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Case No: 13835352

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10th November 2021

Before :

DEPUTY HIGH COURT JUDGE, MISS KATIE GOLLOP QC

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Between :

NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	**Applicant**
- and -	
SR	**Respondent**

- -
- -

Ms Debra Powell QC (instructed by Capsticks Solicitors) for the **Applicant**

Hearing date: 7th October 2021

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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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DEPUTY HIGH COURT JUDGE MS KATIE GOLLOP QC

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 children 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.

Deputy High Court Judge, Miss Katie Gollop QC :

1. At an urgent hearing on the morning of Thursday 21 October I made declarations relating to SR's medical treatment. They will take effect if, and only if, she loses the capacity she had at the time of the hearing to make those decisions for herself. I indicated that I would provide a written judgment and this I now do.

Introduction

2. SR is in her mid-thirties, single, about 36 weeks pregnant with a due date of 9 November 2021, and this will be her first birth. She has been under the midwifery and obstetric care of the applicant NHS Trust, and under the psychiatric care of a neighbouring mental health NHS Trust, since around June 2021. From the outset, she has had a strong desire to have a caesarean delivery, and an equally strong desire to avoid a vaginal delivery. The applicant Trust agrees that a caesarean is the best and safest option for her. Together, the applicant and SR have agreed that on the morning of Monday 25 October, she will come to the hospital for a surgical delivery.

3. SR is assessed by her midwives, obstetrician and psychiatrist to have capacity to make this and all birth related decisions. At the same time, there is a concern that she might lose that capacity on or before the 25 October. Accordingly, on Monday 18 October, the applicant issued an application for what is known as contingent or anticipatory relief. I will use the terms interchangeably.

Evidence

4. I was provided with a psychiatric report made jointly by two treating psychiatrists, one of whom is Dr B from whom I heard oral evidence. I had a statement, also made jointly, by SR's two treating midwives one of whom is HM, and I heard oral evidence from her. Finally, I heard briefly from Ms L, a consultant midwife and the applicant's Clinical Lead for Perinatal Health.

5. On Tuesday 19 October, SR saw her midwife who told her about today's hearing and offered her the court documents. SR was very clear that she did not want them and did not want to attend: she said that she trusted her midwives to do what was best. As the applicant had assessed SR as having capacity to litigate this application, the Official Solicitor was not notified of the application nor invited to represent SR. No family member attended the hearing.

SR

6. I have taken what follows about SR's background and current situation from the psychiatric report and midwifery statement. To say that SR's formative years were turbulent and damaging is an understatement. As a primary school aged child, she suffered the trauma of a very serious sexual assault perpetrated by her father's friend. Her mother died of cancer when she was 11 years old. She lived with extended family for a time but could not settle and moved in with her father. He was a drug dealer who set no boundaries and provided little care. He is currently serving a prison sentence for the murder of the man who sexually assaulted SR.

7. She has consistently misused drugs since her early twenties and at around the age of 26 years, she was diagnosed with paranoid schizophrenia. That condition was well controlled by long lasting injections of anti psychotic medication but in 2020, SR declined them and without treatment, her mental health deteriorated. From around December 2020 to April 2021 she was missing from her home in supported accommodation and she conceived during that time.

8. In the course of her pregnancy, SR was reunited with her extended family and this has been a wholly positive development. Her grandmother, aunts and sisters are all supportive of her. Various family members have accompanied her to ante-natal appointments, and she has named two of them as her birth partners. It is her family who will be bringing her to hospital on Monday morning, if all goes to plan.

9. On 21 September, SR attended at hospital for a scan and consultation with her consultant obstetrician accompanied by family members. There was a discussion about mode and timing of delivery. As she had done before, SR expressed an acute fear of dying in childbirth regardless of mode of delivery, and a fear of pushing the baby out. Offered the choice of vaginal and surgical delivery, she was very clear that she wanted a caesarean.

10. There was a discussion about risks, including the risks posed by her drug taking. Those are that were she to go into labour when under their influence, SR might not recognise what was happening so that there could be a delay in her seeking medical help. Further, she might not seek help in an emergency. Foreseeable emergencies include placental abruption, antepartum haemorrhage, rupture of membranes leading to the risk of infection, and pre-eclampsia. This last risk is heightened by SR's use of crack cocaine which can narrow arteries and increase blood pressure. SR, her doctors, and family were all in agreement at this consultation that a caesarean was the safest option for her. She was clear that this mode of delivery was what she wanted.

11. SR was seen in hospital on 26 September with bleeding but left before she could be assessed. Police brought her back to the hospital the next day and she agreed to staff listening to the fetal heart rate but declined any further examination. From this point, the midwives noticed a change in SR. She began staying out overnight and no-one knew where she was. Her capacity to comprehend information became intermittent. She was fixated on getting drugs and unable to think about anything else. Her fears about dying in childbirth increased.

12. There was a psychiatric home visit on 27 September but SR did not wish to be assessed and appeared agitated, avoidant and distracted. There was evidence of bleeding and she was advised to go to hospital but did not wish to do so and she left the property. At a midwifery home visit on 29 September, there was no evidence of bleeding and no physical abnormality detected but SR's thoughts were dominated by drugs. She explained that she did not go to hospital when she had bleeding in order to avoid being admitted – she wanted to be free to come and go and smoke crack as she pleased. At this point, in discussion with Ms L, the midwives escalated the situation to the legal department. They also increased the frequency of home visits (which, being hospital based, they would not normally undertake) to once a fortnight. That was deemed necessary in view of the fact that crack cocaine use increases some of the risks set out above.

13. On 30 September SR attended hospital in the context of threatened action under the Mental Health Act 1983 if she did not. Though her condition appeared stable, she struggled to stay still long enough for a meaningful CTG trace to be obtained. She removed the equipment and left the building impulsively.

14. There was a further scan and consultant review on 5 October. SR again, as she had many times before, talked about an overwhelming terror of dying in childbirth and a desire to have a caesarean as a means of avoiding death. On 8 October there was a home visit to complete a birth plan. SR was distracted and it took twenty minutes before she was able to sit down and engage with a conversation about her treatment. The midwives explained about anaesthesia for the caesarean. She said she would prefer a spinal block (which would require her to sit still for 10-15 minutes) to a general anaesthetic. Her reasons were that a spinal block would allow her to be awake throughout, and remaining awake and aware would make her feel more in control and safer. She was given information about the legal process and said that she wanted to be involved in it. SR was uninterested in any further conversation, left and did not return.

Evidence From The Consultant Psychiatrist

15. Dr B said that SR suffers from schizoaffective disorder (F25) and mental and behavioural disorders due to multiple drug use and other psychoactive substances (F199) which conditions interact. He had specifically considered and rejected a diagnosis of tokophobia (extreme fear of giving birth). In his formulation, her fears about dying in childbirth were partly a natural response to an objectively anxiety inducing situation, and partly reflective of SR's general inability to cope with distress, that being a reason why she self-medicates with drugs.

16. SR was open with him about her substance misuse. She reported spending about £20 per day on heroin and around £130 a day on crack cocaine. That level of drug taking appeared to have been fairly constant over time and she reported funding it by prostitution.

17. He thought her mental capacity had been less and less affected by drugs since she started taking depot medication. However, getting and taking drugs was still the most pressing and important thing for SR, and it took precedence over her physical health. If the choice was between going to an obstetric appointment and obtaining drugs, she would prioritise the latter. A desire for crack cocaine was a particular driver. At the assessment on Tuesday 19 October, SR told him that her benefits were paid into her account on Monday nights and that she usually used the money to binge on drugs on Tuesdays. She was focussed on finding out from him whether, if she had the baby on Monday as planned, she would be able to leave hospital the next day so she could buy drugs as usual.

18. Dr B last assessed SR's mental capacity on Tuesday 19 October. He did so remotely in a consultation lasting around half an hour. It was his view that at that time she had capacity to make the relevant decisions. He said that in the three months he had been treating her, this was probably the best he had ever seen her. She sat still for about twenty minutes when previously that would not have been possible. She was more kempt than she had been, and she looked physically healthier.

19. He said that six weeks ago, SR had been recommenced on depot injections of an anti-psychotic medication and is prescribed another such medication by daily tablet, which she takes about five days in every seven, together with methadone daily. In his view, this regime had brought about a marked improvement in her mental health and a much more stable presentation.

20. As to the risk of a future loss of capacity, whilst in his report (dated 12 October 2021) he was clear that SR's capacity probably fluctuated depending on recency of substance misuse, his oral evidence was rather different. He was sceptical about the concept that either drug use or withdrawal created a risk that she might lose capacity to make decisions about medical care at the time of birth. He said that methadone is a long acting drug and the effect of cocaine lasts only a few minutes. He could see, but struggled with, the possibility that between now and Monday morning she might use extra drugs and lose capacity in that way. He conceded it was "*technically possible that might happen*" but was clearly unconvinced.

21. Dr B told me that he was not qualified to answer SR's questions about obstetric risks and could only speak to her mental health. Though there had been multi-disciplinary discussions, he had not seen any of her midwifery or obstetric records. He said that sharing of records between the Trusts providing psychiatric and obstetric care was not usual practice. He also said that to date, SR's capacity has not been jointly assessed by an obstetrician or midwife, and a mental health professional.

Evidence From The Midwife

22. HM told me that she and her colleague last saw SR shortly after Dr B's assessment on 19 October. She agreed with him that SR seemed well and stable on that occasion. However, she told me that SR had presented very differently earlier in the month. On 5 October SR had come to A&E unannounced suffering from drug withdrawal. HM and her colleague were called and took her to a safe place. Her eyes were rolling in her head, she was thought disordered, fixated on obtaining Diazepam, unable to focus on anything else, and was in "*an awful, awful state*". HM said that if she were to present in that way on 25 October, it would be very difficult to get her into theatre. That was not least because when in that state, SR was fearful of lying down or being physically restricted in any way.

23. HM said that SR had been in a similar condition during home visits which was why they could take up to 90 minutes. It was her view that because some of the drugs SR takes are short acting, SR is constantly "*chasing the feeling again – she just wants to go out and get more and she doesn't see anything else*". When in this state, the midwives find that SR is unable to understand why various observations and checks are necessary, unable to process or retain the information they are giving her about her pregnancy and birth, and unable to communicate her wishes, feelings or any decisions because she is desperate to leave to get drugs. She described SR when presenting this way as having "*tunnel vision*".

24. Finally, Ms L, consultant midwife, explained the birth plan. On arrival at hospital, a capacity assessment will be made by a mental health and obstetric professional jointly. The operating theatre, and the time of the midwives and obstetrician SR knows and

trusts, have been blocked out for the whole morning so there will be no pressure of time. A stepwise approach to promote relaxation has been set out to maximise the chance of SR being safely delivered using a spinal anaesthetic, in accordance with her wishes. It was touching to hear that SR has requested, and HM and her colleague have agreed, to stroke her hair to remind her of her mother.

25. It is convenient now to mention two practice points that emerge from the evidence. The first concerns communication and information sharing between healthcare professionals. A pregnant woman who is under the care of psychiatric services, whether as an in-patient or in the community needs, and is entitled to, joined up care. The GMC's 2018 guidance *Confidentiality: good practice in handling patient information* says this:

> "*Sharing information for direct care*
>
> ***26***
> *Appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who provide their care do not have access to relevant, accurate and up-to-date information about them.*[9] *Multidisciplinary and multi-agency teamwork is also placing increasing emphasis on integrated care and partnership working, and information sharing is central to this, but information must be shared within the framework provided by law and ethics.*"

26. NHS Trusts making an application to the Court of Protection concerning a pregnant patient who is, or should be, receiving psychiatric care (including substance misuse services), would be well advised to ensure that both sets of care providers have access to and are acquainted with all of her relevant healthcare records. Particularly if capacity or best interests are in dispute, the patient and the Court may well be assisted by an assessment made jointly by the obstetric and midwifery and psychiatric teams.

27. The second is timing. The Guidance given by Keehan J in *Re FG* [2014] EWCOP 30, [2015] 1 WLR 1984 is not limited to pregnant women who lack capacity to make obstetric decisions as a result of a diagnosed psychiatric illness: it also applies to those with fluctuating capacity (see paragraph 9). It requires that application is made "*at the earliest opportunity*". In this case it was, or should have been, clear in September that an application would be necessary because SR fell within two of the four categories identified in the Guidance. Those were and are that there was a real risk that she would be subject to more than forcible restraint, and a real risk that she would suffer a deprivation of her liberty which, absent a Court order, would be unlawful. It is necessary to draw attention to the Guidance again because it is still not as widely observed as it should be.

28. Trusts and their advisors may be tempted to think that in a case where all concerned agree that P has capacity, and the medical treatment the clinicians propose to provide is in accordance with the patient's wishes and feelings, no harm is done by making a late application. That is not the case: the evidence may change, capacity may change requiring the involvement of the Official Solicitor who will struggle to assist if she has no time to prepare, points of complexity may emerge during the hearing, and a late

application puts pressure on an already busy urgent applications list. Where, as here, an ongoing situation mandates an application, delay must be avoided.

Jurisdiction and the law

29. As to capacity, I remind myself of the provisions of sections 1, 2, 3, 4 and 5 of the Mental Capacity Act 2005.

30. Declarations about the lawfulness of an act yet to be done to or for a person who has capacity in the relevant regard when the declaration is made, but who may not have that capacity at the point when that action is required, have been made in a number of cases. In *Guy's and St Thomas' NHS Foundation Trust & Anor v R* [2020] EWCOP 4, [2020] 4 WLR 96, the Vice President reviewed the case law and set out the legal framework. He determined that the power to make such declarations exists and is found in section 15(1)(c) of the Mental Capacity Act 2005 which states:

> *"Power to make declarations*
>
> *(1) The court may make declarations as to—*
>
> *(a) whether a person has or lacks capacity to make a decision specified in the declaration;*
>
> *(b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;*
>
> *(c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.*
>
> *(2) "Act" includes an omission and a course of conduct."*

31. He further determined that the inherent jurisdiction of the High Court may be used to deprive a person of their liberty for the purpose of putting an anticipatory declaration into effect. An issue that I have not found straightforward is the test, if any, to be applied when deciding whether or not to grant discretionary relief pursuant to s15(1)(c).

32. In *United Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24, CD was a woman nearing birth who (unlike SR) lacked capacity to conduct proceedings, but who (like SR) had capacity to make decisions about her care during labour and birth. Francis J made the anticipatory order sought, in circumstances where the clinicians' agreed evidence was that there was "*a substantial risk that* [CD] *may become incapacitous*" in relation to birth related treatment decisions (paragraph 3).

33. Cobb J made anticipatory declarations in *Wakefield MDC and Wakefield CCG v DN and MN* [2019] EWHC 2306 (Fam) which concerned DN, a young man with a severe autistic spectrum disorder. DN occasionally experienced meltdowns during which, it was agreed, he lost the capacity to think rationally and weigh up decisions about his residence and care. There was, therefore, a near certainty rather than a risk, that at times in the future he would lose capacity because occasional meltdowns were a consequence of a lifelong disorder.

34. In Guys and St Thomas' NHSFT , the undisputed evidence was that "there was a substantial risk of a deterioration in R's mental health such that she would likely lose

capacity during labour". That was also expressed as a "high risk" (paragraphs 2 and 3). In paragraph 35, the Vice President said that the Court may:

> "*depending on the individual facts, have to make orders which anticipate a likely loss of capacity if it is going to be able to protect P efficiently*" (emphasis added).

He explained that the underlying purpose of such an order is "*to enable an incapacitous individual to achieve capacity".*

35. In paragraph 48 he said of contingent declarations that:

> "*All agree that they should be made sparingly. The case law to which I have referred, emphasises the "exceptional" circumstances of the particular cases.*"

He then cautioned that the concept of exceptionality must not be corroded by being interpreted as having wider application than the Court might intend. That was to be avoided because the importance of the right to respect for bodily integrity is fundamental and held by the capacitous and incapacitous alike. In the final paragraph of the judgment, he emphasised that one of a pregnant woman's fundamental freedoms "*is her right to take decisions relating to her unborn child based on access, at all stages, to the complete range of options available to her."*

36. I asked Ms Powell QC for submissions as to the correct test in law for making an anticipatory declaration or order. She had been unable to identify any authority which dealt with the point directly. She submitted that it was not apt to apply the interim order test found at s48 MCA to an anticipatory order because the circumstances in which each can be made are not the same: an interim order is made at a time when the evidence is incomplete so that the issue of capacity is not capable of being finally determined. In contrast, an anticipatory order is a final order made on the basis of all the evidence, and after the issue of capacity has been finally determined. It followed, she suggested, that the interim "reason to believe" test is somewhat lower than the threshold that must be crossed before an anticipatory order is made.

37. As to that threshold, she urged me not to set the bar too high by requiring a "significant" or "substantial" risk that P may lose capacity before granting contingent declaratory relief. The appropriate test, she submitted, was whether there exists "a real risk" that P will lack capacity at the relevant time.

Decision And Reasoning

38. The issues I need to determine are:

i. Does SR have capacity to make decisions about her care in pregnancy and birth;
ii. Is there a risk that she will lose that capacity;
iii. Is it appropriate to made a declaration, contingent on her losing capacity, identifying the medical treatment that is in SR's best interests;

iv. Is it appropriate to make an order permitting the use of physical and chemical restraint so that if the need arises, effect can be given to the treatment declaration.

39. I find that at the time of the hearing, SR had capacity to make decisions about her care in pregnancy and at birth. There was no evidence before me to rebut the presumption of capacity in s1(2) of the MCA. Further, Dr B and HM were clear that SR had capacity to make all necessary decisions in relation to her treatment and the birth when they assessed her on Tuesday 19 October. The midwives thought that she has capacity most of the time.

40. The interconnected issues of the level of risk of future loss of capacity that may be required before declaratory relief or an order may be made, and whether it is appropriate to grant relief, then arise. I am not in a position to determine whether a threshold test is necessary and, should it be, what the test is. Ms Powell's Position Statement did not address either point and her research did not reveal any authority that would assist. Further and importantly, as the Official Solicitor was not involved, I lacked the important assistance that her perspective would bring.

41. That said, I would venture some observations. First, the making of contingent declarations will almost always be an interference with, or have the potential to interfere with, the Art 8 ECHR rights of the individual concerned to respect for their private and family life, including their autonomous decision making about what is done to them physically. That potential exists even where, as here, the contingent declaration made accords with, promotes, and facilitates the person's current, capacitous decisions, and thus their autonomy. It exists even in those circumstances because, whether capacitous or incapacitous, people have the right to reconsider their positions and change their minds. Indeed, in an evolving healthcare situation, the changing clinical picture may require reconsideration of previously made decisions. Ideally, everyone should have access to the full range of options when the time comes to put into effect a decision about their private and family life but a contingent declaration or order, restricts that full range. It is for this reason that such relief should only be granted where it is necessary, justified and proportionate, and why the power to grant relief should be used sparingly, or only in exceptional circumstances.

42. In addition, I remind myself that before deciding whether to make any declaration or order, the court must, in accordance with s1(6) MCA, have regard to whether the purpose for which it is needed "*can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action*".

43. Given these safeguards, it is unclear whether an additional threshold test which must be crossed before an anticipatory order can been made is needed. It is possible that without one, a general requirement of "exceptional circumstances" or "sparing use", may risk the corrosion of rights that the Vice President warned against. Here, I bear in mind in his observations in *Guy's and St Thomas's NHSFT* that: "*This factual situation i.e. a capacitous woman who is likely to become incapacitous, during the course of labour is relatively unusual but it is not unprecedented*" (paragraph 3). It could be that the situations requiring anticipatory relief occur more commonly than the small number of decided cases suggests. On the other hand, a threshold test may limit the court's power unnecessarily.

44. If a threshold test is required, then it seems to me that a balance of probabilities would be unduly restrictive. (I do not read the Vice President's use of the word "*likely*" in *Guys and St Thomas' NHSFT* (see paragraph 34 above) as an indication that a contingent declaration should only be made where it is more likely than not that P will lose capacity.) I also agree with Ms Powell that an anticipatory order being final, the existence of a risk, and not merely the reasonable belief that there may be one, is required. I would suggest that "a real risk" that P may lose capacity is the appropriate threshold, and I note that that is the language used by Keehan J in *Re: FG*. "Real" means more than theoretical (or "technically possible" as Dr B put it), based on credible evidence rather than speculation, and the risk must, of course, be person specific and present at the time the relief is granted rather than historical.

45. I find that there is a real risk that SR may lose capacity to make decisions about her labour and the birth during what remains of her pregnancy. Insofar as there was a tension between the evidence of Dr B and HM, I prefer the evidence of the midwives. They have an in depth understanding of SR, her wishes and viewpoint, and they are the professionals who have been most closely involved in advance care planning with her. The chief risk stems from SR's mental health disorder arising from her multiple drug use. At times in the past few weeks she has been so driven by the urge to go out in order to raise money to buy, and then to take, crack cocaine that she cannot think about anything else. That urge may well overcome her again between now and 25 October. If she is in that "tunnel vision" state of mind, to use HM's phrase, she will be unable to use or weigh information to do with the management of her pregnancy or birth. Since SR buys and uses drugs every day, that risk will be present every day of the pregnancy.

46. An additional risk affecting capacity arises from her extreme fear that she will die during delivery, however that is achieved. Dr B did not consider that those feelings reached the threshold for a diagnosis of tokophobia. However, the midwives were clear that SR's fear is real, extreme, and has contributed to her frequent disengagement from ante-natal care and her tendency to leave consultations impulsively. I find that SR's irrational belief that she will die having her baby goes beyond the anxiety that many women giving birth for the first time will experience as the day approaches. It represents a disturbance in the functioning of her mind which renders her at times unable to retain, use and weigh information about labour and birth.

47. I also find that it is necessary, justified and proportionate to make declarations which permit a caesarean section and restraint, and that SR's circumstances are exceptional. The combination of being at term, engaging in frequent prostitution and daily buying and taking of multiple illegal substances including crack cocaine, makes her extremely vulnerable and in need of the court's protection.

48. SR's medical treatment best interests are clear: she wants to have a caesarean delivery, actively does not want a vaginal delivery, and the surgical option is what her treating team consider is safest and best for her.

49. The issue of whether the use of restraint, physical or chemical or both, to bring SR to hospital and facilitate a safe caesarean section operation may be in her best interests and therefore lawful is more nuanced. I recognise that there is no obstetric reason why birth must take place on 25 October, given that the due date is not until 9 November. However, there are three reasons why it is strongly in SR's best interests that the

caesarean takes place as planned and thus, why it is appropriate to make the declaration concerning restraint sought by the applicant.

50. First, the carefully made, bespoke birth plan for delivery on 25 October maximises the chance of SR having the alert, calm, comforted experience with her chosen birth partners that she wishes and which is in her best interests. On any later date, the theatres may be busy causing delay, the staff she knows may not be on duty, family members may be uncontactable, and the prospects of restraint and an unwanted general anaesthetic being required will increase. Second, if the baby is not delivered on Monday, the pregnancy will continue and the chance of SR going into spontaneous labour will increase. Labour is likely to exacerbate her already extreme fear of dying in childbirth and if labour is at an advanced stage when help is sought, a caesarean may not be an option. Third, the risks of pregnancy increase with further drug use. The foreseeability of circumstances in which restraint may be required to achieve the delivery that is in SR's best interests, also means that there is no less restrictive option available. For these reasons, I make the declarations sought.

51. As a postscript, following judgment, I was informed that despite some panic attacks during the process, SR's caesarean section delivery went ahead under a spinal anaesthetic, as planned on the morning of 25 October 2021. Mother and baby are both well.