains an analysis more closely referenced to the test provided by the 2005 Act, that analysis is retrospective, was delivered over a month after the assessment and following a request for clarification and reaches a starkly different conclusion to each of the other capacity assessments performed between 7 November 2022 and 12 December 2022. In these circumstances, I do not consider it would be appropriate to place determinative forensic weight on the single assessment indicating capacity undertaken by Dr Q on 10 November 2022.

Best Interests

74. In circumstances where I am satisfied that the mother lacks capacity to make decisions concerning her obstetric care as I have described above, this court has jurisdiction under the 2005 Act to determine what course is in the mother's best interests and to make declarations accordingly.

75. As noted earlier in the judgment, in assessing best interests in this matter, it is R's best interests that are the subject of the court's jurisdiction. In a case in which the decision taken as to mode of delivery may impact on the health of the unborn child, there is an obvious temptation for the best interests decision to factor in also the health and welfare for the unborn child. However, that temptation must be avoided in circumstances where this court has no jurisdiction over an unborn child for the reasons explained in in *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276 and affirmed by the ECtHR in *Paton v United Kingdom* (1981) 3 EHRR 408. The best interests that fall for consideration in circumstances where R lacks capacity to decide whether or not her baby should be delivered pre-term by elective Caesarean section are those of R alone.

76. Within the foregoing context, the best interests analysis is complicated by the fact that in terms of the *physical* health and safety of R, the evidence before the court is that an elective Caesarean is not necessary to ensure R's physical health and safety. Whilst in this case natural birth is not without risk (there being in particular a greater risk of intrauterine infection if the baby died and birth of the deceased foetus were to be delayed and an increased risk of the need for an emergency Caesarean section in the context of the oligohydramniotic pregnancy) the evidence before the court is that it cannot be said that an elective Caesarean is better for R's physical health than a natural birth. Further, a natural birth would itself avoid the risks attached to anaesthesia, discomfort from the wound, a risk of bleeding at a slightly higher level

than that of a vaginal birth and a risk of further surgery, including hysterectomy. Notwithstanding this position however, I am satisfied that an elective Caesarean section is in R's best interests.

77. As I have noted above, in her first statement Dr Jobson articulated the distinction between the physical safety of R and her emotional wellbeing in the context of which mode of delivery:

> "[2] There is no evidence that surgery (Caesarean Section (CS)) is better for [R's] physical health. A vaginal delivery is "safer" for her physically as the indication for CS is for foetal wellbeing, not maternal complications. A CS in this case is in [R's] best interests because otherwise she may have to deliver a dead baby which would surely impact her mental health. Delivery of a stillborn baby can also be more difficult - lack of foetal tone requires a greater degree of maternal effort in the 2nd stage of labour (pushing stage), increasing the chance of requiring forceps for delivery. If the baby were healthy, we would be recommending a term vaginal delivery, an induction would be considered for her mental health only if it was felt control over timing of delivery was beneficial to her."

78. During her oral evidence, Dr Jobson reiterated her considerable concern that, should R's baby die due to ongoing placental insufficiency before term, R would have to deliver a dead baby. Dr Jobson considered that this would be an extremely traumatic experience for R and a situation that would "very bad for her". Dr Jobson was of the clear view that in such circumstances, whilst a natural birth is the result produced by the best interests analysis if looked at from a purely *physical* perspective for R, having regard to both R's physical *and* psychological wellbeing, given the appreciable risk of the baby dying before labour occurs spontaneously or is induced and the consequent need for R to deliver a dead child, an elective Caesarean section is R's best interests rather than natural birth associated with a far greater risk of traumatic impact on R from having to deliver a deceased foetus. Within this context, during the multi-disciplinary Best Interests Meeting R's midwife had also articulated the same point:

> "SC: Yes, I agree. I think in terms of the benefits for her long-term health, a vaginal birth would be best, but the reality of the situation is that that is very unlikely to happen with a live baby. In view of the opinion that she would want a live baby the elective caesarean would be able to be managed and be the least distressing out of all those options."

79. Whilst this court has no jurisdiction to consider the best interests of the unborn child, the impact on *R* of any adverse impact on the unborn child of taking or not taking the decision *is* a legitimate factor to be taken into account when assessing R's best interests. In *Guys and St Thomas NHS Foundation Trust & Anor v R* [2020] EWCOP 4 the Vice President observed as follows:

> "[63] The caselaw has emphasised the right of a capacitous woman, in these circumstances, to behave in a way which many might regard as unreasonable or "morally repugnant", to use Butler-Sloss LJ's phrase. This includes the right to jeopardise the life and welfare of her foetus. When the Court has the responsibility for taking the decision, I do not consider it has the same latitude. It should not sanction that which it objectively considers

> to be contrary to P's best interests. The statute prohibits this by its specific insistence on 'reasonable belief' as to where P's best interests truly lie. It is important that respect for P's autonomy remains in focus but it will rarely be the case, in my judgement, that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus. In this case it may be that R's instincts and intuitive understanding of her own body (which it must be emphasised were entirely correct) led to her strenuous insistence on a natural birth. Notwithstanding the paucity of information available, I note that there is nothing at all to suggest that R was motivated by anything other than an honest belief that this was best for both her and her baby. It is to be distinguished, for example, from those circumstances where intervention is resisted on religious or ethical grounds. In the circumstances therefore, it seems reasonable to conclude that R would wish for a safe birth and a healthy baby."

80. In this case, evidence is clear that mother has suffered a continual deterioration in foetal growth from 28 weeks with an abdominal circumference now well below the 5th centile, reduced liquor volume from 32 weeks and unknown foetal movements. The obstetric evidence is that, in the context of a natural birth, there is a significant risk that the unborn child will die or suffer severe brain damage. Were this risk to manifest to its maximum extent, the mother would be required to deliver a dead child. Whilst in her conversation with the representative of the Official Solicitor, R did at one point state when asked about the baby "no, even if it is dead it has nothing to do with me", as I have recounted there is also evidence that R wishes to give birth to a live, healthy child, inferred from her showing occasional interest in the baby, such as asking for scan photos and wanting baby clothes, and speaking about going to see the baby. The same may be inferred from the fact that, whilst I am satisfied that she does not have capacity to consent, R has not objected to date to an elective Caesarean. In any event, the court cannot ignore the fact that being required to give birth a dead child is an obviously traumatic experience, one that must count as among the most traumatic that a person may be required to endure. Dr Jobson's evidence is that the traumatic nature of such an event risks being further increased in R's by the need to utilise forceps to in order to deliver the dead child.

81. Within the foregoing context, I accept the evidence of Dr Jobson that, were an elective Caesarean not to be performed and her unborn child died, delivering that dead child would likely be an extremely traumatic experience for R. This is particularly so when the evidence of Dr Zacharia regarding the impact of trauma past on R is recalled. In the context of Dr Jobson's concerns regarding the impact of R of having to deliver a dead child, Dr Zacharia pointed out R has lost her previous two children to the care of others. As I have noted Dr Zacharia considers that trauma to be an element of R's current lack of capacity. The assessment of best interests is a holistic exercise in which the court must examine R's welfare in the widest sense, not just medical but social and psychological. In the circumstances, whilst satisfied that a natural birth is the end result of a best interests analysis narrowly focused on R's *physical* health and safety, when both R's physical *and* psychological welfare a accounted for a different result emerges. Given what I am satisfied is the would be the extremely traumatic experience for R of having to give birth to a dead child should the appreciable risk of the baby dying before natural or induced labour can occur

become manifest, I am satisfied on balance that an elective Caesarean section is in R's best interests.

82. I am further reinforced in my view that an elective Caesarean is in R's best interests by the, albeit limited, views she has expressed in respect of the same. Whilst I am satisfied that R does not have capacity to consent to an elective Caesarean section, it is relevant that she has never expressed an objection to such a procedure when it has been discussed with her. Lack of objection is not assent. However, I consider that this is nonetheless a further factor providing support for the court's conclusion as to best interests. As does the preference R has shown, on occasion for giving birth to a live, health baby.

83. For these reasons, on balance I accept the submission of the Trust and the Official Solicitor that it is in R's best interests to undergo an elective Caesarean section. The procedure will be carried out using spinal anaesthesia, with the option of chemical sedation if required, but no physical restraint.

CONCLUSION

84. As I have had cause to observe in another urgent case of this nature that came before me in the week I dealt with this matter, for the court to authorise a planned Caesarean section is a very serious interference in a woman's personal autonomy and Art 8 rights. As the Vice President noted in in *Guys and St Thomas NHS Foundation Trust & Anor v R*, Caesarean sections present particular challenges in circumstances where both the inviolability of a woman's body and her right to take decisions relating to her unborn child are facets of her fundamental freedoms. Against, this Parliament has conferred a jurisdiction on this court to authorise medical treatment where a person lacks capacity to decide whether to undergo that medical treatment and where the medical treatment is in the person's best interests. I am satisfied it is appropriate to exercise that jurisdiction in this case, for the reasons I have given.

85. In the circumstances, I make a declaration that R lacks capacity to decide whether or not her baby should be delivered pre-term by means of an elective Caesarean section. I further declare that it is lawful, being in R's best interests, for the Trust to perform an elective Caesarean operation on R in accordance with the care plan.

86. That is my judgment.

POSTSCRIPT

87. The court was informed the day after the hearing that R had undergone an elective Caesarean section in accordance with the care plan, which proceeded smoothly. R's baby was born in good condition and is doing well for his gestation.