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Case No: 13766836

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/06/2021

Before :

MRS JUSTICE LIEVEN

- -

Between :

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST [1]
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST [2]

Applicants

and

MISS K
(by her litigation friend, the Official Solicitor)

Respondent

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Miss Emma Sutton (instructed by **DAC Beachcroft LLP**) for the **Applicants**
Miss Katie Gollop QC (instructed by the **Official Solicitor**) for the **Respondent**

Hearing dates: **10 June 2021**

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Approved Judgment

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MRS JUSTICE LIEVEN

The Judge hereby gives leave for this judgment to be reported in this anonymised form. The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them may be identified by name or location.

Mrs Justice Lieven DBE :

1. This is an application by University Hospitals Dorset NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust under the Mental Capacity Act 2005 ("MCA") for declarations that it is in Miss K's best interests that she is given an elective caesarean section, the plan being that the caesarean section takes place tomorrow morning. The first applicant is responsible for providing Miss K's obstetric care, and the second applicant is responsible for providing Miss K's mental health care. Miss Sutton appears on behalf of the applicants and Miss Gollop QC on behalf of the Official Solicitor. During the course of this hearing I have heard evidence from Miss K's consultant obstetrician, Dr A, and Miss K's consultant psychiatrist, Dr B.

2. Before turning to the facts of the case I will say something about the timing of the application. The application was made this morning, Thursday 10 June 2021. It was placed into a very busy list for Mr Justice Hayden and it was impossible for him to hear it. It was therefore transferred to me at lunchtime, again into a busy list. Whilst the documents in the bundle suggested initially that the need for the application had only arisen on Tuesday or Wednesday of this week, and therefore it initially appeared to me to have been made in good time, when I got to the end of the bundle I discovered a witness statement from Dr B. It is entirely clear from his written and oral evidence that there was a very strong risk, at least from last week, that Miss K would lose capacity to give consent for the treatment proposed. In those circumstances, it was incumbent upon the Trusts to have made this application significantly earlier than today.

3. I appreciate that these cases are very difficult, and that everyone is trying to act in good faith and in the patient's best interests. I also appreciate that doctors and Trusts are unwilling to make these applications unless they really need to. However, as has been said in so many cases before it feels like a waste of breath, the burden of making an application at the eleventh hour ultimately falls upon the Court and the Official Solicitor.

4. On the facts of this case, the Official Solicitor was instructed today, making her task virtually impossible. No medical notes have been produced, which, for reasons I will explain later, puts me and the Official Solicitor in a difficult position. It was impossible for the Official Solicitor to take any sensible view of the case. Heroically she was able to send her agent, Mr Spooner, to the hospital to visit Miss K this afternoon, with further attempts being made to talk to Miss K. I received a note from the agent at something like 5.30pm when the evidence had finished and Miss Gollop's closing submissions had already started. It is wholly unacceptable that NHS Trusts routinely put the Official Solicitor in such an impossible situation where she cannot do the job she is instructed to do, and where her role effectively becomes a tick box exercise. This is a waste of resources and wholly unhelpful to P's best interests. It is also unfair on the court, that being to Mr Justice Hayden and me today, who have to deal with applications at extreme urgency.

5. It is not good enough for NHS Trusts to routinely say they were acting in good faith when in truth that simply becomes an exercise in burden-shifting. Here, there appears to have been a failure between the two Trusts to work together and exchange information in a helpful and appropriate manner. I will return to that in a moment. I should add on the delay point that Miss Sutton, who appears on behalf of the NHS Trusts, has appropriately apologised profusely on behalf of the Trusts for what has

happened. Miss Sutton, who as always has been extremely helpful to this court has, expeditiously, produced a very helpful position statement and a draft of the final order sought, however there comes a point where apologies are not enough.

6. Turning to the facts, Miss K is a lady in her late thirties currently detained in a psychiatric intensive care unit under section 2 of the Mental Health Act 1983. It transpires from the oral evidence of Dr B that she had an appeal before a Mental Health Review Tribunal last week although that was not referred to in any of the documentation. She has a long history of mental illness with a diagnosis of schizophrenia. This has had a significant degree of medication resistance and it has been difficult to treat, however I note (again) that we do not have the psychiatric notes available to us. Miss K is now 37 weeks and 4 days pregnant. This is her first pregnancy. She has a partner who has not been referred to in the documentation I have seen, save that his name and mental health difficulties are referred to in Miss Sutton's position statement. He is said to have significant mental health issues and is currently under the supervision of the mental health trust as a forensic mental health patient in the community. In those circumstances, Miss K's partner, who we are all assuming is the father, has not been involved in these proceedings.

7. The immediate background to the case is from the first date I have in Miss Sutton's chronology of Miss K's involvement in obstetric care. This was on 22 February 2021 when there is evidence of a telephone conversation with Miss K and her partner at 22 weeks' gestation. At that stage she was stable without medication and under the care of the community mental health team. The plan was for monthly checks to take place via telephone, presumably due to the COVID-19 pandemic, and safety net advice was given. On 12 April 2021, Miss K could not be contacted by telephone for her appointment. This was raised with a community midwife and she was seen by the community mental health team. Following this date, Miss K was under the combined care of the community mental health team and perinatal mental health team.

8. By mid-May 2021, Miss K's mental health had deteriorated and she was admitted initially to a perinatal mental health unit and then to a psychiatric intensive care unit, where she currently remains, under section 2 of the Mental Health Act 1983 as the first unit were unable to manage her complex needs. Importantly, on 20 May 2021 a Child Protection Case Conference concerning Miss K occurred and according to Miss Sutton's chronology there was an agreed plan for the baby to be removed at birth by the Police using their powers of protection pending the Local Authority applying for an emergency protection order. It is of considerable concern to the court that no notes of this conference have been produced and that it appears that Miss K was not told of that plan until Tuesday of this week.

9. According to Miss Sutton's position statement, and I make no criticism of her in this as it was drafted on the basis of information she had at the time, the next event was on Monday 7 June 2021 where Dr A, the consultant obstetrician, first met Miss K. According to Dr A, at that meeting she discussed with Miss K the pros and cons of a vaginal birth versus a caesarean section and Dr A thought that Miss K had capacity at that meeting to make treatment decisions regarding her obstetric care. She discussed with Miss K the benefits of having a planned caesarean section and Miss K agreed with that plan. It became clear when Dr A gave evidence to the court that she either did not know about, or had forgotten, that the plan was that the baby would be removed at birth and she said nothing to Miss K about this. It also appeared that she had not investigated

Miss K's psychiatric history and did not know that during the previous week, Miss K had been significantly unwell and, having heard Dr B's evidence, was extremely unlikely to have had capacity to make treatment decisions regarding the birth of her child that past week or over the weekend. Both I and the Official Solicitor were extremely concerned regarding Dr A's apparent ignorance of Miss K's psychiatric background and the plans for the baby.

10. On 8 June 2021, according to Miss Sutton's chronology, Miss K's mental health significantly deteriorated, and concerns were raised regarding her capacity to consent to and cooperate with a caesarean section. The caesarean section planned for Wednesday 9 June 2021 was therefore cancelled and an urgent multi-disciplinary team meeting was arranged. On 9 June 2021, that meeting took place and it was agreed that Dr A would go to the psychiatric intensive care unit to assess Miss K's capacity regarding the proposed birth plan. Dr A saw Miss K that afternoon and found her to be verbally aggressive, experiencing delusional beliefs, agitated and swearing at staff. Miss K was unable to engage in any conversation regarding the delivery of her child and was unable to recall her conversation with Dr A on Monday 7 June 2021. Dr A concluded, plainly rightly, that Miss K did not have capacity either regarding litigation capacity or with regards to a caesarean section and the birth plan. The application was issued this morning and the proposal is that the elective caesarean section will take place tomorrow on Friday 11 June 2021.

11. I am not going to rehearse the legal framework as it well known to all those concerned and it is set out in great detail by Miss Sutton in her detailed note, which I accept as accurate, and endorse. This is not a case where the law is in issue. The first issue under the MCA is, as always, whether or not P has capacity. As I have said, as assessed by Dr A yesterday, there is very clear evidence that Miss K could not process or understand the information given to her, she could not retain the information, and she could not weigh it up because of her current psychosis. Section 3(1)(a)-(c) and section 2(1) MCA are therefore satisfied. There is no evidence that would support a finding that she has capacity, and no suggestion by the Official Solicitor that she does. I therefore find that Miss K neither has litigation capacity, nor decision making capacity in respect of her obstetric choices.

12. I of course take into account that Dr A thought on Monday that Miss K did have capacity but, at its highest, this must be a case of fluctuating capacity. I also note that there is very little prospect of Miss K regaining capacity before the time when she would give birth naturally. Therefore, the real issue in this case is that of best interests.

13. The best interests decision is whether Miss K should have an elective caesarean section or a vaginal birth. I will note at this point the position of the Official Solicitor who, as I have said, has been put in an exceptionally difficult position by the very late nature of the application. Miss Gollop appeared before me and asked questions of Dr A and Dr B but her concluded position was that the Official Solicitor did not feel it was right to advocate a position in respect of best interests. She gave four reasons for that stance.

14. First of all, there is much we do not know about Miss K's psychiatric condition in the absence of the notes or any background information regarding her family, her family support, and whether or not she has support from her partner. I note at this stage, unusually in this case, and doubtless partly as a result of the urgency, there is simply no information in the papers regarding Miss K's family at all. Dr B said something

regarding it being known that Miss K's mother died earlier this year and that this may have been a factor in the deterioration of her mental state, and that it was believed that some family (including her father) lived abroad. There has been no investigation or consideration of Miss K's wider support network and therefore I entirely endorse Miss Gollop's comments about all of the things we do not know, and ought to know, regarding Miss K.

15. Secondly, Miss Gollop points to the minimal engagement that the Official Solicitor's agent has been able to have with Miss K. The agent has gone to the ward however it appears that he saw Miss K at a bad moment and plainly she has a condition which fluctuates, and she is currently very agitated. If the application had been made at an earlier time, there would have been more of an opportunity for the Official Solicitor to have had some prospect of seeing Miss K when she was in a less fraught state.

16. Thirdly, Miss Gollop has suggested that the Trust has not put forward all of the options as there has been no consideration of a planned induction for a vaginal birth. I am less sympathetic to Miss Gollop on that point. As submitted by Miss Sutton in response, Dr A could have been asked about that in cross examination, and the suggestion that a planned induction would have had any real benefits over a vaginal birth or a caesarean section seem to me rather slim. So although I acknowledge the Trust has not set that out formally, I do not think that it takes the matter any further.

17. Fourthly, and I will set this out verbatim, the Official Solicitor was "appalled" at parts of Dr A's evidence. In particular, the Official Solicitor's concern, which I share, is that Dr A gave evidence that her view was that Miss K had given capacitous informed consent on Monday to a planned caesarean section, but did so stating that she wanted to hold her baby and keep the baby safe and that she was delighted to give birth sooner rather than later (by having a caesarean section) so that she could hold her baby earlier. This evidence was deeply moving because it had already been decided on 20 May 2021 that the Local Authority would take the baby away at birth. So the true position is that when Miss K comes round from the general anaesthetic, there will be no baby. However, Dr A appears not to have understood this or known it. The Official Solicitor, as I am, is staggered by this as Dr A did not seem to have any understanding of what would happen to the baby following the caesarean section taking place. So in those circumstances, I completely understand why the Official Solicitor is not able to advocate a particular position on best interests.

18. However, and this is no criticism of the Official Solicitor, I do not have that luxury. I have an application before me that I have to determine urgently. For good or ill, the best interests decision is relatively straightforward. In terms of Miss K's wishes and feelings, she is not currently in a situation in which she is able to express her wishes and feelings. She identified on Monday and expressed a willingness to have the planned caesarean section. Most importantly on Monday and today, as is clear from the notes of the agent, Mr Spooner, who saw her today, she is plainly concerned about the safety and best interests of her baby. I have no reason to believe her wishes would be anything other than to have the safest birth possible.

19. In terms of the medical best interests, there are a number of significant risks that would go with allowing this pregnancy to continue to a vaginal birth. Miss K is already very distressed and is in a very heightened and emotional state, being aggressive on the ward on occasion. There is clearly a danger that if she continues with the pregnancy until

spontaneous labour occurs that the situation may get worse. Further, she is currently receiving some medication for her schizophrenia and although Dr B is doing his utmost to ensure that the medications are appropriate for someone who is heavily pregnant, continuing with the pregnancy plainly poses some risks to the baby and is far from ideal. Probably most importantly, it is very difficult to know with certainty how Miss K would react to going through a vaginal birth. As Dr A puts it, the birth process does not simply "happen to" a woman, she has to cooperate in order for it to happen safely. Miss K is unable to physically or mentally cooperate. Therefore, allowing her to go through a vaginal birth would be highly risky to her and her baby.

20. On the other hand, with a planned caesarean section, although there are some risks, there is greater scope for those risks to be minimised. It is important to note that Miss K is very unwell. In answering questions put by Miss Sutton, Dr B stated that Miss K is under considerable levels of restraint on the ward, is often placed in seclusion due to her behaviours, and has required intramuscular antipsychotic medication against her will. He explained that this presents additional risks to a heavily pregnant woman, both in relation to her physical and mental health. Dr B also explained in his answer to Miss Sutton that if Miss K's pregnancy progressed to full term that she would be unable to reliably alert those caring for her if she experienced reduced foetal movements, or similar issues, which was a real concern.

21. None of that makes a planned caesarean section easy, however the care plan I have seen does set out a carefully calibrated way of getting Miss K to the obstetric unit, if possible through co-operation in the first instance, and then through the use of some form of sedative drugs if deemed appropriate, and, only if appropriate and as the last stage, through the use of physical restraint. The caesarean section carries some risks but there is nothing in her medical history to suggest that she is at any greater risk than any other woman. There are considerable difficulties once Miss K recovers from the general anaesthetic, but that is dealt with in some detail in the care plan before me.

22. In those circumstances it seems to me to be absolutely clear that a planned caesarean section is a better option than a vaginal birth or an induced vaginal birth and that it is in Miss K's best interests to have a planned caesarean section tomorrow morning. I will therefore make the order as set out in draft form by Miss Sutton.

Postscript

23. At a little after 11am on Friday 11 June 2021, I was informed that Miss K was successfully transferred from the psychiatric hospital to the acute hospital earlier that morning and that she did not resist transfer and no restraint was required. Miss K was compliant with her pre-medication and whilst she became slightly agitated at one stage, she met with the clinicians and engaged with them fully and walked into theatre. She agreed to a pre-operative CTG which was tachycardic and non-reassuring which was further supportive of the decision to deliver on 11 June 2021. Miss K was delivered of a live baby boy who has been transferred to the neonatal intensive care unit and is currently doing well.