This judgment was delivered in open court. 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 PQ 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.

Neutral Citation Number: [2024] EWCOP 73 (T3)

Case No: COP 20007438

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/12/2024

Before :

MR JUSTICE PEEL

- -

Between :

(1) LEICESTERSHIRE PARTNERSHIP NHS TRUST
(2) UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST **Applicants**

- and -

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

- -
- -

Ranald Davidson (instructed by **Browne Jacobson)** for the **Applicants**
Parishil Patel KC (instructed by **the Official Solicitor**) for **the Respondent**

Hearing date: 2 December 2024

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 5 December 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE PEEL

Mr Justice Peel :

1. This is an application made on 28 November 2024 by the relevant NHS Trusts for authorisation to carry out a planned caesarean section ("CS") in respect of PQ whose baby in utero reached full term that day.

2. At the start of the hearing before me, the Official Solicitor tentatively opposed the application, but (sensibly and properly, in my view) reserved her position until after hearing the oral evidence, so as to explore some of the matters raised in written evidence. After the treating Consultant Obstetrician had given her evidence, the Official Solicitor and the NHS Trusts reached agreement as to the appropriate way forward, namely that the NHS Trusts be authorised with effect from Thursday of this week (1 week after full term), or upon PQ's waters breaking (whichever is sooner), to carry out a planned CS.

3. I informed the parties that I proposed to do a written judgment, setting out my reasons for endorsing the agreement, and drawing attention to a failure in this case to comply with relevant procedural requirements.

Capacity

4. It is common ground, and I concur, that, applying sections 1-3 of the Mental Capacity Act 2005, PQ lacks the relevant capacity.

Best interests: the Law

5. The legal principles are well established and I do not propose to rehearse them in detail. I have regard to s4 of the Mental Capacity Act 2005. I bear in mind the jurisprudence which has emphasised the need to construe best interests broadly, most notably in **Aintree University Hospital NHS Trust v James [2013] UKSC 67**. In weighing up best interests, where the wishes and feelings of the patient can be ascertained, they must be given proper consideration but are not determinative; para 45 of **Aintree (supra).**

Evidence

6. I only heard from one witness, PQ's treating consultant obstetrician. She was very impressive and clarified the queries of the Official Solicitor.

The application and procedural failings

7. The applicants have known about PQ's pregnancy since week 20, and have long been aware of her mental health history, including potential capacity issues. The application before me should have been made far sooner than the date upon which full term was reached and the birth was due. I understand that the applicants failed to take legal advice until the last moment. As a result, they did not follow the judgment of Keehan J in **NHS Trust v FG [2014] EWCOP 30**, and in particular the annex thereto, which sets out in clear terms what is required of applicant Trusts in cases concerning obstetric care. Regrettably, almost none of the stipulated steps were taken, including making an application no later than 4 weeks before the due date.

8. When the application was made on Thursday 28 November 2024, it was inevitably accompanied by a request for a hearing that day or the next because of the perceived urgency. The court was placed in an extremely difficult position to try and arrange a listing. It came before me the next day, Friday 29 November 2024. Papers trickled in during the morning. There was no bundle. I had a flurry of last minute requests for legal representatives and clinicians to attend remotely. The Official Solicitor had not been notified of the application until the day before and had next to no information. She was not able to arrange for an agent to meet PQ. Counsel instructed on behalf of the Official Solicitor said candidly that the Official Solicitor could not advance a positive case. Counsel for the applicants invited the court to proceed to a full hearing, with oral evidence, to enable the CS, if approved, to take place at 4.30pm that day. All of this was, to put it mildly, unsatisfactory, as well as being unfair to the subject of these proceedings, PQ.

9. In the end, I decided to adjourn from Friday 29 November 2024 to Monday 1 December 2024. By good fortune, the medical presentation which was thought to be so urgent on Friday 29 November 2024 (the risk of pre-eclampsia) dissipated over the weekend and the case, while still urgent, was not at the level of immediate and imperative necessity which it appeared to be.

10. The lesson from all of this is for applicant Trusts, when dealing with potential issues about obstetric care, to follow the guidance of Keehan J scrupulously. Failure to do so is likely to create the difficulties which faced me in this case, at a time when judicial resources are under enormous strain. As I have already said, failure to do so is unfair to the patient and likely to be contrary to their best interests.

The facts

11. PQ is 29 years old. This is her first known pregnancy and birth. Her due date was 28 November 2024 at 40 weeks gestation.

12. PQ has treatment resistant paranoid schizophrenia and is a known abuser of class A drugs, including cocaine, before and during pregnancy. She was detained under s3 of the Mental Health Act 1983 from April 2019 to April 2021, then made subject to a community treatment order.

13. PQ is registered as homeless. Her partner (the baby's father) is also registered homeless, and has paranoid schizophrenia. He has recently been sectioned. He is aware of the impending birth but does not appear to have taken any active interest in it.

14. PQ was recalled from the community treatment order to the mental health unit on around 13 November 2024, before being transferred on 28 November 2024 to the hospital where she is due to give birth. Her engagement with midwifery staff has been poor. She became convinced she was being filmed by a device in the ceiling and lost trust in many members of staff. She is reluctant to agree to investigations or examinations. She dislikes people being around her and being touched. She is resistant to engagement with male members of staff.

15. Capacity assessments have concluded that she is unable to understand, use or weigh information about the birth. She presents with a high level of anxiety.

16. She has expressed a wish to have a natural, or spontaneous, birth with as little intervention as possible, although the picture is not entirely one way as she told a clinician on 28 November 2024 that she would be happy with a CS if it were to protect her child. She expects a natural birth would be painful, but is opposed to any pain relief, saying she has a high pain threshold.

17. The baby had scans in September and about 2 weeks ago. The baby was of a good size and healthy. However, a urine sample on 27 November 2024 evidenced some protein. The mother's blood pressure was elevated on 28 and 29 November 2024. Together, these signs were suggestive of pre-eclampsia which can lead to seizure or stroke, haemorrhage, and failure of organs. That was the position before me on Friday 29 November 2024, and was the principal reason advanced by the applicants for an urgent elective CS. Having decided to adjourn until Monday 2 December 2024 (the next working day), I gave various directions for updating information.

18. On the morning of 2 December 2024, I was told that the concerns about pre-eclampsia had eased following re-testing of urine and blood pressure. PQ was yet to go into labour and an ultrasound scan carried out on 30 November showed no cause for concern about the baby's health.

19. The applicants therefore altered their position. They still sought authorisation to carry out an elective CS, but no earlier than Thursday 5 December 2024 rather than immediately.

Best interests: outcome

20. For any expectant mother, discussions would take place about the options from about 1 week after full term onwards, to explore spontaneous labour, induced birth, and elective CS.

21. In PQ's case, induced labour is not appropriate and is not offered by the obstetric team. It would require a high degree of cooperation by PQ and intense, prolonged monitoring, investigation, and examination that she would find unpleasant and distressing. Absent such cooperation, the medication would be dangerous to both PQ and the baby.

22. That leaves for PQ (i) spontaneous labour which might, in the event of complications, result in an emergency CS or (ii) an elective CS.

23. I am satisfied that the application for authorisation to carry out an elective CS should be granted for a number of reasons.

24. First, there is an increased risk to both PQ and/or the baby of physical harm from 1 week after full term (i.e 5 December 2024), which can be mitigated by a planned CS:

i) The risk of stillbirth rises from 4 in 10,000 during the first week post full term to 35 in 10,000 from the end of the first week post full term.

ii) Where, as here, there is a history of cocaine use in pregnancy, that figure rises further still because of associated poor placental function, although the witness could not put a precise number on it.

iii) Elective CS carries some risks, but these would be offset by the advantage of safe delivery of the baby.

iv) From 1 week onwards, the risk of complications in birth leading to an emergency CS are, as the witness told me, much higher, including bleeding, infection, and organ damage.

25. Second, there would be increased risk to PQ of emotional or psychological harm if the CS is not carried out:

i) An emergency CS, carried out in urgent circumstances with little or no warning, as a result of birth complications, would be more traumatic for PQ than an elective CS, not least because she would be less likely to be surrounded by staff she knows and likes.

ii) Forcing an elective CS on PQ would have some detrimental impact on her, and for up to 10 minutes she would need to be restrained by two trained members of staff while the general anaesthetic is administered intravenously, but the trauma would be smaller than either emergency CS or labour without pain relief, both of which would involve a significant level of intervention (including touching and feeling her) which she objects to and finds intrusive.

26. Third, PQ's views are important, but in the light of at least one comment made about willingness to accept a CS, there is a degree of nuance about them. In any event, the evidence satisfied me that she has been unable to weigh up the benefits and burdens of CS as against spontaneous labour. Were she fully able to do so, it is likely that she would wish to take reasonable medical steps to ensure the wellbeing of her baby in the safest way.

27. Fourth, an elective CS would take place in a calm, controlled environment, with an all-female team of people she trusts. PQ sets great store by achieving a state of calm and I am satisfied that this is more likely to be achieved by an elective CS than by spontaneous labour (especially if the latter is followed by an emergency CS). Once the general anaesthetic is administered, she would be pain free.

28. I therefore approve the proposed plan for authorisation to carry out an elective CS from Thursday 5 December save that, as agreed between the parties, it may be carried out sooner if PQ's waters break, because of the high risk of infection.