[2008] IEHC 104

THE HIGH COURT

2006 No. 4427 P

BETWEEN

CHRIS FITZPATRICK AND JOHN RYAN

PLAINTIFFS

AND
F.K.
AND
THE ATTORNEY GENERAL

DEFENDANTS

Judgment of Miss Justice Laffoy delivered on the 25th day of April, 2008.

I. The Proceedings

The parties

1. The first plaintiff is the Master of the Coombe Women's Hospital (the Hospital) and the second plaintiff is the Secretary/Manager of the Hospital. The Master and the second plaintiff sue in such respective capacities.

2. The first defendant, who will be referred to as Ms. K, an African woman from the Democratic Republic of Congo (DRC), aged 23 years of age at the time, was a patient of the Hospital on 21st September, 2006. At 9.46 a.m. on that day she gave birth to a baby boy. Shortly thereafter she suffered a massive post partum haemorrhage resulting in cardiovascular collapse. As part of the resuscitation procedures when O Negative blood, which is stored in the delivery suite fridge for emergencies, was being prepared for immediate transfusion, the medical personnel present were told that Ms. K would not take blood because she was a Jehovah's Witness.

3. The second defendant, the Attorney General, was joined in these proceedings because it was anticipated by the plaintiffs that questions as to the interpretation of the Constitution would arise in the proceedings, and that the plaintiffs would be required to serve notice on him by virtue of O. 60, r. 2 of the Rules of the Superior Courts, 1986 (the Rules). It is not clear to me, however, that the court directed the service of such notice.

Novelty of the core issue

4. Apparently, this is the first case in which an Irish court has been asked to decide the core issue which underlies these proceedings. It is whether and, if so, in what circumstances, a court may intervene in the case of a patient, who is an adult and is not *non compos mentis*, who has refused medical treatment, and by order authorise the hospital and its personnel in which he or she is a patient to administer such treatment to the patient. The issue arises in circumstances in which Ms. K was transfused in the Hospital on the afternoon of 21st September, 2006 on the authority of an order of this Court (the *ex parte* order) granted on an *ex parte* application made by the plaintiffs.

5. This judgment follows a plenary hearing which lasted 37 days. It is necessary, because of the unusual nature of the process and the range of issues raised at the hearing by the parties, to outline the process to date in some detail, although ultimately the outcome of the proceedings largely turns on questions of fact.

Ex parte application

6. In order to put the *ex parte* application in context, it is necessary to elaborate on the essential facts. The evidence will be considered in greater detail later.

7. As I have stated, the emergency occurred shortly before 10 a.m. on 21st September, 2006. The immediate concern of the medical personnel was to resuscitate and stabilise Ms. K. That process continued for approximately one and a half hours, during which Ms. K persisted in her refusal to accept a blood transfusion. The medical personnel treating Ms. K. were concerned that she would die without a blood transfusion. The Master, who is the most senior obstetrician in the Hospital and has ultimate responsibility for the patients being treated there, was called to the delivery suite where he arrived at about 11.30 a.m. I think it is fair to record that the Master accepted full responsibility for the crucial decisions which were subsequently made in relation to Ms. K's treatment, the decision to apply to the High Court and the decision to transfuse Ms. K on the authority of the High Court Order.

8. Having examined Ms. K and reviewed her management up to that time, and having considered what products, procedures and therapies were available as an alternative to administration of a blood transfusion, some of which had been put in place, the Master concluded that a blood transfusion was necessary to save Ms. K's life. Following discussions with Ms. K as to her condition, during which she reiterated her refusal to accept a blood transfusion, the Master had doubts as to the quality of her refusal, that is to say, whether it was a valid refusal. At around noon he contacted the Hospital's solicitors for legal advice. At 12.30 p.m. he left the Hospital for the Four Courts with a view to applying to this Court for authority to transfuse Ms. K. On his arrival, at around 1 p.m., he met the Hospital's solicitor and counsel. He had a hurried consultation with them, partly en route to the court room in which applications were being heard on that day.

9. The judge hearing urgent applications on that day was Abbott J. He commenced hearing the plaintiffs' *ex parte* application at about 1.15 p.m. Counsel disclosed to the court the information he had been given by the Master. The Master testified that the facts given to the court were true. Counsel then made submissions. At about 1.45 p.m. Abbott J. made the *ex parte* order, the operative part of which, as perfected, was in the following terms:

> "It is ordered that the Plaintiff be authorised to administer to the Defendant including all appropriate steps by way of restraint or otherwise all appropriate medical treatment and other ancillary procedures including blood transfusion and clotting agents."

10. Having regard to the adopted by her counsel on behalf of Ms. K, it is appropriate to note the following matters in relation to the *ex parte* order. First, it was made before a plenary summons had issued. This fact is recorded on the face of the order, in that it was expressly made in the matter of an "intended" action between the plaintiffs and Ms. K. It is also recited that counsel had undertaken to issue a plenary summons by close of business on the following day, Friday, 22nd September, 2006. Secondly, it was made *ex parte*. This fact is recited in the order. Thirdly, no affidavit was filed in support of the application. Again, this is apparent on the face of the order, in that it recited that oral evidence was given by the Master. Fourthly, it was not limited in time, for example, until further order made on an interlocutory application. It did not envisage there being an *inter partes* application for an interlocutory

injunction pending the hearing of the action following service of the proceedings on, and notice of such application to, Ms. K. Instead, it directed the plaintiffs to deliver a statement of claim within seven days and ordered that the matter be listed for mention on Monday, 9th October, 2006. Fifthly, apparently, no undertaking as to damages was proffered by the plaintiffs. Finally, it provided that each party should have liberty to apply.

11. There was no stenographer present for the hearing. However, there was admitted in evidence at the plenary hearing an attendance note made by the plaintiffs' solicitor of what transpired. I am fully satisfied that the attendance note is as comprehensive and accurate as could be expected given the circumstances. I will be returning to it later.

12. The Master arrived back at the Hospital about 2.30 p.m. He told Ms. K that the court had made an order authorising that she be transfused. She remained adamant that she did not want a blood transfusion. She was upset and agitated. She was administered a sedative. The transfusion commenced at around 2.35 p.m. Accordingly, the *ex parte* order of the court was given effect to about an hour after it was made.

The pleadings

13. The plenary summons was issued on 22nd September, 2006 and the statement of claim was delivered on 29th September, 2006 in compliance with the *ex parte* order. As I have indicated, the Attorney General was named as a co-defendant in the proceedings.

14. In the statement of claim the plaintiffs pleaded the facts in terms similar to the factual evidence given to Abbott J. on 21st September, 2006. The assertions on which they based their case, insofar as it was pursued at the hearing, may be summarised as follows. First, it was asserted that, notwithstanding that Ms. K was fully conscious and had been stabilised, the plaintiffs were concerned that she might not be in a position to make a fully informed decision to refuse consent to the medical procedures necessary to save her life, setting out the factors which gave rise to the concerns, to which I will return. Secondly, it was asserted that the State, including its judicial arm, was obliged by Article 40.3.1, Article 40.3.2, Article 41 and Article 42.5 of the Constitution to safeguard the constitutional rights of Ms. K's baby, which rights included the right to be nurtured and reared by Ms. K. The State's duty extended to ensuring that all appropriate medical steps were taken to safeguard Ms. K's life, especially since the medical procedures required for the purpose were routine and non- life-threatening and the plaintiffs had genuine and real concerns that she might not have been in a position to give a valid informed refusal of consent to treatment. The reliefs sought by the plaintiffs included an injunction in terms broadly similar to the *ex parte* order. Happily, Ms. K made a full recovery and she was discharged from the hospital with a healthy baby boy on 28th September, 2006. Therefore, there is no longer a basis for granting permanent injunctive relief. However, the plaintiffs have also sought declaratory relief, including:

> (a) a declaration that the Hospital was and is entitled to apply to the court for the injunction sought by virtue of the Articles of the Constitution referred to above and a declaration that the court was and is entitled to and/or obliged to grant that relief by virtue of the same Articles; and
>
> (b) a declaration that Ms. K's rights under Article 44.2.1 of the Constitution must yield to the State's obligations under the Articles referred to above.

15. Ms. K's defence, coupled with a counterclaim, was delivered on 16th December, 2006. Prior to that, the solicitors who appeared for Ms. K in these proceedings had issued an application seeking to join the Watch Tower Bible and Tract Society of Ireland (the Society), which is the legal body which represents Jehovah's Witnesses in Ireland, either as a co-defendant or as a notice party. The application was heard by Clarke J., who also considered whether it might be appropriate to join the Society as an amicus curiae. Clarke J. delivered his judgment on 7th December, 2006 (reported as *Fitzpatrick and Ryan v. F.K.* [2007] 2 I.R. 406: [2008] I.L.R.M. 68) refusing the application.

16. Ms. K was given leave in July, 2007 to amend her defence and counterclaim. I propose considering her case on the pleadings by reference to the amended defence and counterclaim which was subsequently delivered. Broadly speaking, Ms. K's case as pleaded, insofar as it relates to the plaintiffs' case as pursued at the hearing, contains the following assertions and traverses:

> (1) That the *ex parte* order should not have been applied for and should not have been made and should be set aside pursuant to O. 52, r. 3 of the Rules on the ground that it was obtained without notice to Ms. K, a competent adult. It was contended that the order sought was in the nature of a final order, which was made in breach of Ms. K's rights under the rules of natural justice and, in particular, the principle *audi alteram partem*, and in violation of her rights under article 6 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (the Convention). The first relief sought in the counterclaim arising out of that contention was an order "that these proceedings be struck out and dismissed as an abuse of the process of the court and/or alternatively" pursuant to O. 52, r. 3.
>
> (2) That the transfusion administered was unlawful in that it was not in compliance with the *ex parte* order. The import of this assertion, as amplified in replies to notices for particulars, is that it is contended that the order only authorised a transfusion where it was necessary to do so for the preserving of Ms. K's life and at the time of the transfusion no such necessity existed.
>
> (3) A denial of the plaintiffs' assertion that Ms. K was not in a position to make a fully informed decision to refuse consent to medical procedures necessary to save her life, coupled with a denial that a blood transfusion was necessary to save her life.
>
> (4) That, if Ms. K's baby's constitutional rights included the right to be nurtured and reared by Ms. K, such right did not entitle the plaintiffs to override her autonomous refusal of medical treatment as a competent adult.
>
> (5) That the *ex parte* order having been made without notice to Ms. K, the plaintiffs committed an assault and trespass to her person in administering the blood transfusion in reliance on it.
>
> (6) That Ms. K was entitled to refuse all or any medical treatment proposed by the plaintiffs by virtue of Article 40.1, Article 40.3.1 and Article 40.3.2 and Article 44.2.1 of the Constitution and articles 8 and 9 of the Convention.
>
> (7) That the plaintiffs were in breach of Ms. K's rights under article 3 and article 14 of the Convention.

17. In addition to seeking various declarations as to her rights, including her constitutional right to refuse medical treatment, Ms. K counterclaimed for the following reliefs:

(i) a declaration that the plaintiffs acted in violation of Article 40.3.1 and Article 40.3.2 of the Constitution in purporting to proceed against Ms. K by way of ex parte application for an order authorising violation of her bodily integrity and autonomy when she was and is a competent adult; and

(ii) a declaration that the actions of the plaintiffs in applying for the ex parte order and in proceeding to transfuse Ms. K against her will were incompatible with the Convention;

(iii) damages for assault, trespass to the person and breach of constitutional rights; and

(iv) damages for breach of Ms. K's rights under the Convention pursuant to s. 3(2) of the European Convention on Human Rights Act, 2003 (the Act of 2003).

18. The defence delivered by the Attorney General on 26th February, 2007 underscored his limited role. While he was a defendant to the plaintiff's claim, no allegation was made against any organ of the State by the plaintiffs and no relief, other than costs, was claimed. He was not a party to Ms. K's counterclaim. He was a stranger to the factual issues which arose between the plaintiffs and Ms. K. He had not been on notice of, and was a stranger to, the making of the *ex parte* order. Apart from pleading by way of preliminary objection that the issues raised in the statement of claim were moot and ought not be determined by the court, although acknowledging that the issues raised by Ms. K on her counterclaim as to whether or not her constitutional rights were infringed as a result of the administration of the blood transfusion remain to be determined, the Attorney General pleaded to the matters raised on the statement of claim in an abstract manner. While the Attorney General did not participate in the evidential aspects of the hearing, the transcripts of evidence were furnished to him and his counsel participated in the closing submissions and gave considerable assistance to the court.

19. As already outlined, in her defence and counterclaim Ms. K impugned the validity of the *ex parte* order on the basis that it was made without notice to her and in contravention of her constitutional and Convention rights. At the hearing it was also alleged that it was procured on the basis of material non-disclosure. While dealing with the process, I think it is important to record that no application was made to discharge or vary the order pursuant to the liberty to apply contained in it, or under O. 52, r. 3 of the Rules prior to the delivery of the defence and counterclaim. Moreover, it has not been appealed to the Supreme Court although, in reality, there was no opportunity to appeal prior to the administration of the blood transfusion. The significance of the existence of the order is that it is an impediment to the prosecution of Ms. K's claim to damages. In that regard, the case made on her behalf is that it is prosecutable on the basis that (1) the authority given to the plaintiffs by the order was exceeded, assuming it is valid, or (2) the order was a nullity and of no effect or should be set aside.

II. Identifying the core legal issue

20. Counsel for the plaintiffs emphasised two matters which are not at issue.

21. First he accepted that there is no question but that the right of patient autonomy is embraced by the State's obligation to protect the "person" in Article 40.3.2 of the Constitution and he submitted that the right is also a dimension of the unenumerated right to bodily integrity as recognised in *Ryan v. Attorney General* [1965] I.R. 287. It follows, it was acknowledged, that a competent adult with full capacity has an absolute right to decline medical treatment, subject to one qualification. However, counsel for the plaintiffs distinguished between competence generally, on the one hand, and the lack of capacity to make a particular decision, such as a decision as to accepting or refusing medical treatment, on the other hand. That such distinction exists is undoubtedly the case, and that was recognised by counsel for Ms. K, properly in my view. The qualification, which is implicit in the case made on behalf of the plaintiffs, is that the absoluteness of the recognised right to decline medical treatment may be watered down by a competing constitutional interest, whether the concept of the common good or the constitutionally-protected right of a third party, of sufficient weight to override the right.

22. In the light of the decision of the Supreme Court in *In re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79, it could not be argued that a competent adult is not free to decline medical treatment. While that case concerned the withholding of medical treatment in the case of a person who had been found to be incompetent, the foundation of the *ratio decidendi* is the Court's exposition of the position of a competent adult. That is succinctly encapsulated and explained in the following passage from the judgment of Denham J. (at p. 156):

> "Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g. in regard to contagious diseases or in a medical emergency where the patient is unable to communicate. This right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be a trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights. The consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus, medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons.
>
> If the patient is a minor the consent may be given on their behalf by parents or guardians. If the patient is incapacitated by reason other than age, then the issue of capacity to consent arises. In this instance, where the patient is a ward of court, the court makes the decision."

23. Later, in the context of analysing Article 40.3 of the Constitution, Denham J. stated (at p. 160):

> "The right to life is the pre-eminent personal right. The State has guaranteed in its laws to respect this right. The respect is absolute. This right refers to all lives – all lives are respected for the benefit of the individual and for the common good. The State's respect for the life of the individual encompasses the right of the individual to, for example, refuse a blood transfusion for religious reasons. In the recognition of the individual's autonomy, life is respected."

24. The substance of the foregoing dicta is incorporated in "A Guide to Ethical Conduct and Behaviour" issued by the Medical Council (6th edition, 2004). Paragraph 17.1 explicitly provides that a competent adult patient has the right to refuse treatment. It further provides that, while the decision must be respected, the assessment of competence and the discussion on consent should be carried out in conjunction with a senior colleague. Paragraph 18.4 deals with the special situation of emergency treatment and provides that in an emergency when consent cannot be obtained, for example, where the patient is unconscious, the doctor may provide the treatment that is necessary to safeguard the patient's life or health.

25. The second matter which counsel for the plaintiffs accepted was not in doubt was that Ms. K's right to the free profession and practice of her religion is protected by Article 44 of the Constitution. A plea in the statement of claim that Ms. K's decision came

within the "public order and morality" exception to Article 44.2.1 was not pursued. Indeed, I understood counsel for the plaintiff to accept that certain tenets of the Jehovah's Witness faith, which he suggested were factors to be taken into account in determining Ms. K's capacity, principally, disfellowship and disassociation, are protected by Article 44, in the same way as such practices are protected by the First Amendment of the United States Constitution, as was held by the US Court of Appeals for the Ninth District in *Paul v. Watch Tower Bible and Tract Society of New York, Inc*. 819 F. 2d 875.

26. It was acknowledged by the plaintiffs in making the *ex parte* application to Abbott J. on September, 2006 that Ms. K was not non compos mentis on 21st September, 2006 and that position has been maintained by the plaintiffs. Therefore, the position of Ms. K differs from that of the notice party whose position was considered by this Court (Finnegan P.) in *J.M. v. St. Vincent's Hospital* [2003] 1 I.R. 321. There the notice party, a patient who was critically ill and required immediate blood transfusions and a liver transplant, was in a coma when the application was made by her husband. She was admitted to wardship and Finnegan P. made an order directing the hospital to provide appropriate medical treatment, including a liver transplant and blood transfusion, in exercise of the court's *parens patriae* jurisdiction. Following the decision of the Supreme Court in *In re a Ward of Court*, he stated that the approach to be adopted is that the court should consider the right of the person to determine for herself provided she was competent to make such a decision.

27. What is significant about that decision for present purposes is the manner in which it was made. It is clear from the *ex tempore* judgment of Finnegan P. that he was satisfied that the matter was one of great urgency. Because of the urgency he allowed the applicant to proceed on foot of a draft plenary summons and he took oral evidence from the applicant and one of the respondents, whom I assume was her clinician. In this case, because of the emergency, a similar approach, which I consider to be in line with usual practice, was adopted on the *ex parte* application. Finnegan P. decided that, in view of the urgency, it was inappropriate that delay should be incurred by compliance with the statutory provisions of the Lunacy Regulation Act, 1871. It was for that reason that he exercised his *parens patriae* jurisdiction. The notice party was not represented, but in that respect the case differs fundamentally from this case because, in the circumstances which prevailed there, the notice party was found to be *non compos mentis*.

28. The core issue in this case is whether the court was entitled to intervene and make the *ex parte* order authorising that Ms. K, a competent adult, be transfused notwithstanding that she had expressly refused a blood transfusion. Counsel for the plaintiffs submitted that the issue raised gives rise to two questions.

29. The first question is whether Ms. K had given a legally valid refusal of treatment. It is common case that for a refusal of treatment to be valid it must be based on the appropriate treatment information, be made by a person with the necessary capacity and be voluntary. The answer in this case turns on Ms. K's capacity to make a decision to refuse at the time she articulated the refusal. That question, which, for the sake of brevity, I will refer to as the "capacity question", was posited by counsel for the plaintiffs in terms whether the Hospital was entitled to consider that Ms. K had not given a legally valid refusal. In the context of the capacity question, I will address whether the issue of voluntariness arises. I did not understand there to be any real controversy as to the treatment information which was given to Ms. K.

30. The second question is whether, if Ms. K had capacity to make a valid decision to refuse a blood transfusion, the court was, and is, entitled to have regard to her baby's constitutional rights and find that, when balanced against Ms. K's constitutional rights to autonomy, self determination, and the free practice of her religion, the baby's rights outweighed Ms. K's rights so as to entitle the judicial arm of the State to intervene. For the sake of brevity, I will refer to this question as the "balancing of rights" question.

III. Order in which the question should be determined

31. As will be demonstrated later, both the capacity and the balancing of rights questions were raised before Abbott J. made the *ex parte* order, although he made the order authorising the blood transfusion exclusively on the basis of the submissions which had been made to him on the balancing of rights question.

32. It is common case that the capacity question falls to be considered and determined first. The balancing of rights question only arises in the event that the court were to find that Ms. K's refusal of a blood transfusion was a valid refusal. Indeed, whether the balancing of rights question should be considered at all was put in controversy on behalf of the Attorney General.

33. In essence, the argument made on behalf of the plaintiffs was that Ms. K's right to refuse medical treatment was not an absolute one, whether it derived from the protection of the person in Article 40.3.2 (and the assumption that Ms. K had validly waived her constitutional right to life) or the protection of freedom of conscience and religion in Article 44.2.1. It is to be balanced against the competing Article 41 and Article 42 rights of her baby to the company, care and parentage of his parents within a family unit. It was submitted that the court was entitled to conclude that the competing interests of Ms. K's son outweighed her constitutional right. That proposition was advanced on the basis that, in the light of the Hospital's knowledge at the time, the death of Ms. K would result in the abandonment of her baby. Counsel for the plaintiffs cited the judgments of the Supreme Court in *North Western Health Board v. H.W*. [2001] 3 I.R. 622, (the *PKU Test* case) which address the nature of the conduct on the part of a parent and the consequences for the parent's child which may justify intervention by the State in exceptional circumstances as envisaged by Article 42.5.

34. Ms. K's baby was born before the emergency occurred, so that no issue arises under Article 40.3.3, wherein the State acknowledges the right to life of the unborn. Ms. K's decision to refuse treatment did not in any way jeopardise her baby's right to life, so that the right to life is not a factor in the balancing of rights equation, if it arises.

35. The position advanced on behalf of the Attorney General was to recognise in principle that, if Ms. K had capacity to refuse and give a valid refusal, the issue as to whether any other constitutional right might negate the effect of such decision would arise. It was also recognised that Ms. K's baby, although not an Irish citizen, enjoyed the constitutional protections afforded by the Constitution, including the family rights under Article 41 and the individual personal rights protected by Article 40.3. It was accepted that the baby had a right to have the nurture and support of his mother. It was made clear that the Attorney General was not submitting that such a right would or should have superior constitutional status to the right of the mother to refuse medical treatment, so as to override the mother's right in this case, the baby's right to life not being in issue. However, counsel for the Attorney General advocated restraint in addressing the balancing of rights question. He did so for the pragmatic reason that it is not grounded in reality, in that it became clear during the course of the hearing that Ms. K's husband, the father of the baby, was in the jurisdiction on 21st September, 2006 and, in fact, was in the Hospital at around 3 p.m. that afternoon. Therefore, the reality was that, in the unfortunate event of Ms. K's death, her baby was not going to be left without a parent in the State. At the time the hearing commenced, he was just over a year old and was living in the State with both his parents.

36. The scheme of the remainder of this judgment is as follows:

(1) The law on the capacity question will be considered in section IV.

(2) The *ex parte* application and the determination made by Abbott J. will be outlined in detail in section V.

(3) The evidence relevant to the capacity question will be outlined and considered in section VI.

(4) The application of the law on the capacity question to the facts will be dealt with in section VII.

(5) Whether the balance of rights question should be considered will be addressed in section VIII.

(6) The issues raised as to the manner in which the *ex parte* order was sought and the reliefs claimed in respect of it will be considered in section IX.

(7) The form of order will be dealt with in section X.

(8) Some measures which would assist medical and legal personnel in dealing with the type of emergency which arose in this case will be considered in section XI.

IV. Capacity question: the law

Irish jurisprudence
37. I have already alluded to the novelty of the core issue in this jurisdiction. Specifically, an Irish court has not had to consider previously how capacity to refuse consent to medical treatment on the part of an adult should be tested. The decisions of the High Court in *Geoghegan v. Harris* [2003] 3 I.R. 356 and the Supreme Court in *Fitzpatrick v. White* [2007] IESC 51, in which, in the context of claims for damages for medical negligence, the test to be adopted by the court as to what risks ought to be disclosed to a patient before he or she consents to a medical procedure so that the patient makes a real choice, in my view, are not apposite. I appreciate that those decisions were cited in the written submissions on behalf of Ms. K for the purpose of delineating the information which the treating clinician should give to a patient in Ms. K's position, which it was suggested was the following:

(a) that she was bleeding,

(b) that there was a risk that she would die as a result of that blood loss,

(c) that she required blood or blood products if she was to avert that risk of death, and

(d) that there was a range of blood products that she might wish to consider in the event that she was refusing whole blood and/or "major" blood factors.

Authorities from other jurisdictions
38. There are authorities from other jurisdictions which afford guidance on how capacity is to be tested in relation to decisions to refuse medical treatment in both elective and emergency situations where the treatment is considered to be necessary to save the patient's life. I propose considering such of those authorities those authorities as I consider relevant to the issues which arise in this case. I will consider them in chronological order, because I believe that the jurisprudence has become established over the years as the courts have had more experience in dealing with these difficult issues. A number of cases involving patients who were minors were cited in argument. However, I have not found those cases to be of assistance because they raise distinct issues which do not arise in cases involving competent adult patients.

Malette v. Schulman 72 O.R. (2d) 417
39. While, unlike the situation which arose in the Hospital on 21st September, 2006, the Court of Appeal of Ontario was not concerned with the capacity of a conscious adult patient to refuse a blood transfusion in *Malette v. Schulman*, its decision has influenced courts in the United Kingdom which have considered the capacity question. The plaintiff, Mrs. Malette, was severely injured in a car accident and brought to hospital unconscious. The defendant, Dr. Schulman, having examined her, concluded that a blood transfusion was indicated. A nurse found what is commonly called an advance directive card in her purse which was signed by her and on which "as one of Jehovah's Witnesses with firm religious convictions" she requested that no blood or blood products be administered to her "under any circumstances", stating that she fully realised the implications of that position but had resolutely decided to obey the Bible command. The card went on to state that she had no religious objection to the use of non-blood alternatives, examples of which were given. Notwithstanding the advance directive, Dr. Schulman, being of opinion that a blood transfusion was necessary to save Mrs. Malette's life and health, administered transfusions to her. At first instance she was awarded $20,000 by way of damages for battery in her action for damages against Dr. Schulman.

40. That decision was appealed. It is clear from the judgment of Robins J.A. on the appeal that, in substance, the law on the right of a competent adult patient to reject a blood transfusion applicable in Ontario at the time corresponds with the current law in this jurisdiction. A competent adult was generally entitled to reject specific or all treatment or to select an alternative form of treatment, even if the decision might entail risks as serious as death and might appear to be mistaken in the eyes of the medical profession or of the community (per Robins J.A. at p. 328). The emergency situation, in which a patient is incapable of either giving or withholding any consent, was an exception to the general rule.

41. An argument advanced on behalf of Dr. Schulman was that, unless a doctor can obtain the patient's informed refusal of blood transfusions, he need not follow the instructions provided in the advance directive card, because nothing short of a conscious, contemporaneous decision made after having been fully informed by the doctor of the risk of refusing blood in specific circumstances would suffice to eliminate the doctor's authority to administer emergency treatment or relieve the doctor of his obligation to treat the emergency patient as he would any other. Robins J.A. rejected that argument. Having pointed to the fact that in the particular emergency circumstances the doctor could not inform the patient of the risks involved in her prior decision, so that, whatever the doctor's obligation to provide the information needed to make an informed choice might be in other doctor-patient relationships, he could not be in breach of any such duty in the circumstances of his relationship with Mrs. Malette, he went on to say (at p. 336):

"The patient manifestly made the decision on the basis of her religious convictions. It is not for the doctor to second-

guess the reasonableness of the decision or to pass judgment on the religious principles which motivated it. The fact that he had no opportunity to offer medical advice cannot nullify instructions plainly intended to govern in circumstances where such advice is not possible. Unless the doctor had reason to believe that the instructions in the Jehovah's Witness card were not valid instructions in the sense that they did not truly represent the patient's wishes, in my opinion he was obliged to honour them. He had no authorisation under the emergency doctrine to override the patient's wishes. In my opinion, she was entitled to reject in advance of an emergency a medical procedure inimical to her religious values."

42. On the question whether Dr. Schulman factually had reason to believe the instructions were not valid, the Appeal Court upheld the trial judge's finding that the doctor's doubt about the validity of the card was not rationally founded on evidence before him. The Court of Appeal also upheld the trial judge's finding that there was no basis in evidence to indicate that the card did not represent the current intention and instruction of Mrs. Malette, Robins J.A. observing (at p. 337) that there was nothing to give credence to or provide support for the speculative inferences implicit in questions as to the current strength of Mrs. Malette's religious beliefs, or as to the circumstances under which the card was signed, or her state of mind at the time. Robins J.A. continued:

> "In short, the card on its face set forth unqualified instructions applicable to the circumstances presented by this emergency. In the absence of any evidence to the contrary, those instructions should be taken as validly representing the patient's wishes not to be transfused. If, of course, there were evidence to the contrary – evidence which cast doubt on whether the card was a true expression of the patient's wishes – the doctor, in my opinion, would be entitled to proceed as he would in the usual emergency case.

43. There being no such contradictory evidence in relation to Mrs. Malette's wishes, the Court of Appeal upheld the finding that the doctor's administration of the transfusion constituted a battery and affirmed the award of damages.

44. By analogy to the approach adopted by the Court of Appeal, in principle, the instructions of a patient not to transfuse given verbally to a doctor, even in an emergency, should be followed unless there is evidence to cast doubt on the capacity of the patient to give instructions at the time. Nonetheless, in the light of the submissions made by counsel for the plaintiffs, it is important to reiterate that the facts which gave rise to the decision in *Malette v. Schulman* are very different from the facts in this case. It is clear from the evidence in this case that members of the Jehovah's Witness faith in this jurisdiction do carry advance directive cards. Although she professed to have one, Ms. K did not produce an advance directive in card form or any other form to the Hospital or to any of the other hospitals she attended in this country. The issue of the validity of an advance directive card or its efficacy in the event of an emergency does not arise in this case. It is for another day, as are the concerns voiced by counsel for the plaintiffs as to the approach adopted by the Court of Appeal in *Malette v. Schulman*. In particular, the suggestion that the annual advance directive renewal process at a service in Kingdom Hall, coupled with risk of disfellowship or disassociation, may influence a decision of a Jehovah's Witness in relation to blood transfusion and that the Canadian Court's approach did not have regard to the propensity for a change of mind, for the reasons mentioned later in the context of the concept of voluntariness, in my view, are not matters which should in any way influence the decision of the court in this case.

Re T (adult: refusal of medical treatment) [1992] 4 All E.R. 649

45. Turning to the United Kingdom authorities, the starting point for the decision of the Court of Appeal in *Re T* was the same as the starting point for the Supreme Court in *In re a Ward of Court* and the starting point for the court of Appeal of Ontario in *Malette v. Schulman*: "an adult patient who … suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered" (per Lord Donaldson M.R. at p. 652). Lord Donaldson added that the only possible qualification was a case in which the choice might lead to the death of a viable foetus, but he left that question over. As will be clear from what I will say later, the Court of Appeal subsequently decided that no such qualification exists.

46. *Re T* concerned the refusal of treatment by an adult Jehovah's Witness and it was a case in which the question of capacity to refuse and the validity of the refusal arose. Miss T, who was 34 weeks pregnant, was admitted to hospital following a car accident. The possibility of her requiring a blood transfusion arose. She had been brought up by her mother, who was a Jehovah's Witness, but she was not herself a member of that faith. After a private conversation with her mother, Miss T told the staff nurse that she did not want a blood transfusion for religious reasons. When she went into labour it was decided that her delivery should be by Caesarean section. After being alone with her mother, Miss T again told medical staff that she did not want a blood transfusion. She was informed that other solutions to expand the blood could be used and that blood transfusions were not often necessary after a Caesarean section. She then, as it is put in the head note, "blindly" signed a form of refusal of consent to blood transfusions but it was not explained to her that it might be necessary to give her a blood transfusion to save her life. After undergoing an emergency Caesarean operation her condition deteriorated and a blood transfusion was medically indicated. However, the Consultant Anaesthetist felt inhibited from administering the transfusion in the light of her expressed wishes. She was put on a ventilator and paralysing drugs were administered.

47. Miss T's father and her boyfriend applied to court for assistance. The application was heard *ex parte*. The judge, Ward J., took evidence over the telephone from a doctor who had spoken to Miss T in the maternity unit after she had stated for the second time that she did not wish to have a blood transfusion and before she signed the refusal form. Ward J. recorded that he was told by the doctor that Miss T was under the influence of a narcotic drug, pethidine. Her demeanour was drowsy and detached. He expressed the opinion that she was not fully *compos mentis*; that she was not fully rational in making an assessment of her medical condition, being unaware how critical her condition was; and that she was not fully rational at the time of signing the refusal. Ward J. granted interlocutory relief by way of a declaration that it would not be unlawful for the hospital to administer a blood transfusion to Miss T despite the absence of her consent. Thereupon, Miss T was transfused.

48. Two days later there was a full hearing before Ward J. at which the evidence of the doctors and the nurses involved in the care of Miss T was heard. Lord Donaldson summarised his findings as follows (at p. 659):

> "In essence Ward J. found that the physical and mental state of Miss T on the Sunday afternoon and evening were such that, although she was undoubtedly under the influence of her mother, she was capable of reaching and did reach a decision as to her own treatment. However, he went on to find that Miss T was lulled into a sense of false security by hospital staff and that she was misinformed as to the availability and effectiveness of alternative procedures. Against this background and his assessment of the shallowness of Miss T's acceptance of the beliefs of the Jehovah's Witnesses, he construed Miss T's refusal of treatment by blood transfusion as not extending to the question of whether or not she would receive transfusions in the extreme situation which had arisen. In other words he concluded that, as to that, Miss T had neither consented nor refused. As Miss T was no longer able to express any view, it was a classic 'emergency' situation in which it was lawful for the doctors to treat her in whatever way they considered, in the exercise of their clinical judgment, to be in her best interests."

49. Miss T, acting by the Official Solicitor as her guardian *ad litem*, appealed. The Court of Appeal dismissed the appeal but without approving of the findings of fact made by Ward J., Lord Donaldson stating that there was abundant evidence which would have justified the Court of Appeal substituting findings that Miss T was not in a physical or mental condition which enabled her to reach a decision binding on the medical authorities and, even if she was, the influence of her mother was such as to vitiate the decision she expressed. The significance of the decision of the Court of Appeal is that, for the guidance of hospital authorities and the medical profession, Lord Donaldson in his judgment set out the principles by which the issue of the validity of an adult patient's refusal is to be determined. He summarised the principles at the end of his judgment (at p. 664).

50. The first principle, that, *prima facia*, every adult has the right and capacity to decide whether or not he will accept medical treatment, even if the refusal may risk permanent injury to his health or even lead to premature death, and whether the reasons for refusal are rational or irrational, unknown or even non-existent, mirrors the dicta of the Supreme Court in *Re a Ward of Court*. However, on the question of capacity, he stated that the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable and continued:

> "(2) An adult patient may be deprived of his capacity to decide either by long-term mental incapacity or retarded development or by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs.
>
> (3) If an adult patient did not have capacity to decide at the time of the purported refusal and still does not have that capacity, it is the duty of the doctors to treat him in whatever way they consider, in exercise of their clinical judgment, to be in his best interests.
>
> (4) Doctors faced with the refusal of consent have to give very careful and detailed consideration to what was the patient's capacity to decide at the time when the decision was made. It may not be a case of capacity or no capacity. It may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health. Others may not.
>
> (5) In some cases doctors will not only have to consider the capacity of the patient to refuse treatment but also whether the refusal has been vitiated because it resulted not from the patient's will, but from the will of others …
>
> (6) In all cases doctors will need to consider the true scope and basis of the refusal. Was it intended to apply in the circumstances which have arisen? Was it based upon assumptions which in the event have not been realised? A refusal is only effective within its true scope and is vitiated if it is based upon false assumptions.
>
> (7) …
>
> (8) In cases of doubt as to the effect of a purported refusal of treatment, where failure to treat threatens the patient's life or threatens irreparable damage to his health, doctors and health authorities should not hesitate to apply to the courts for assistance."

51. Before embarking on that analysis, Lord Donaldson pointed to the conflict of principle which arises in the case of a refusal of consent to treatment between the interest of the patient and the interest of society. The patient's interest is his right to self determination – to live his own life as he wishes, even if it will damage his health or lead to premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. Having stated that it is well established that in the ultimate the right of the individual is paramount, he continued (at p. 661):

> "But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so the way in which, the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life, for if the individual is to override the public interest he must do so in clear terms."

52. Counsel for Miss K took issue with the proposition enunciated by Lord Donaldson, which is reflected in the fourth principle, that the patient's capacity should be commensurate with the gravity of the decision which he purports to make, suggesting instead that the level of capacity required should be measured against the nature of the decision, that is to say, its complexity, rather than its consequences. It was also submitted that the proposition may have the effect of reversing the burden of proof of capacity. In my view, Lord Donaldson, who clearly recognised the presumption in favour of capacity, was saying no more than that, where the patient's choice is of death over life, the question for the doctor is whether the patient has the capacity at the time to make a decision of that gravity. The principle enjoins the doctor to view the issue by reference to the gravity of the outcome, in much the same way as the High Court of England and Wales (Munby J.) in *H.E. v. A Hospital NHS Trust* [2003] E.W.H.C. 1017 (Fam), in a case involving an issue as to the existence and continued validity and applicability of an advance directive, held that where life is at stake the evidence must be scrutinised with special care. Clear and convincing proof is required. Similarly, the Supreme Court in *In re a Ward of Court* upheld the approach adopted by Lynch J. at first instance (p. 92) in requiring that "the evidence should be clear and convincing having regard to the gravity of the matter for decision …" (c.f. Hamilton C.J. (at p. 127)).

Re C (adult: refusal of medical treatment) [1994] 1 All E.R. 819

53. There was consensus among the parties that the test for capacity adumbrated in Re C is the appropriate test to assess capacity or lack of it in the context of a refusal of medical treatment. Counsel for Ms. K also submitted that the judgment is instructive as to how the test should be applied having regard to the manner in which it was applied on the facts of the case.

54. The facts were that C, a 68 year old patient suffering from paranoid schizophrenia, who was being detained in Broadmoor, developed gangrene in a foot. He was removed to a general hospital, where the consultant surgeon diagnosed that he was likely to die imminently if his leg was not amputated below the knee. C refused to consider an amputation. The hospital authorities considered whether the operation could be performed without C's consent and made arrangements for a solicitor to see him. Treatment with antibiotics and conservative surgery averted the immediate threat of imminent death. However, the hospital refused to give an undertaking to C's solicitor that, in recognition of his repeated refusals, it would not amputate in any future circumstances. C applied for an injunction restraining the hospital from carrying out an amputation without his express consent. The application was successful. Thorpe J. held that the High Court, exercising its inherent jurisdiction, could direct by way of injunction or declaration that an individual was capable of refusing or consenting to medical treatment, including future medical treatment.

55. On the question of the definition or test of capacity which enables an individual to refuse treatment Thorpe J. stated as follows (at p. 824):

> "I think that the question to be decided is whether it has been established that C's capacity is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation.
>
> I consider helpful Dr. Eastman's analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, second, believing it and, third, weighing it in the balance to arrive at choice."

56. In applying that test to his findings on the evidence, Thorpe J. stated that he was completely satisfied that the presumption that C had the right of self determination had not been displaced. He continued (at p. 824):

> "Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice."

57. Thorpe J. arrived at his decision on the facts, finding that C had passed all three elements of the test, having heard oral evidence from three consultant psychiatrists and from C. As his analysis of, and findings on, the psychiatric evidence was crucial to his decision, I do not attach the weight to the application of the test to the facts which counsel for Ms. K urged. The facts there were unusual and, in the final analysis, the case was decided on how the judge viewed the totality of the evidence. In particular, in finding that C passed the second element of the test, that he believed the treatment information, Thorpe J. specifically found that C believed it "in his own way".

58. It is, I think, worth noting the circumstances in which Thorpe J. decided the *C* case, which are in stark contrast to the circumstances in which Abbott J. had to determine the *ex parte* application. C was told of the necessity for an amputation on 15th September, 1993 and refused consent for the procedure. By the time the originating summons was issued on 4th October, the emergency had subsided. Nonetheless, there was a full *inter partes* hearing almost immediately – on 8th and 9th October. The Official Solicitor appeared as *amicus curiae*. Judgment was delivered on 14th October. The outcome, in effect, gave effect to an oral advance directive by C as the court order extended into the future beyond the prevailing circumstances when it was made.

59. Counsel for the Attorney General accepted that it is part of the State's duty to respect and vindicate rights under Article 40.3 to ensure that a person refusing life-saving treatment has the necessary capacity. He indicated that the Attorney General does not disagree that the test formulated in the *C* case is the correct test. However, counsel emphasised the panoply of constitutional rights and duties which form the backdrop against which the test must be applied: the rights to life, bodily integrity, privacy, self-determination and freedom to practice religion; and the State's corresponding duties. He also submitted that the right of a new-born baby to be reared by his parents is also part of that backdrop and the position of the new-born baby is highly relevant in assessing capacity in the case of Ms. K.

60. It is convenient at this juncture, to analyse a submission made by counsel for Ms. K in relation to the application of the *C* case test in this type of case. It was submitted that, in assessing capacity to refuse medical treatment where the refusal is on religious grounds, the law must have regard to the subjective views of the patient whose beliefs are protected by Article 44. In relation to the application of the second element of the *C* case test, the requirement of belief in the treatment information, to a case where a patient's refusal of a blood transfusion is based on a tenet of the patient's religious belief it is immaterial, it was submitted, whether the patient believes that the acceptance of a blood transfusion would be efficacious or not to save his or her life. Otherwise, it was argued, a rational scientific analysis would supplant faith.

61. In my view, that submission is not correct. What the law, as set out in the *C* case, requires is that the patient be given the relevant information about his or her condition, the proposed treatment, any alternative treatment available and the likely outcome of adopting such options as are open to the patient. In a case in which the doctor considers that a blood transfusion is necessary to save the patient's life and that without it the patient will die, that is the information which the patient has to be given, as counsel for Ms. K acknowledged. But it is also the information which the patient has to assimilate, has to believe and has to factor into the decision making process. Article 40.3 protects life and requires that, as does the common law. If the patient is not given the relevant information or, alternatively, fails to assimilate it and believe it, the first two elements of the *C* case test are not fulfilled. If the patient does assimilate and believe the information but nonetheless rejects the treatment on the basis of a religious conviction, for example, adherence to a scriptural proscription on accepting the treatment, he or she has passed the *C* case test as to capacity notwithstanding that the doctor and non-believers may consider the basis of his or her refusal to be wholly irrational. Article 44, which protects the patient's religious belief, requires that, as does the recognition at common law of his right to self-determination.

62. I consider that a fundamental fault line in the case made on behalf of Ms. K is the argument that the Hospital personnel who were treating her and were confronted with the issue whether she had given a valid refusal should have accepted her refusal as being based on religious grounds without considering her capacity by reference to her understanding of her medical condition and, in particular, whether she understood and believed that a blood transfusion was necessary to save her life. The approach advocated on behalf of Ms. K effectively elides the second element of the **C** case test.

63. It also ignores the following guidance given by Butler Sloss L.J. in *Re B (Adult: Refusal of Treatment)* [2002] 2 All E.R. 449 (at para. 100, p. 474) quoted in the written submission submitted on behalf of Ms. K, and also referred to in the written submission on behalf of the Attorney General:

> "If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision."

Re M.B. (Medical Treatment) [1997] 2 F.L.R. 426.

64. The *C* case test was applied by the Court of Appeal in *Re M.B.* The patient in that case was advised to have a Caesarean section because the foetus was in breech position and a vaginal delivery posed a serious risk of death or brain damage to the baby. She agreed and signed a consent form. However, when successive attempts were made to carry out the operation she panicked at the last moment, because she had needle phobia, and withdrew her consent. In the emergency, the health authority applied to the High Court for, and was granted, a declaration that it would lawful to operate on her, using force if necessary. That night the Court of

Appeal dismissed the patient's appeal. In a reserved judgment delivered later, the Court of Appeal addressed the question of capacity, drawing on the judgment of Lord Donaldson in *Re T* and the judgment of Thorpe J. in *Re C*. In her judgment, Butler-Sloss L.J. reiterated (at p. 436) that a competent woman who has capacity to decide may, "for religious reasons, other reasons, for rational or irrational reasons, or for no reason at all", choose not to have medical intervention even though the consequence may be her own death or, addressing the issue which was left over in *Re T*, the death or serious handicap of the child she bears. She went on to consider the meaning of irrationality in this context in the following passage (at p. 437):

> "Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question that is to be decided could arrive at it. As Kennedy and Grubb *Medical Law* … point out, it might be otherwise if a decision is based on a misperception of reality (e.g. the blood is poisoned because it is red). Such a misperception will be more readily accepted to be a disorder of the mind. Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, commensurately greater the level of competence is required to take the decision …"

65. That passage highlights the distinction which the fault line in Ms. K's argument overlooks. It distinguishes irrationality of the decision, on the one hand, from misunderstanding or misperception of the information which is material to the decision-making process, for example information as to the likely consequences of having or not having the treatment proffered, on the other hand. The proper application of the three step C case test, in my view, should obviate a blurring of the distinction, but the evidence of experts does not always do so, as will be illustrated later.

66. On the facts, Butler-Sloss L.J. found that M.B. was incapable of making a decision at all, at that moment she was suffering from an impairment of her mental functioning which disabled her, and she was temporarily incompetent, so that the doctors were free to administer an anaesthetic if that was in her best interests.

67. At the end of her judgment Butler-Sloss L.J. set out guidelines on the practice to be followed when the medical profession consider it necessary to seek assistance from the courts, which were elaborated on in the next case considered.

St. George's Healthcare and N.H.S. Trust v. S [1998] 3 W.L.R. 936

68. This is the final United Kingdom authority on the capacity question which I propose to consider in detail. It is an authority on which reliance was placed by counsel for Ms. K. It was the decision of the Court of Appeal.

69. The facts were that S, who was 36 weeks pregnant and had not previously sought ante-natal care, attended her local NHS practice and was diagnosed as suffering from pre-eclampsia and advised of the need for bed rest with an induced delivery without which her life and that of her unborn child would be in danger. She understood the risks but rejected the advice since she wanted a natural delivery. A social worker approved under the Mental Health Act, 1983 and two doctors repeated the advice but she still refused to accept it. The social worker applied under that Act for her admission to a mental hospital for assessment and the two doctors signed the necessary recommendations. That evening she was admitted to a mental hospital against her will and shortly afterwards transferred to a general hospital, St. George's Hospital, against her will, when she continued to refuse to consent to treatment. The next day at lunch time the hospital authorities applied *ex parte* to a judge in chambers who granted a declaration, which dispensed with the applicant's consent to treatment. The hospital carried out a Caesarean section and the applicant was delivered of a baby girl. A few days later she was returned to the mental hospital. Her detention under the Act was subsequently terminated and she discharged herself from hospital. Her appeal against the declaration and her application for judicial review of the decisions of the social worker for her admission to a mental hospital and of the hospital authorities to detain her were successful. The judgment of the court, of which Butler-Sloss L.J. was a member, was delivered by Judge L.J.

70. What emerges clearly from the judgment of the Court of Appeal is that, prior to the moving of the *ex parte* application, the psychiatrist who was assessing S was of the view that her "capacity" for consent "was intact" and she apprised the counsel moving the application accordingly, although she added that "it could be affected by a mental/psychiatric state". No evidence whatsoever was tendered at the hearing. The court was told that S had been in labour for 24 hours, which was not the case. The court was told that S had been admitted under the Mental Health Act for assessment of her mental and psychiatric condition, that the assessment was "ongoing" and that only "moderate depression" had been diagnosed. The Court of Appeal recorded that, beyond that, the question of the capacity of S to consent was not addressed. It was suggested before the Court of Appeal by counsel for the hospitals that the topic was not addressed at all because it was assumed throughout the hearing that S was competent. The court was not told that S had already instructed solicitors, which was known to the hospital, or that she or her solicitors were ignorant of the proceedings. The Official Solicitor was not involved. At the time it was not appreciated that S was not lawfully detained at St. George's Hospital.

71. The Court of Appeal concluded that S knew perfectly well what she was doing and that there was no sufficient evidence from which to conclude that her competence on that day was in question.

72. Following *In re M.*B., the Court of Appeal held that S was entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depended on it.

73. The Court of Appeal was highly critical of the conduct of the *ex parte* application and held that S was entitled to have it set aside *ex debito justiciae*. I will be returning to this aspect of the case later. However, I think it is important to point out, even in the context in which I am considering the decision of the Court of Appeal at this juncture, that in setting aside the order, which opened the way for a claim for damages for trespass by S against St. George's Hospital, the Court of Appeal was exercising its appellate jurisdiction in relation to the declaratory order.

74. At the end of the judgment, Judge L.J. set out guidelines for dealing with the type of problem which arose in that case, describing them as an attempt to repeat and expand the advice given in *In re M.B*. The guidelines envisage an application to court in two situations only. The first is where there is concern about a patient's competence to consent to or refuse treatment to the extent that, following assessment, there remains a serious doubt about the patient's competence or the seriousness or complexity of the issues require the involvement of the court. The second arises where a patient has given an advance directive and there is reason to doubt the reliability of the advance directive, for example, where it may sensibly be thought not to apply to the circumstances which have arisen. However, the Court of Appeal recognised that that there may be occasions when the situation is so urgent and the consequences so desperate that it is impracticable to attempt to comply with the guidelines. In my view, the situation which arose when Ms. K suffered a massive haemorrhage and disclosed for the first time that she would not accept a blood transfusion on religious grounds was such a situation.

The C case test in the context of constitutional protections and imperatives
75. In the authorities from other jurisdictions which I have considered above, the courts were concerned with the formulation of a common law test as to capacity to make a decision to refuse life-saving treatment. A consistent thread in the authorities is a recognition of society's interest in preserving life if at all possible, notwithstanding that in the ultimate the right of the individual is paramount. But there is also a consistent thread that a court should act with caution where there is a conflict between society's interest in preserving life and the individual's right of self-determination. That thread is reflected in the passage from the judgment of Lord Donaldson M.R. in *Re T* (at p. 661), which I have quoted earlier, which emphasises that, in case of doubt, "that doubt falls to be resolved in favour of preservation of life, for if the individual is to override the public interest, he must do so in clear terms."

76. Counsel for the plaintiffs submitted that in this jurisdiction, where the decision to refuse life-saving treatment amounts to a waiver of the individual's constitutional right to life guaranteed by Article 40.3.2, the court should have regard to the jurisprudence on the conditions for a valid waiver of constitutional rights. In *G. v. An Bord Uchtála* [1980] I.R. 32 at p.74, Walsh J. articulated the test for a valid consent to waiver of a constitutional right, in the context of a mother's consent to place her child for adoption, as follows:

> "I am satisfied that, having regard to the natural rights of the mother, the proper construction of the [statutory] provision … is that the consent, if given, must be such as to amount to a fully informed, free and willing surrender or abandonment of these rights. However, I am also of the opinion that such a surrender or abandonment may be established by her conduct when it is such to warrant the clear and unambiguous inference that such was her fully informed, free and willing intention. In my view, a consent motivated by fear, stress or anxiety, or a consent or conduct which is dictated by poverty or other deprivation does not constitute a valid consent."

77. It follows, counsel for the plaintiffs submitted, that a refusal of treatment which in effect constitutes a waiver of the patient's right to life must, in this jurisdiction, reach a particularly high threshold before it can be considered a valid refusal. It seems to me that the appropriate threshold has been identified by the Supreme Court in *In re A Ward of Court* in the requirements that there should be "clear and convincing proof having regard to the gravity of the decision" referred to earlier, and that "the court should not draw its conclusions lightly or without due regard to all the relevant circumstances including the consequences …" (per Denham J. at p. 155).

Voluntariness
78. The passage from the judgment of Walsh J. in *G. v. An Bord Uchtála* quoted above emphasises that to be valid the consent must be "free and willing", in other words it must be voluntary. That a decision to refuse life-saving treatment must represent the patient's independent decision and that a doctor or a court evaluating capacity must be satisfied that the patient's will was not overborne in such a way that the refusal will not have represented "a true decision" (per Lord Donaldson in outlining the fifth principle in *Re T*) is beyond question.

79. In the course of the hearing I ruled that no issue arose that Ms. K's decision to refuse a blood transfusion was induced by undue influence, because there was no allegation of undue influence in the pleadings. However, I left open the issue of the voluntariness of the decision. I think it is fair to record that I am satisfied that one could not conclude on the evidence that Ms. K was influenced or pressurised in the making of her decision to refuse a blood transfusion by the only person with whom she had contact after the haemorrhage other than Hospital personnel, Ms. F, who will be referred to later.

80. I have already alluded to the fact that counsel for the plaintiffs questioned the approach adopted by the Ontario Court of Appeal in *Malette v. Schulman*, the sub-text being that the practices of, and sanctions imposed by, the Jehovah's Witness religion should raise doubts as to a decision of member of that faith to refuse a blood transfusion on religious grounds. It is possible that in a particular case a court might conclude that the decision of a Jehovah's Witness to execute an advance directive or, in particular circumstances, to refuse a life-saving blood transfusion was motivated by peer pressure or fear of social or economic deprivation due to disfellowship or disassociation to the extent that the decision was not voluntary. However, for a court to have regard to such factors, in my view, they would have to be specifically pleaded (cf O. 19, r. 5 of the Rules), and there would have to be evidence from which the court could conclude that the decision was not a voluntary decision. Those matters were not pleaded in this case and, accordingly, are not issues. Nonetheless, I think it is fair to record that while that Ms. K was cross-examined in relation to her perceived dependence at the time on members of the Jehovah's Witness faith in this jurisdiction, I am satisfied that one could not conclude on the evidence that her decision was motivated by fear of economic deprivation.

81. It is noteworthy that, while there have been many cases in which the issue as to undue influence of a family member of a particular faith, for example, of the Jehovah's Witness faith, over a patient refusing life-saving treatment has arisen, in none of the authorities involving an adult patient to which the court has been referred was the issue of the influence of the sanctions imposed by a particular faith explored in the context of whether such a decision of a patient was voluntary. Every case must be decided on its own facts. I am satisfied that the practices and sanctions of the Jehovah's Witness religion were not, and could not properly have been, in issue in the evaluation of the quality of Ms. K's refusal on 21st September, 2006, either in the hospital or on the *ex parte* application. They were not raised on the pleadings and are not in issue now. In short, in my view, no issue as to the voluntariness or otherwise of Ms. K's refusal of a blood transfusion arises. This aspect of the case is about Ms. K's capacity to refuse a blood transfusion after she haemorrhaged on 21st September, 2006 and, in particular, whether there was evidence which objectively raised doubts as to her capacity.

Law Reform Commission recommendation
82. Counsel for Ms. K referred the court to the discussion on capacity in a Law Reform Commission publication in 2005: Consultation Paper on Vulnerable Adults and the Law: Capacity (LRC CP37-2005). Following a consultation process the Law Reform Commission published in 2006 a report on Vulnerable Adults and the Law (LRC 83-2006). It is pointed out in the report (at p. 82) that there is no obvious reason why capacity to make a Healthcare decision should not be covered by the statutory test of capacity proposed in the report. That test is to be found on p. 51, which contains the following recommendation:

> "The Commission recommends that capacity will be understood in terms of an adult's cognitive ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is made."

83. The Commission further recommends –

> "… that a person will not be regarded as lacking capacity simply on the basis of making a decision which appeared unwise."

84. That test is decision-specific and time-specific and is formulated so as to encompass possible impairment of capacity from whatever cause. It is consistent with the C case test, if more pithily expressed.

85. In the course of the hearing I drew counsels' attention to a recently published article which is relevant to the capacity question: "Assessing Legal Capacity: Process and the Operation of the Functional Test" by Mary Donnelly (Judicial Studies Institute Journal, 2007 No. 2 at p. 141), which contains a useful commentary on the process of capacity assessment.

The test for assessing capacity: the law
86. On the basis of the foregoing analysis of the authorities from other jurisdictions and having regard to the constitutional framework within which the capacity question must be determined in this jurisdiction, it seems to me that the relevant principles applicable to the determination of the capacity question are as follows:

> (1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment, but that presumption can be rebutted.
>
> (2) In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether –
>
> > (a) by reason of permanent cognitive impairment, or
> >
> > (b) temporary factors, for example, factors of the type referred to by Lord Donaldson in In *re T*,the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.
>
> (3) The three-stage approach to the patient's decision-making process adopted in the *C* case is a helpful tool in applying that test. The patient's cognitive ability will have been impaired to the extent that he or she is incapable of making the decision to refuse the proffered treatment if the patient–
>
> > (a) has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment,
> >
> > (b) has not believed the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient's death, has not believed that outcome is likely, and
> >
> > (c) has not weighed the treatment information, in particular, the alternative choices and the likely outcomes, in the balance in arriving at the decision.
>
> (4) The treatment information by reference to which the patient's capacity is to be assessed is the information which the clinician is under a duty to impart – information as to what is the appropriate treatment, that is to say, what treatment is medically indicated, at the time of the decision and the risks and consequences likely to flow from the choices available to the patient in making the decision.
>
> (5) In assessing capacity it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision-making process (which may sometimes be referred to colloquially as irrationality), on the one hand, and an irrational decision or a decision made for irrational reasons, on the other hand. The former may be evidence of lack of capacity. The latter is irrelevant to the assessment.
>
> (6) In assessing capacity, whether at the bedside in a high dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the proffered treatment. In the private law context this means that, in applying the civil law standard of proof, the weight to be attached to the evidence should have regard to the gravity of the decision, whether that is characterised as the necessity for "clear and convincing proof" or an enjoinder that the court "should not draw its conclusions lightly".

87. The fourth principle set out above was prompted by the evidence adduced and the arguments advanced on behalf of Ms. K on the issue as to whether a blood transfusion was "necessary" when Ms. K was transfused and will be elaborated on later.

V. The ex parte application and its determination

The application
88. The application was made in open court, but Abbott J. directed that the defendant should be referred to as Ms. K.

89. Counsel for the plaintiffs apprised the court of the background to the matter. Ms. K was a 23 year old woman from the DRC. She had gone into labour during the course of the night and, following a difficult delivery, had given birth to a baby at approximately 9.30 a.m. that morning. It was her first delivery. Insofar as the Hospital was aware, her husband remained in the DRC. Ms. K presented for her booking visit in the Hospital on 6th July, 2006. She was accompanied by a friend, who interpreted for her. The court was told that Ms. K's language was French and she did not speak any English. The Hospital understood up until that morning, when the patient refused a blood transfusion, that she was a Roman Catholic. It was when she refused the blood transfusion that the patient, speaking through her interpreter friend, had informed the Hospital that she was a Jehovah's Witness.

90. In relation to the emergency and the patient's condition, counsel informed the court that shortly after the delivery Ms. K had a massive haemorrhage, when she lost approximately 75% to 80% of her blood. She required a huge blood transfusion in order to survive. Since delivery she had been under the care of four or five consultants.

91. In the course of informing the court about the emergency, counsel informed the court that it was the opinion of the Hospital that Ms. K was *compos mentis*. She was also *sui juris.* The gravity of the situation had been explained to her through her interpreter friend. Counsel then identified what he considered to be the principal difficulty. Ms. K. was then currently stable, in that the Hospital had managed to stabilise her using a number of artificial products, including products which are deemed suitable by Jehovah's Witnesses. However, there was a real risk, if not a probability, that if she began to bleed again she would die in a matter of hours if the transfusion and all associated procedures did not proceed.

92. The factual situation having been opened in that manner, Abbott J. stated his view that Ms. K should be taken as being notionally present and opposing the application. He also stated that he was making the assumption that Ms. K might shortly be unable to oppose the application. Counsel confirmed that that was a possibility.

93. Abbott J. then indicated that he would hear oral evidence from the Master. The Master testified that the account which counsel had presented to the court was accurate. When asked by counsel whether there was any relevant material which was omitted, the Master indicated that there was not.

94. Abbott J. then sought submissions on the law in relation to the issue before him. In doing so, he commented that he had granted orders previously, overriding the wishes of Jehovah's Witness patients in relation to treatment of minor children. He commented that, as far as he was aware, such an order had not been made in a case in which a competent adult was refusing treatment. He remarked on the fact that Ms. K was conscious. He acknowledged that the case involved a life or death situation and that, if Ms. K were present in court on a stretcher, she would object to the administration of the treatment.

95. In making submissions in relation to the law, counsel referred to the decision of the Supreme Court in the PKU test case, stating that the Supreme Court had found that the court could not override the wishes of the child's parents in the absence of a real risk to the life of the child. However, the effect of the decision was that the court would, in the event of a real risk to the life of the child, intervene to protect the child's constitutional right to life and, in doing so, would override the wishes of the parents.

96. The attendance note records that counsel submitted that there would be no difficulty or no question if Ms. K was unconscious. However, there was a real risk that she would slip into unconsciousness and that she would subsequently die.

97. Counsel then submitted that it was fair to observe that "there may be some issues about the quality of the refusal", referring to facts which had already been proven: that Ms. K was in a foreign country; that there was the assumption, based on the entry in the medical record, that she was a Roman Catholic; that had the Hospital been aware that she was a Jehovah's Witness in advance of the delivery she would have been prepared and counselled; that the delivery had been a difficult delivery; and that there was no other parent, insofar as the Hospital was aware, of the baby in the State. Counsel made it clear that he was not suggesting that she was incompetent to make the decision, but suggested that "the question was open to the court as to what extent her refusal was made on the basis of an informed decision".

98. In response to an intervention by Abbott J. in the course of which he stated that he was satisfied that, in the event that Ms. K said that she never wanted to see her child again, the court would be entitled to direct her to provide her child with access to Ms. K, the mother, counsel agreed and submitted that the court was required to consider the effect of the principle enunciated in the *PKU* test case, that is to say, that the religious or other objections of the parents would be overborne if there was a real and substantial risk to the life and welfare of the child. Abbott J. queried whether the judgment referred to the welfare of the child, in addition to the life of the child, and counsel confirmed that it did, stating that all members of the court agreed that the court should intervene in that latter situation. Counsel indicated that he was not in a position to respond to a query by Abbott J. as to whether the child would have a potential action in negligence against the Hospital in the event that his mother died.

99. Counsel also referred the court to a recent decision in an adoption case, where the courts were found to have general jurisdiction to protect the welfare of children, even where the course of action required did not accord with the wishes of their parents.

100. Counsel informed the court that the Hospital apprehended the possibility that Ms. K might resist the transfusion. According to the attendance note he explained that, in the view of the Hospital, it would be unsafe to administer a sedative to as to facilitate the administration of the transfusion, on which Abbott J. commented that it was very much a matter for the Hospital to decide what it would do if that arose.

101. On my reading of the attendance note, counsel for the plaintiffs put to the court the two bases on which it was contended that the court should intervene to authorise the transfusion of Ms. K notwithstanding her refusal: that the court was entitled to conclude that there was a doubt as to whether her refusal was a valid refusal; and that Ms. K's right to refuse on religious grounds could be overborne if there was a real or substantial risk to the life and welfare of her baby.

Ex tempore judgment of Abbott J.

102. In setting out the basis on which he was making the order he made, Abbott J. stated that he was of the view that Ms. K was competent and in a position to oppose the application if she was physically present in court. He stated his view that Ms. K could possibly relapse into unconsciousness or lapse into a state in which she would no longer be competent to make a decision. The attendance note also records that he also stated that it might be the case that the transfusion would have no effect and that death would follow in any event.

103. Abbott J. stated that he was prepared to override Ms. K's decision in spite of the above, which I take to mean that she was competent, and the respect which was held for her faith. He found that the welfare of the child, which was newly born into this State with no parent in sight other than Ms. K, was paramount. Therefore, it was in the interests of the child that the wishes of his mother, which might result in her death, should be overridden. Abbott J. stated that he was influenced by erring on the side of preserving life, stating that any arguments in relation to whether or not this was a correct decision could be made at a later stage. The reference to erring on the side of preserving life is resonant of the statement of Lord Donaldson in Re T. to which I have referred in two contexts earlier, that doubt in this type of case falls to be resolved in favour of preservation of life. It is also resonant of the final sentence of the judgment in a case relied on by counsel for the plaintiffs in advancing the argument that Ms. K's baby's constitutional rights took precedence over her constitutional rights – *Application of the President and Directors of Georgetown College Inc*. (1964) 331 F2d 1000 (and on re-hearing 331 F2d 1010). Having stated that to refuse to act, only to find later that the law required action, was a risk he was unwilling to take, Judge Skelly Wright of the US Court of Appeals for the District of Columbia Circuit stated that he was determined to act on the side of life. On my understanding of that judgment, Judge Skelly Wright regarded the *parens patriae* jurisdiction as the source of the state's right to intervene, which was founded on a common good concept rather than on a constitutionally-protected personal right of the child.

104. Finally, Abbott J. stated that the issue of the balance of convenience had to be considered and that the balance of convenience lay in preserving life.

105. Abbott J. then made the order in terms of the wording suggested by counsel.

Criticism of the plaintiffs' reliance on the capacity question

106. A strong theme which ran through the submissions made by counsel for Ms. K was that, not only could the Hospital not have had

doubts about Ms. K's capacity to refuse a blood transfusion on the morning of 21st September, 2006, but that the Hospital personnel did not in fact have doubts as to her capacity and capacity was not an issue before Abbott J. Insofar as the attendance note touches on the issue of capacity, it appears to have been a side issue or a "make weight", counsel suggested. It was submitted that, if the plaintiffs had not raised the issue of Ms. K's capacity to refuse before Abbott J., it is not open to them to raise it later, nor to seek to displace the presumption that Ms. K had capacity on 21st September, 2006 by establishing a lack of capacity by reference to the C case test.

107. I reject the argument that Ms. K's capacity was not an issue on the *ex parte* application. The resumé of the outline of the facts, which were verified on oath by the Master, and of the submissions made by counsel set out earlier illustrates that it was. A consistent approach was adopted by the plaintiffs when their case was subsequently pleaded.

108. In the plaintiffs' statement of claim, which was delivered just a week after the *ex parte* application in a much less pressurised context than the application had been made, in setting out the factors which gave rise to the plaintiffs' concern that Ms. K might not have been in a position to make a fully formed decision to refuse to consent to a blood transfusion, the plaintiffs itemised the following factors:

> (a) the fact that Ms. K had registered with the Hospital as a Roman Catholic;
>
> (b) the fact that the Hospital had only been informed that she was a Jehovah's Witness subsequent to the haemorrhage;
>
> (c) the fact that there were potential communication difficulties as English was not Ms. K's native tongue and she had to rely on her friend to interpret for her; and
>
> (d) the fact that there was a concern that she might not have fully recognised the seriousness of her condition, in that she might not have fully appreciated the lack of any additional alternative treatments to a blood transfusion.

109. The factors listed at (a), (b) and (c) were spelt out by counsel on the *ex parte* application. As regards the factor at (d), it is true, as counsel for Ms. K pointed out, that one does not find in the attendance note any record that the court was expressly apprised that the Hospital personnel were concerned that Ms. K did not understand the gravity of her condition, nor an explicit reference to the fact that she might not have fully appreciated that only a blood transfusion would save her life. However, it seems to me that it was implicit in the facts of which the court was apprised and the submissions made by counsel for the plaintiffs that the Hospital personnel had such concerns. That a blood transfusion was necessary to save Ms. K's life was the central fact which was emphasised by counsel on the *ex parte* application. By suggesting that there was a question as to the extent to which Ms. K's refusal was made on the basis of an informed consent, counsel was obviously raising the question, based on his instructions and the Master's evidence, of the adequacy of Ms. K's understanding that a blood transfusion was necessary to save her life. Even if that was not spelt out at the *ex parte* hearing, and it is understandable that it might not have been because of the urgency of the application, nonetheless it was part of the case made to Abbott J.

110. It is also true that Abbott J., as is apparent from his interjections and from his exposition of the basis on which he was making the order, focused on the alternative ground advanced by counsel for the plaintiffs, namely, the balancing of the rights of the baby and expressed no view on the capacity issue. It has to be acknowledged that on an objective appraisal of the basis which he advanced for making the order, as set out in the attendance note, the only reasonable inference is that Abbott J. was not basing his decision on any concern as to the capacity of Ms. K to make a valid refusal. On the contrary, it is implicit in his statement that he was overriding her decision that he considered her decision to be legally valid. However, in my view, that does not mean that the capacity question was not raised and it does not mean that it was not open to the plaintiffs to raise the capacity question in the substantive action.

VI. The evidence on the capacity question

The Question

111. On the facts here the capacity question concerns Ms. K's capacity to refuse a life-saving blood transfusion in the circumstances which prevailed between approximately 10.00 a.m. and 2.35 p.m. on 21st September, 2006. That question is now being considered on the basis of evidence adduced at a hearing which commenced over a year after the question arose and after Ms. K was transfused on the authority of an order of this Court without the question having been expressly judicially resolved. The significance of that is twofold. First, the question of capacity falls to be determined by reference to what was known to the Hospital personnel at the time of her refusal about Ms. K's condition and her circumstances. Indeed, as the decision of the Court of Appeal of Ontario in *Malette v. Schulman* indicates, if the Hospital had transfused Ms. K without the intervention of the court and was facing a claim for damages of the type for which Ms. K has counterclaimed, the approach to be adopted in such hypothetical situation would be similar: was there evidence at the time to cast doubt on Ms. K's capacity? Accordingly, the court must be astute in recognising the effect of hindsight and retrospection in the evidence. Secondly, in evaluating the evidence it is important not to lose sight of the fact that decisions made in relation to Ms. K by Hospital personnel were made in the context of an emergency, not in an elective situation. In stating that, I am not ignoring the fact that there was controversy as to whether the emergency had ceased before the *ex parte* application to court was made and before the first unit of blood was transfused. That controversy has to be resolved.

112. In the light of those observations, the question which arises as to Ms. K's capacity is whether, having regard to all of the circumstances as known to them, the Hospital personnel were objectively justified in doubting the capacity of Ms. K to make a valid decision to refuse a blood transfusion between 10.00 a.m. and 2.35 p.m. on 21st September, 2006. In answering that question by reference to the C case test, it is necessary to consider whether the evidence establishes that at the relevant time -

> (a) Ms. K understood and retained the information given to her by the Hospital personnel as to the necessity of a blood transfusion to preserve her life;
>
> (b) Ms. K believed that information and, in particular, whether she believed that she was likely to die without a blood transfusion being administered; and
>
> (c) in making her decision to refuse a blood transfusion, Ms. K had weighed that information in the balance, balancing the risk of death inherent in that decision and its consequences against the availability of a blood transfusion which would preserve her life.

113. That formulation of the application of the C case test to Ms. K's refusal assumes that, in layman's terms, a blood transfusion was "necessary" to save Ms. K's life. That assumption has been challenged on behalf of Ms. K. I will consider what "necessary" means in

this context and whether the assumption is correct according to its true meaning separately. The same issue arises on the allegation that the Hospital personnel exceeded the authority given by the order of Abbott J.

The evidence: general observations

114. The evidence was heard over approximately thirty-one days. The Master was in the witness box for approximately eight days and under cross-examination for six of those days. With one exception, namely, Dr. Paul Bowman, the Consultant Obstetrician and Gynaecologist to whose team Ms. K was assigned, all of the clinicians, namely, the Specialist Registrar in Obstetrics and Gynaecology (Dr. Noreen Russell), the Consultant Anaesthetist (Dr. Steve Froese), the Consultant Haematologist (Dr. Evelyn Conneally who is attached to St. James's Hospital and the Hospital) and the Senior House Officer in Anaesthetics (Dr. Farjad Sultan), and all of the midwives who treated and cared for Ms. K after the post partum haemorrhage and until she received the first unit of blood at around 2.35 p.m. testified on behalf of the plaintiffs. All of Ms. K's medical records from the Hospital were put in evidence. Accordingly, there is a very extensive body of evidence of what happened on the day from the Hospital's perspective.

115. The only other witnesses to the events on the day prior to the transfusion were Ms. K and her "birth partner", who has been referred to throughout the proceedings as "Ms. F".

116. There was also evidence from six independent experts, three of whom were called on behalf of the plaintiffs and three on behalf of Ms. K. The three experts who testified on behalf of the plaintiffs were:

(1) Dr. Peter Boylan, Consultant Obstetrician and Gynaecologist at the National Maternity Hospital, Holles Street, Dublin;

(2) Dr. Daniel Gerard Connaghan, Consultant Haematologist at St. Vincent's University Hospital, St. Michael's Hospital and St. Colmcille's Hospital, Dublin; and

(3) Dr. John Loughrey, Consultant Anaesthetist at the Rotunda Hospital and Mater Hospital, Dublin.

117. The three experts who testified on behalf of Ms. K were:

(a) Dr. Malcolm Griffiths, Consultant Obstetrician and Gynaecologist at Luton & Dunstable Hospital in England;

(b) Dr. Vanessa Martlew, Consultant Haematologist at the Royal Liverpool and Broad Green University Hospital's NHS Trust and Liverpool Women's Hospital; and

(c) Dr. Felicity Platt, Consultant Anaesthetist, the Lead Clinician for Obstetric Anaesthesia at Queen Charlotte's Hospital, London.

118. The expert witnesses expressed opinions on a whole range of issues from the quality of the record and note taking on the day to what the expert would have done if he or she had been in the position of the clinician with corresponding specialty treating Ms. K on the day. A vast array of articles, text book extracts, clinical advice and guidelines from professional bodies and such like were put in evidence. In many respects the evidence resembled evidence which would be led in a medical negligence claim. Leaving aside Ms. K's medical condition and the clinical judgments which flowed from it, for example, when the emergency ceased and whether a blood transfusion was necessary to save Ms. K's life at the time it was administered, in my view, the capacity question falls to be determined primarily by reference to the evidence of the witnesses who were there on the day.

Evidence on relevant facts

119. Ms. K's first attendance at the Hospital was on 3rd July, 2003 on a self referral. On that occasion she indicated that she had been booked into Sligo General Hospital but she wished to have her baby in the Hospital. She was examined and advised to make an appointment for an antenatal booking.

120. Ms. K returned to the Hospital on 6th July, 2006 for the antenatal booking appointment. She was accompanied by Ms. F. Ms. F is an African woman from Angola who, with her husband, had been granted asylum in this State a few years previously. When booking, Ms. K gave her religion as Roman Catholic. She named Ms. F as her "next of kin", but did not disclose that Ms. F was related to her by marriage, Ms. F being the wife of Ms. K's husband's brother. That relationship was not known to the Hospital personnel on 21st September, 2006 and it was only clearly disclosed in these proceedings in a letter of 19th September, 2007 from Ms. K's solicitors, correcting an earlier reply to notice for particulars dated 3rd August, 2007. When booking, Ms. K had a private interview with a staff midwife. Ms. K spoke French but the interview was conducted through the medium of a telephone interpreter. During the course of the interview Ms. K confirmed the demographic details she had given earlier to the staff at reception and signed off on, including that her religion was Roman Catholic. She told the staff midwife that she lived alone. When pressed by the midwife, because the ethnic origin of the father of the baby was important from a medical perspective, reluctantly she told the midwife that her husband was a black African from the DRC, but that she no longer lived with him. Her medical history was taken. She answered "No" to a query as to whether she had had a blood transfusion. She stated that she was 28 weeks pregnant and that she had attended hospital in the DRC in February or March, 2006 in connection with her pregnancy. Ms. K signed a consent to having blood samples taken from her and they were taken subsequent to the interview.

121. Between 6th July, 2006 and her admission on 20th September, 2006 Ms. K made eight antenatal visits to the Hospital and she was admitted to the delivery suite on at least three occasions and had two overnight stays in the Hospital. On 24th August she was interviewed by a social worker when she called for a letter of referral to a community welfare officer. She told the social worker that she had come to Ireland via Belgium in April, 2006 on a false passport and that she had applied for asylum. She also told the social worker that the father of her baby was not with her and that he might or might not be in the DRC.

122. It is clear from her own evidence that Ms. K had given false information to the Hospital as to the circumstances in which she arrived in the State. She was an asylum seeker, but she had arrived in the State via Belfast with her husband in March, 2006. Her husband returned to the DRC after a short stay, but came back in early September, 2006. Ms. K was the holder of a current DRC passport and a current visa for Schengen states issued by the German Embassy in Kinshasa on 9th January, 2006 and a current United Kingdom visa issued in Kinshasa on 2nd March, 2006 when she entered the State in March, 2006. Ms. K's evidence was that she came to Ireland to protect her baby and to get good medical care. It is also clear from her own evidence that Ms. K misrepresented her financial circumstances to the Hospital personnel. As the Hospital personnel were unaware that the facts had been misrepresented to them until Ms. K testified at the hearing, this does not bear directly on the question of Ms. K's capacity on 21st September, 2006, but it has relevance to Ms. K's credibility.

123. What does bear on the capacity question is that Ms. K, on her own evidence, gave false information to the Hospital in registering

as a Roman Catholic on booking in. The reason she advanced for so doing, that she thought it was necessary for consistency with her asylum application, was most unconvincing. There was an opportunity for her to deal with her objection to blood transfusion on religious grounds in confidence at the private interview on 6th July, 2006. There was an obvious opening at that interview, when the inquiry in relation to a blood transfusion and the requirement for blood tests arose, for her to inform the staff midwife that in an emergency she would not take a blood transfusion or blood products on religious grounds. Further, Ms. K had ample opportunity on her many visits to the Hospital before the emergency occurred on 21st September, 2006 to correct the false information she gave the Hospital as to her religion.

124. A question which hung in the air until the hearing commenced was whether the information given by Ms. K to the Hospital as to her religion was false at the time she gave it. The plaintiffs sought particulars as to when Ms. K first became a Jehovah's Witness but the information was not furnished on the basis that the matter was not relevant to the pleadings. A recurring theme throughout the Master's evidence was the assumption that Ms. K was a recent convert to a Jehovah's Witness faith. There was evidence adduced on behalf of Ms. K that documentation had been received by the Jehovah's Witness congregation in the State from Ms. K's former congregation in the DRC evidencing that she had been baptised in Kinshasa in August, 1995. Ms. K confirmed that she had been a Jehovah's Witness since 1995 and, indeed, her evidence was that her parents were Jehovah's Witnesses and that her father was a member of the Hospital Liaison Committee in the DRC. Ms. K admitted, however, that subsequent to the administration of the transfusion she had told a Hospital social worker that she had converted to the Jehovah's Witness faith in Ireland. She denied that on the day following the transfusion she told Catherine Manning, the Clinical Midwife Manager in charge of Ms. K's care in the delivery suite on 21st September, 2006, that she had converted six weeks previously, but I consider Ms. Manning's evidence that she had is to be preferred. There is no doubt that there was serious concern on the part of the medical personnel who were caring for Ms. K during and after the emergency and on the part of the Master that Ms. K had given her religion as Roman Catholic when she booked into the Hospital some two and a half months previously and was then asserting that she was a Jehovah's Witness. It may be that those circumstances, either consciously or subconsciously, gave rise to the assumption on the morning of the 21st that Ms. K was a recent convert, but it is equally possible that the evidence on this point was informed by Ms. K's subsequent assertions that she was a recent convert.

125. Ms. K arrived on her own by ambulance to the Hospital at 4.15 p.m. on 20th September, 2006. Half an hour later it was noted that she was in labour and the labour continued throughout the night. Her friend, Ms. F, arrived some time later and stayed with her through the night during her labour, delivery and the subsequent emergency. Ms. F acted as interpreter for Ms. K. Her first language is Portuguese, but she also has a level of proficiency in French and English and Lingala, one of the national languages of the DRC. She translated the communications between the Hospital personnel and Ms. K. The information furnished to the Hospital was that Ms. K's first language was French. However, it is clear from Ms. F's evidence that communications between Ms. F and Ms. K were in French mixed with Lingala. Ms. F is not a professional interpreter. She readily admitted that her proficiency in English did not extend to medical terminology. She testified in English. Her evidence was that she had no difficulty translating what the Hospital personnel asked her to translate, for example, that Ms. K really needed to take a blood transfusion or she would die. I accept Ms. F's evidence in this regard.

126. Ms. K was transferred to a delivery room at 8.20 p.m. on the evening of 20th September, 2006 and she remained there until about 2.20 p.m. on the following afternoon, when she was transferred to a room in the high dependency unit prior to the administration of the first unit of blood following the making of the court order. An epidural was administered at 9.30 p.m. on the 20th and it was last topped up before delivery at 8.10 a.m. on the following morning, presumably because she was experiencing pain. The delivery which, as the court was told on the 21st was difficult, commenced at around 9.00 a.m. that morning. The baby was delivered by the Dr. Bowman at about 9.46 a.m. Dr. Bowman had been called following a failed attempted vacuum suction and instrumental delivery. In an almost contemporaneous note he recorded a foetal malposition, which was corrected by manual rotation, because it proved difficult to rotate with a forceps. He also noted that shoulder dystocia was encountered. About two minutes after the successful delivery of the baby boy, the placenta was delivered.

127. Because of concerns for the foetus because of the shoulder dystocia, the paediatric team had been alerted. When the baby was delivered he required full resuscitation and he was handed over to the care of personnel from the special care baby unit who were present at the delivery.

128. It would appear, on the evidence, that the haemorrhage occurred about 9.50 a.m. At the outset I described it as a "massive" haemorrhage. There was some controversy as to how much blood Ms. K. lost, although it was generally accepted that estimation of blood loss in the context of an obstetric emergency is an inexact science, the tendency being to underestimate. On the basis of the data available in Ms. K's chart, the experts' estimates of the blood loss ranged from 50% of circulating volume (Dr. Griffiths) to 60% to 70% (Dr. Boylan). All of the experts called on behalf of Ms. K described the haemorrhage as "massive", although Dr. Griffiths later resiled from the use of the epithet, preferring "major" or "serious".

129. The Hospital personnel responded immediately to the emergency. The obstetric team commenced suturing the cervical and vaginal vault tears which were identified as the source of the bleeding. When suturing was completed a vaginal pack was inserted at about 10.20 a.m. Dr. Bowman held the vaginal pack in situ, exerting pressure to it, for about an hour thereafter. The anaesthetic team were called and Dr. Sultan and Dr. Froese arrived within minutes. They commenced fluid resuscitation. There is no issue as to how the Hospital personnel reacted to and managed the haemorrhage. On the contrary, all of the experts called on behalf of Ms. K commended the manner in which it was managed, variously describing it as having been managed "superbly" and in an "exemplary" manner.

130. As I stated at the outset, the event which initiated the chain of events which gave rise to these proceedings occurred during the resuscitation process – the first intimation to the Hospital personnel that Ms. K would not accept a blood transfusion. Ms. K's blood pressure was unobtainable for approximately five minutes between 9.52 a.m. and 9.57 a.m. Therefore, on the evidence, this event could not have occurred until after 9.57 a.m. Because of the gravity of the situation, a decision was made not to wait for cross-matched blood to be available but to transfuse Ms. K with O Negative blood which was kept in the delivery suite for emergencies. When the blood was being run through the giving set, the Hospital personnel became aware that Ms. K would not accept a blood transfusion. The recollections of the witnesses as to how precisely the Hospital personnel were told that Ms. K would not accept a blood transfusion diverge. It is difficult to resolve the conflict, but, given that neither undue influence nor lack of voluntariness is in issue, I consider that nothing much turns on it.

131. Ms. F testified that she saw "the blood bag" and told Ms. K that she might be transfused. Ms. K then saw the blood bag and told Ms. F to tell the Hospital personnel that she did not want to take blood. Ms. F translated Ms. K's instruction. Ms. F was then told by a female member of staff whom she believed to be a midwife that Ms. K really needed blood because she was bleeding too much. Ms. F translated that for Ms. K. Ms. K told Ms. F to tell the Hospital personnel: "I cannot take blood. I am a Jehovah's Witness". Ms. F did so. The recollection of most, but not all, of the Hospital witnesses was that it was Ms. F who reacted first and said: "No blood" or "No

blood, Jehovah's Witness" first without any communication from, or consultation with, Ms. K.

132. Whichever is the correct version, it is common case that this was the first intimation which the Hospital personnel had that Ms. K would refuse a blood transfusion on religious grounds. I am satisfied that this immediately raised concerns for the Hospital personnel and that their concerns were heightened when Ms. K's chart was consulted and it was discovered that she had booked in as a Roman Catholic. However, in the face of Ms. K's refusal, the Hospital personnel did not attempt to transfuse her.

133. Over the next hour and a half, before the arrival of the Master, Hospital personnel informed Ms. K of the gravity of the situation and the need for a blood transfusion and sought her permission to transfuse. Four such incidents are recorded in Ms. K's chart. As the relevant notes have been parsed and analysed intensively and as much significance has been attached to them by Ms. K's legal team, I think it appropriate to identify and quote them verbatim as follows:

> (1) The incident the subject of the first note is timed at 9.52 a.m. The timing is obviously incorrect as the note relates to the initial refusal. It states:
>
> > "Explained to patient re need for blood transfusion. Same refused and patient voiced that she is a Jehovah's Witness and will not take blood"
>
> (2) The second note is timed at 10.22 a.m. and states:
>
> > "Patient asked again for permission to give blood transfusion. Refused same, aware of complications."
>
> (3) The third note is timed at 11.05 a.m. and states:
>
> > "Hb [haemoglobin] 5.1 mmols [millimoles]. Same explained to patient and aware of consequences of not taking blood transfusion. Refused same."
>
> (4) The fourth note is timed at 11.15 a.m. It states:
>
> > "Explained again to [Ms. K] re need for blood transfusion. Refused."

134. Those notes were made by a student midwife, who was a qualified nurse. Her evidence was that the first three notes were written after 11.05 a.m. and all four were written before 11.30 a.m. The first three notes were counter-initialled by Ms. Manning. Ms. Manning's evidence was that she did not instruct the student midwife to make the notes and she counter-initialled the notes on the afternoon of the 21st. Ms. Manning did not stand over the notes as reflecting the views of the medical personnel who were interacting with Ms. K from the time the emergency commenced to the arrival of the Master and her evidence, on the basis of a discussion which she testified she had that afternoon with the student midwife, was that they merely reflected the student midwife's opinion.

135. The student midwife's recollection was at variance with that of Ms. Manning in a number of respects. She testified that she was instructed by Ms. Manning to make the notes, as well as to keep a record of Ms. K's clinical observations. Her recollection was that the notes were counter-initialled by Ms. Manning shortly after they were made. She had no recollection of a discussion with Ms. Manning in relation to their content. Her evidence was that, on reflection, the word "informed" would have been more appropriate than "aware" in the second and third notes, which were written in haste.

136. On the evidence it appears that it was Dr. Russell who was interacting with Ms. K through the medium of Ms. F at the time to which the second note relates and that it was Dr. Froese who was interacting with her at the times to which the third and fourth notes relate.

137. Dr. Russell's evidence was that overall she was concerned that Ms. K did not understand the gravity of the situation and that she voiced her concerns to her senior medical colleagues. Specifically in relation to her interaction with Ms. K at about 10.22 a.m., she was not convinced that Ms. K was really aware of the consequences of not being transfused. Her evidence was that to identify understanding and comprehension in a patient is a subtle thing and the doctor relies on visual cues and the patient's response. Dr. Russell stated that she would have expected a different, more focused, response from Ms. K and more interaction from her. However, she got only monosyllabic responses from her. Dr. Russell answered "Yes" to the final question put to her in cross-examination, whether she accepted that Ms. K "well knew she needed blood, according to your view". I understand the question and the response to mean that Ms. K knew that the medical personnel considered that she needed a transfusion. Her answer to the penultimate question was that she and her colleagues did not believe that Ms. K understood that she needed blood and that they were uneasy with the quality of her refusal. In re-examination, Dr. Russell stated that because she and her colleagues were communicating via an interpreter they were not getting what they would have considered the appropriate responses from Ms. K, which would have suggested to them that she understood and was making a fully informed refusal. Dr. Russell contrasted the situation they found themselves in with an elective situation in which the patient's wishes are discussed free of time constraints and in which the patient has the opportunity to ask questions.

138. As is clear from the third note, by 11.05 a.m. the medical personnel had received results from the laboratory. In fact, haematology results and coagulation results timed at 10.55 a.m. had come through. The results disclosed that Ms. K's haemoglobin had dropped from 11.8 g/dl on the previous evening to 5.1 g/dl. Her platelets had also fallen. The coagulation results suggested evolving coagulopathy. Dr. Froese's evidence was that in that context he would have been concerned to ascertain whether Ms. K would have accepted any form of blood product, other than red cells. His evidence was that he was more worried then than he had been at an earlier stage and was concerned that without the administration of either blood or blood products Ms. K would die. His interaction with Ms. K, through the medium of Ms. F, at the time to which the third note relates was to ascertain whether she would accept any blood product. His evidence was that he was not happy with the responses he was getting. He did not hear anything which would have led him to believe that Ms. K understood the consequences or the seriousness of the situation which prevailed. Dr. Froese's evidence was that Ms. K did not give an informed consent to refuse a blood transfusion at any time that morning and he communicated that view to the Master on the morning, although not necessarily in those terms.

139. I am satisfied that, insofar as the second and third notes *ex facie* are open to the construction that there was understanding on the part of Ms. K of the consequences of not accepting a blood transfusion, they do not represent the contemporaneous assessment of either Dr. Russell or Dr. Froese of Ms. K's comprehension. The Master's evidence was that he did not review those notes before leaving for the High Court. However, he had been made aware by the clinicians present when he arrived at the delivery suite that Ms.

K had been informed that a blood transfusion was necessary and of the consequences of not accepting blood had been explained to her. On the totality of the evidence I conclude that those notes are not of assistance in determining the capacity question. It is regrettable that they formed part of Ms. K's medical record because I have no doubt that the experts called on behalf of Ms. K were misled by them.

140. At some time before 10.30 a.m. Ms. F left the delivery room to make telephone calls. She called her husband, as she testified, to explain the situation. She also called a person she described as "one of the brothers from HLC". Ms. F is a Jehovah's Witness, a fact the Hospital personnel first became aware of around that time. She called a man she understood to be a member of the Hospital Liaison Committee for Jehovah's Witnesses. In the course of the call she had difficulty understanding some of the information she was being given on medical matters and she passed the phone to one of the midwives who was involved in Ms. K's care. The outcome of the call was that at about 10.30 a.m. the Hospital received by fax a document entitled "Care plan for women in labour refusing a blood transfusion". It was stated in the document that it had been prepared as an aid for medical staff and midwives who are managing Jehovah's Witness or other patients who refuse blood transfusion and, *inter alia*, are experiencing post partum haemorrhage. It was stated that the document, which was dated January, 2002, reflected current clinical and scientific knowledge and had been reviewed by consultant obstetricians, anaesthetists and haematologists practising in the United Kingdom. It is clear from the evidence that the clinicians treating Ms. K on the 21st implemented such of the strategies outlined in the document as were considered appropriate to Ms. K's condition before she was transfused. One of the strategies mentioned in the document was the administration of tranexamic acid (cyklokapron) in combination with recombinant factor VIIa (NovoSeven). NovoSeven was administered by Dr. Conneally at 12.16 p.m. So as not to digress from the chronology, I will outline Dr. Conneally's input between 12 noon and 1.30 p.m. later.

141. I now turn to what I consider to be the most crucial part of the evidence, the evidence relating to the period shortly before the arrival of the Master and what transpired while he was in the delivery suite.

142. Shortly before 11.30 a.m., prior to the arrival of the Master, Ms. Manning had informed midwifery management about the emergency. She was requested to ask Ms. K about her family. Ms. Manning had a conversation with Ms. K with the assistance of Ms. F, who translated. Ms. K. told Ms. Manning that her husband was in the Congo and was uncontactable and that she had no telephone number for him. She also stated that she had no other family in Ireland or the Congo and that her new baby boy was her only family. In her evidence, Ms. K acknowledged that the information she gave Ms. Manning was incorrect and expressed regret for a lot of things she said that were not true. This particular untruth has been pointed to as one of the indicia of Ms. K's capacity to understand, it being suggested that it was indicative of cerebral dexterity. However, the Hospital personnel were unaware that the information given by Ms. K was untrue. The true position was that Ms. K's husband was in the State, having arrived from the DRC one or two weeks previously because of the imminent birth. He visited Ms. K in the Hospital on the previous evening with his brother, Ms. F's husband. He was also in the Hospital at about 3 p.m. on the 21st after the transfusion commenced in the company of Ms. F and Mr. Peter Barnes, when he was introduced to the midwives by Mr. Barnes as Ms. K's husband. At that stage and on the following day, as she admitted, Ms. K reiterated to the Hospital personnel that her husband was not in the State and that he was lost in the Congo. Ms. K also admitted telling the Hospital social worker on the following day that the man who was in the Hospital at 3 p.m. on the 21st was Ms. F's husband.

143. Ms. K's excuse for misrepresenting her husband's whereabouts to the Hospital personnel at around 11.30 a.m. was that she was afraid he would be arrested because he was in the State without a visa, she was worried because the doctor said she would die, and she thought the only person who could stay with her child should not be arrested. Her excuse for persisting in the misrepresentation was the same as the excuse she gave for misrepresenting her religion – that she did not want to jeopardise her asylum application. I am satisfied that, as a result of Ms. K's misrepresentations as to the whereabouts of her husband on the 21st and as to the true identity of the man who was represented as her husband at 3 p.m. on that day, throughout Ms. K's stay in the Hospital the Hospital personnel believed that Ms. K's husband was not in the State.

144. The obvious inference to be drawn from Ms. K's evidence is that her husband was in the State illegally. It was suggested on her behalf that, in misrepresenting the true situation to the Hospital personnel, Ms. K adopted an entirely rational approach. I do not accept that. It is clear on the evidence that one of the reasons the enquiry as to the whereabouts of her husband and family was made was concern in relation to the care and custody of her baby in the event of her death. It was hardly a rational response to that enquiry to leave the Hospital with no information on the basis of which the Hospital could identify the baby's next of kin. This episode raises not only a serious question about Ms. K's credibility, but also about her ability to understand the consequences of a decision to refuse a blood transfusion for her baby's future care.

145. Another aspect of the evidence which goes to Ms. K's credibility is the fact that, while she testified that she is the holder of an advance directive card setting out her objection on religious grounds to being transfused, she gave no proper explanation as to why she did not produce the card on the 21st. The evidence established that every *bona fide* baptised Jehovah's Witness carries an advance directive card. Ms. F, who had experience of giving birth in the State, testified that she had given advance notice to the Hospital in which she gave birth that she was a Jehovah's Witness. The evidence of Mr. Barnes, who is the Presiding Overseer of a French-speaking community of Jehovah's Witnesses in Clondalkin, was that Ms. K told him that she held an advance directive card in French which issued in the DRC. When asked in cross-examination whether she had an advance directive card with her when she went to the Hospital, Ms. K's response was that she was in an emergency situation and she did not even have her bag with her. Ms. K had to be reminded that Ms. F's evidence, which she accepted, was that her husband and his brother brought her bag to the Hospital the previous evening. In my view, the evidence raises a serious doubt as to whether Ms. K had an advance directive card on 21st September. If she had, it could have been produced in court, but it was not.

146. The Master arrived at the delivery suite at about 11.30 a.m. Before his arrival he had been informed of the nature of the emergency – that a patient who had had a significant haemorrhage had ongoing bleeding and was declining a blood transfusion. On his arrival he spoke with medical personnel, Dr. Bowman, Dr. Froese and Dr. Russell, to ascertain the clinical situation. He was given Ms. K's history in abbreviated form. He noted that the blood loss was approximately 4.5 litres or in excess of that. He also noted the drop in Ms. K's haemoglobin. He was told that Ms. K's observations were stable "at present". He learned of the circumstances in which Ms. K refused the transfusion and that there was considerable concern as to how the information that her objection was on religious grounds had been imparted. The Master then reviewed Ms. K's chart, including her antenatal notes and her delivery suite notes.

147. The Master was aware that Ms. K had a vaginal pack in situ. He examined Ms. K himself and noted that the uterus was well contracted and that there was no bleeding occurring from the pack at the time of his examination. However, he was concerned that there might be occult bleeding, that is to say, bleeding behind the pack. The view he formed was that the appropriate management of Ms. K was to transfuse because of the amount of blood she had lost, the drop in her haemoglobin level, the evolving coagulopathy and the fact that there was a surgical cause, the vaginal lacerations, for the bleeding. His evidence was that he could not envisage a circumstance in which a patient in the Hospital in that condition would not be transfused. His view was that, leaving aside the issue

of religion, a transfusion was absolutely necessary.

148. The Master's evidence was that he spent about half an hour in the delivery room with Ms. K. He discussed her condition with her on a number of occasions. Ms. F was present. The Master spoke in English and Ms. F relayed the conversation to Ms. K both in English and in French. Initially, he emphasised his strong recommendation that she needed to have a blood transfusion because of the amount of blood that she had lost, without indicating that he thought she was going to die. However, because he felt Ms. K did not understand the seriousness of his concern and the seriousness of her condition he told her of his concern that, if she was not transfused with blood or blood products, she might die and he said that on more than one occasion. On each occasion Ms. K's response was "No" in English. The Master's evidence was that a factor which alarmed him and which suggested to him that there was a failure on the part of Ms. K to comprehend the seriousness and precarious nature of her medical condition was a suggestion that she made that, as an alternative, she could be given Coke and tomatoes. Ms. K admitted that she made that suggestion and I will return to it later when considering Ms. K's evidence.

149. The Master made a comprehensive note at 12 noon in which he reviewed Ms. K's history and her then current condition, including the results of his own examination. He recorded the products which had been administered to her. He outlined four matters which were under consideration. The first was to get haematology advice from St. James's Hospital, meaning from Dr. Conneally. Dr. Conneally's input was necessary because only a Consultant Haematologist was authorised to prescribe NovoSeven in an obstetric context. The Master consulted Dr. Conneally when she arrived at the delivery suite at around 12 noon. Secondly, consideration was being given to intervention radiology in St. James's Hospital. The Master described such intervention, which would have been pursued if a blood transfusion had not been authorised, as adjunctive, not a substitute for a blood transfusion. Dr. Russell's evidence was that she had spoken with the consultant in St. James's Hospital and had ascertained that Ms. K could be accepted in St. James's that afternoon for arterial embolisation if required but that the consultant had raised the issue as to whether Ms. K was stable enough to move her to St. James's. Thirdly, contacting the Hospital's solicitors was under consideration. Contact was made with the solicitors at around 12 noon. Fourthly, liaison with what was described as the Jehovah's Witness group was under consideration, with a view to ascertaining, without breaching the duty of confidentiality owed to Ms. K, whether, by reason of any religious dispensation, minor blood products could be utilised. The Master was aware that the "Care plan …" document to which I referred earlier had been received in the Hospital. He was provided with a telephone number to contact the Jehovah's Witness group and he made a telephone call and, perhaps, a second but was unable to establish contact. His evidence was that he did not persist in trying to make contact because he felt there were more pressing issues.

150. In his note, the Master outlined a thirteen point plan for the management of Ms. K, which did not provide for blood transfusion. The plan incorporated the haematological advice from Dr. Conneally and it also envisaged exploring two other options, if Ms. K should bleed through the pack: to substitute a balloon for the pack to tamponade the bleeding; and interventional radiology. Notwithstanding that the plan did not provide for transfusion, it is clear on the evidence that the Master's opinion was that a transfusion was absolutely necessary. While this observation may sound trite, he would hardly have taken what was for him an unprecedented step in the circumstances prevailing, to apply for a court order, if that was not his opinion. The Master characterised NovoSeven and the other alternative options considered as adjunctive treatment, not a substitute for a blood transfusion, which, in his opinion is the cornerstone of management of massive blood loss.

151. Before leaving for the High Court, at approximately 12.30, the Master reassessed Ms. K's condition and he noted that the vaginal pack was heavily soaked. On his return from the High Court he made the following retrospective note in her chart: "Oozy via pack again Pack heavily soaked". I am satisfied that the retrospective note represents the true position as of 12.30 p.m. and I so find.

152. Dr. Conneally had arrived from St. James's Hospital to the delivery suite at around 12 noon. She discussed Ms. K's condition with the Master, Dr. Bowman and Dr. Russell. On the basis of what she learned of Ms. K's condition she was of the opinion that a blood transfusion and clotting factors were the appropriate treatment, the initial fluid resuscitation and oxygenation having been done. She had a discussion with Ms. K because she wanted to satisfy herself as to Ms. K's position in relation to blood. She was aware that some Jehovah's Witnesses will accept fractions of blood or clotting factors. Dr. Conneally communicated with Ms. K mainly with the assistance of Ms. F, in that Dr. Conneally spoke in English and Ms. F translated to French. However, at one stage there was interaction in English between Dr. Conneally and Ms. K. When Dr. Conneally was endeavouring to explain to Ms. K about blood products, blood clotting factors such as cryoprecipitate or plasma, Ms. K asked in English: "Are they red?" Dr. Conneally explained that the clotting factors were not red, but that they were derived from human blood.

153. Dr. Conneally testified that the mode of communicating with Ms. K was not satisfactory because the topic being discussed was relatively complicated and communicating with Ms. K was dependent on the ability of Ms. F to understand the information, to synthesise it and to translate it for Ms. K. Dr. Conneally described Ms. K as lying in bed, with her feet in the lithotomy position. Ms. K looked very tired. Dr. Conneally's evidence was that she would have anticipated that Ms. K would have been more upset than she seemed to be while Dr. Conneally was explaining that she was in a critical situation and that she might die. This raised a question for Dr. Conneally as to how much Ms. K really understood of what Dr. Conneally was trying to explain to her. However, the message Dr. Conneally took from her interaction with Ms. K was that Ms. K did not wish to receive any product derived from blood.

154. Before leaving St. James's Hospital, Dr. Conneally had ordered NovoSeven from the Hospital blood transfusion laboratory and it was administered to Ms. K at 12.16 p.m. Dr. Conneally was in attendance on Ms. K for approximately one hour and a half, from 12 noon to 1.30 p.m. There is no doubt that her input into Ms. K's treatment was premised on the likelihood of Ms. K not being transfused. As explained by Dr. Conneally, the purpose of the administration of NovoSeven, in layman's terms, was to promote clotting at the site of the lacerations. However, NovoSeven was not a substitute for a blood transfusion. Her evidence was that, while it could, and did, improve Ms. K's coagulation profile, it did not result in Ms. K being less coagulopathic overall, because it did not increase any clotting factors, other than factor VII, measurably.

155. Dr. Conneally's opinion was that by 1 p.m. Ms. K's bleeding had substantially ceased, and she ascribed this to the effect of NovoSeven. In a note in Ms. K's chart made at 1 p.m., which was relied on by the expert witnesses, she recorded that there was no oozing from the intravenous sites. On the basis of what she was told by the midwives she noted that there was no evident bleed in the area of the vaginal pack. Dr. Conneally outlined a plan for Ms. K's future management, involving four hourly full blood counts and coagulation tests, the possibility of NovoSeven being repeated and other treatment such as Ms. K being started on iron the next day. That plan was also premised on Ms. K not being transfused, although when it was devised Dr. Conneally was aware that the Master had gone to seek the assistance of the High Court.

156. In her evidence Dr. Conneally emphasised the limited effects of NovoSeven. It did nothing to change the underlying parameters: the low haemoglobin, the low platelet count and the deficit of clotting factors. In her opinion, at 2.35 p.m. a blood transfusion was necessary in the sense that, in accordance with the guidelines for best practice, in the case of a person with a haemoglobin of 5.1 g/dl and a coagulopathy a transfusion was indicated. The risk which in Dr. Conneally's opinion necessitated a transfusion was the risk

of a re-bleed. In her opinion, if Ms. K had re-bled later on the 21st, in the absence of a transfusion, the prognosis would have been very poor. As Dr. Conneally put it at one stage in her evidence, from a medical perspective it was totally appropriate to transfuse Ms. K, and, if the issue of her religion had not arisen, there would have been absolutely no discussion about transfusing her.

157. Dr. Conneally's assessment of Ms. K at the critical time was that she understood the fact that the medical personnel wanted to give her blood and she was refusing it. However, Dr. Conneally's evidence was that, in terms of Ms. K's understanding of how critical her situation was, she would have concerns in relation to her level of understanding of that.

158. Backtracking slightly in time, before leaving for court the Master did not inform Ms. K that he intended seeking a court order giving authority to transfuse her. He accepted that it was an omission on his part not to have informed her, but he did so in the context of a clinical emergency and not purposely. The tenor of the cross-examination of both the Master and Dr. Russell was that there was a deliberate concealment of the intention to seek a court order lest Ms. K would take some action. I accept the Master's evidence that the omission to inform Ms. K was an oversight.

159. After the court order was made, the Master telephoned Dr. Froese and requested him to order the blood products and to move Ms. K to the high dependency unit and prepare her for transfusion. When the Master returned Ms. K was in the high dependency unit and Ms. F was also there. The Master's evidence, which I accept, was that he reviewed Ms. K's condition, although he did not examine her physically because that was not indicated. He concluded that her condition had not changed nor was there any discernible change in relation to her capacity to validly refuse a blood transfusion. The Master told Ms. K of the court order and that he had permission of the court to transfuse her. This information was conveyed through Ms. F. It is common case that Ms. K was upset. The Master's evidence was that he recognised that the transfusion was going to be upsetting and difficult for Ms. K. He suggested that she should take medication that would make her sleepy to facilitate the transfusion. Dr. Froese administered an anxiolytic, 5 mg. of midazolam in two doses of 3 mg. and 2 mg. to lessen the stress of the situation. His evidence, which I accept, was that the reason for titrating was in the interests of Ms. K's safety to make sure it did not have a negative effect on her cardiovascular status.

160. In the particulars of personal injuries set out in Ms. K's counterclaim it is alleged that she was forcibly restrained and coerced into undergoing a blood transfusion. In replies dated 19th September, 2007 to a notice for particulars served on behalf of the plaintiffs it was alleged as follows on behalf of Ms. K:

> "Because she was so ill at the time, she was not able to physically fight them as well as she wanted to and she felt that they were capable of doing anything they wanted to her. She felt that it was a rape, it was done against her will. She tried to struggle but she couldn't, she was restrained. She tried to get up and they put her back down on the bed and they held her wrists. They injected her with some form of sedation and then they administered the transfusion while she was so sedated."

161. It is undoubtedly the case that the first unit of blood was administered to Ms. K at 2.35 p.m. against her wishes and that she endeavoured to resist being transfused. It is common case that she made an unsuccessful attempt to pull out the IV canula. However, the evidence does not bear out the very serious allegations which are made against the Hospital in that reply. First, the evidence does not support the contention that Ms. K was under some type of pharmacological restraint when she was transfused although, in my view, the only reasonable inference is that Ms. K was not consenting to being sedated. Dr. Platt was critical of the sedation of Ms. K on two grounds. One was that she was of the view that midazolam would not have relieved some of Ms. K's emotional distress. The other was on clinical grounds, citing that in someone who has had a major bleed it can affect the respiratory system and the cardiovascular system. However, she did accept that Dr. Froese was in a position to assess Ms. K's clinical reaction to the first bolus administered. On the basis of Dr. Froese's evidence, I find that the administration of midazolam to Ms. K was not clinically inappropriate. Secondly, on the evidence, I find that there was no physical restraint of Ms. K in administering the blood transfusion. There was evidence from Dr. Sultan of difficulty he had in inserting an arterial line which had the dual purpose of monitoring Ms. K's blood pressure and taking samples of blood. Ms. K resisted this procedure. Dr. Sultan's evidence was that he stabilised Ms. K's hand just for long enough to get the arterial line in, but that the procedure was explained to Ms. F and Ms. K. It may be that Ms. K genuinely misunderstood what was happening. Thirdly, while Ms. K's evidence was that what had been done to her was like "rape" she explained what she meant by rape. She thinks in French. The definition of rape in French is to abuse a person without the person's consent. That is what she meant.

162. Over the following eleven and a half hours from 2.35 p.m. Ms. K was administered four units of red cells. Two units of cryoprecipitate were given from approximately 5 p.m. and platelets were infused from 7 p.m.

163. The Master's evidence was when he returned from the High Court he was of the opinion that he should proceed to transfuse Ms. K because his clinical judgment was that she was at significant risk of a maternal death. As I have stated, his view was that Ms. K's condition at 2.30 p.m. was not distinctly different from her condition at 12.30 p.m. His primary concern was the risk of Ms. K re-bleeding, a risk he put at between 20% and 30%. His opinion was that, in the event of a re-bleed from a haemoglobin of 5.1 g/dl, the outcome would have been catastrophic, in that Ms. K would have died. The laboratory results timed at 12.44 p.m. which came through while the Master was in the High Court showed Ms. K's haemoglobin still at 5.1 g/dl.

164. Turning now to Ms. K's evidence as to what happened after the haemorrhage, understandably there are gaps in her recollection. For instance, she did not recollect that Dr. Bowman held the vaginal pack in situ for a long time, nor did she recollect having two bouts of diarrhoea, which were clearly documented in the chart and of which there was evidence, in the early afternoon. She did recollect having been told before the Master arrived that she could die if she did not take blood and that she was told that several times. Ms. K also recollected the exchanges between the Master and her, which were translated by Ms. F. She stated that the Master found her lying down and said to her that it was very important that she must have a blood transfusion and that if she did not have the transfusion she would die. She answered stating that she did not want a blood transfusion because she had already said that she was a Jehovah's Witness. The Master repeated that she must have a blood transfusion and if not she would die. He was very decisive. Her reply was that she did not want it, that she did not want a blood transfusion. She recollected the Master leaving the room and coming back later and insisting that she had to have a blood transfusion. She also testified that she heard the nurse who was present, who was obviously Ms. Manning, insisting to Ms. F that she tell her that she must have a transfusion or she would die.

165. Ms. K's evidence was that she understood that it was true that she was in danger of dying. When she was asked whether she believed the Master, she said that she thought that he was telling the truth, adding that he is a doctor. She remembered Ms. F being upset and she thought it was because Ms. F understood that the medical staff were saying that she was going to die. Ms. K said that she tried to calm Ms. F down and to tell her not to cry and, if it was possible, just to pray. When asked again whether she understood that she was going to die, Ms. K answered in the affirmative "because when a doctor tells you that you are going to die,

it is not a joke".

166. Ms. K's account of the discussion about tomatoes and Coke was that she initiated the suggestion. When the Master told her that the only solution was a blood transfusion she thought they could give her another solution that she had and proposed tomatoes, Coca Cola, eggs and milk. She clarified this by saying that she proposed the eggs, the Coca Cola and the tomatoes but that milk she knew she could find. She expressed the view that those products were very important in the human body, that tomatoes come from the earth, that they are very important because they contain vitamin A and iron, eggs also contain iron and Coca Cola contains energy. Her view was that those products would improve her blood because her parents had used them and a lot of Jehovah's Witnesses use them. However, the Master told her that he did not think the products would help.

167. Later, in the context of explaining what she found so offensive about taking blood, Ms. K stated that it was because the order, which I understand to be the order of the court, made her transgress. She added:

> "The doctors are not one hundred per cent sure that the blood is good for the person, and I am sure that later on there is effects of the blood transfusion."

168. Ms. K testified in French. Even with a professional interpreter the process was difficult. On occasions during her cross-examination it was difficult to determine whether she was being evasive or whether she genuinely did not understand what was being put to her. It was put to Ms. K that, by falsely stating when she was booking into the Hospital that she was as Roman Catholic, when in fact she was a Jehovah's Witness, she placed the Hospital in an impossible position when the emergency occurred. While acknowledging that maybe she put the Hospital in a difficult position, she quoted the following saying: "The doctor advises and the patient decides". In the course of the subsequent exchanges, Ms. K repeated the saying four times, demonstrating that she had no understanding of the responsibilities of a doctor to his patient or of the dilemma he is confronted with in an emergency when a patient, out of the blue, says he or she will not accept treatment which the doctor considers is necessary to save the patient's life. Her responses demonstrated no understanding that the doctor has a responsibility to ensure that the patient has properly assimilated the advice.

169. In later exchanges in which she was cross-examined about what she had learned at meetings in Kingdom Hall or from other members of the Jehovah's Witness faith about the medical benefits of blood transfusion and alternatives to it, Ms. K demonstrated an unwillingness to engage in an exposition of what she had been taught and understood about those matters. Her response was: "We respect the law of God, we respect the principle of God". On the first occasion on which she made that response she read the passage from the Bible, from Acts, which is the cornerstone of Jehovah's Witness's rejection of blood and blood products, the injunction "to keep abstaining from things sacrificed to idols, and from blood and from things strangled and from fornication". When the question was pursued by reference to whether at Jehovah's Witness meetings there was discussion that with very low blood count a blood transfusion is not medically necessary, Ms. K repeatedly gave the same response – that they were told to respect the principle, the law of what is said in the Bible. She qualified the response on a number of occasions by adding that it was a personal choice whether to respect the principle or not. On one occasion she added that it was a personal decision "because it is a question of life and death". Ms. K did testify that the Elders tell the community that they are often situations that are very dangerous and she added that they are told that the person has to make his own personal decision and the decision is between the person and Jehovah. When Ms. K was questioned further as to whether members of the community are told that there are medical products which are alternatives to blood transfusion where the blood count is extremely low, she reverted to her reliance on the principles of the Bible and did not answer the question. I draw no inference from the foregoing exchanges as to what Ms. K was taught by the Elders of her church about the efficacy or otherwise of medical or other alternatives to blood transfusions. It may be that Ms. K did not understand that counsel for the plaintiffs was not trying to elicit information about the principles of her faith but was trying to ascertain what she was taught and had learned about the efficacy of various remedies in a situation where a patient's blood count is low. However, she manifested a persistent unwillingness to open her mind to questions concerning her understanding of the medical realities of her case. Her demeanour gave some insight as to why the Hospital personnel who were treating her on 21st September, 2006 would have harboured doubts about her understanding of the gravity of her condition.

170. In the course of cross-examination it was put to Ms. K that the Coke and tomatoes suggestion showed that she had no real medical understanding of the nature of the situation which confronted her on the morning. Her response was that she proposed those products because the doctors told her there was no other alternative and she proposed what she knew. She thought that Coke and tomatoes were going to be as effective to improve her low blood count as a blood transfusion, but "not as fast as that", and it could help her "little by little". She stated that she understood the situation, that it was between life and death, so that she could not play around with the situation. Later, when it was put to her that from a medical point of view a blood transfusion was medically indicated and appropriate given that her haemoglobin had fallen below 6 g/dl, her response was as follows:

> "What I have understood with visits of all the doctors is that my health wasn't as serious as that and there was some alternative to propose."

171. When she was asked whether she thought coke and tomatoes would have been an acceptable medical alternative, her response was that counsel was taking it too lightly because he did not understand how many lives that, meaning Coke and tomatoes, had saved.

172. There were also gaps in Ms. F's recollection of the events on the morning of 21st September, 2006, which is also understandable. She had been awake all night. She obviously found herself in a very difficult situation when the emergency occurred. It is clears on the evidence that following the haemorrhage she was very upset and distressed about Ms. K's condition. I have no doubt on the evidence that Ms. F understood the gravity of Ms. K's condition and the need for a blood transfusion. I have also no doubt that she translated the basic message which the Hospital personnel requested her to communicate to Ms. K, that Ms. K needed a blood transfusion and that without it she might die, accurately and that she communicated it with conviction to Ms. K.

173. The aspect of Ms. F's evidence which I consider to be most crucial relates to the circumstances in which the Hospital Liaison Committee was contacted before 10.30 a.m. on the 21st. Ms. K testified that she asked Ms. F if she, Ms. F, could contact "certain people, Brothers" who could advise her about transfusion. Ms. F had testified before Ms. K. When asked in examination in chief why she contacted the HLC, she did not say that she did so at Ms. K's request. Her evidence was that she knew that there are members of what she called "the HLC" in Jehovah's Witness congregations all around the world who work with hospitals when a Jehovah's Witness refuses blood who know other treatment which can help to save life and that is why she made the call. I think it probable on the evidence that the initiative to call the HLC did not come from Ms. K but came from Ms. F. The replies to the particulars furnished on behalf of Ms. K on 5th September, 2007 do not suggest that Ms. K had any input in the initiative to contact the Hospital Liaison Committee.

Expert evidence on necessity for blood transfusion
174. As it is a central argument in Ms. K's case that a blood transfusion was not necessary either before the *ex parte* order was applied for or when Ms. K was transfused on the authority it conferred, it is necessary to consider the expert evidence on this issue in detail, not least for the purpose of ascertaining what the experts understood by "necessary".

175. I have already outlined the Master's clinical judgment as to the necessity for a blood transfusion and Dr. Conneally's view on the issue. I think it is not an oversimplification to say that the evidence illustrates that, as regards the management of an obstetric haemorrhage, anaesthetists defer to haematologists and obstetricians and haematologists defer to obstetricians. In considering the evidence of the experts, I propose starting with the evidence of the anaesthetists, followed by the evidence of the haematologists, and lastly I will address the evidence of the obstetricians.

Expert anaesthetists
176. On the basis of Dr. Conneally's note at 1 p.m., which I have referred to earlier, and the coagulation results timed at 12.48 p.m., Dr. Platt's opinion was that the NovoSeven had normalised Ms. K's clotting and that there was no sign of coagulopathy. There was controversy as to whether the coagulation results timed at 12.48 p.m., half an hour after NovoSeven was administered, were apt to give a misleading picture but from Dr. Platt's perspective the results were normal in the sense that a haematologist would not administer another dose of NovoSeven. On the evidence, I consider that the opinion of the haematologists that there was an underlying coagulopathy is to be preferred.

177. However, Dr. Platt regarded the haemoglobin of 5.1 g/dl as being at an extremely low level and, as I understand her evidence, that is what informed her view on the necessity for a transfusion. She recognised that, at the time of the haemorrhage, before fluid resuscitation, the correct management was to reach for the emergency blood which was kept in the delivery suite. She was also of the view that once the haematology results came through showing Ms. K's haemoglobin level at 5.1 g/dl, that was around 11 a.m. on the 21st, a blood transfusion was clinically indicated, meaning that it was medically appropriate. Her evidence was that she could not think of a clinician who would not give blood to someone with a haemoglobin of 5 g/dl. However, she emphasised that that was not the same as saying that, if a transfusion was not administered, a life would be lost. Having regard to the fact that the haematological results which were timed at 12.44 p.m. indicated that Ms. K's haemoglobin level was still at 5.1 g/dl, Dr. Platt was of the opinion that at 2.30 p.m. a blood transfusion was still indicated. Again, she emphasised that in her opinion, given the clinical situation, Ms. K did not need blood to save her life, to prevent death, but blood would have been advisable because it would have improved her chances of recovery and made recovery quicker.

178. So Dr. Platt was drawing a distinction between what was medically appropriate and what in her opinion was necessary to save Ms. K's life. She went so far as to say that it was probable, not merely possible, that Ms. K would survive without a blood transfusion. Dr. Platt measured Ms. K's chance of surviving at better than 50% and she stated that she had factored the risk of a re-bleed into that conclusion. However, she would defer to the obstetricians and surgeons in relation to quantifying the risk of a re-bleed. Dr. Platt was of the view that, if she re-bled, Ms. K might die if she was not transfused and, if the re-bleed was of the magnitude of the first bleed, Dr. Platt believed she would die. She accepted that NovoSeven would be less effective in the case of a re-bleed that it had been when it was used.

179. On my understanding of Dr. Platt's evidence, the only discernible reason for not following what she stated was the invariable practice of transfusing where the haemoglobin level fell as low as Ms. K's had fallen due to an acute haemorrhage was the fact that Ms. K had refused blood on religious grounds. She assumed, on the basis of her reading of Ms. K's clinical notes, that the refusal was valid and she stated with unanswerable logic that, if one considers the refusal valid, the patient had the capacity to refuse, and then, like it or not, one has to abide by it. Apart from being logical, in my view, that statement coincides with the law in this jurisdiction. But it seems to me that Dr. Platt's evidence begs the question which the court has to answer.

180. There was little divergence of opinion between Dr. Platt and Dr. Loughrey as to when a blood transfusion is clinically indicated. Like Dr. Platt, he was of the view that, as a haemoglobin of 5.1 g/dl was recorded, that was an indication on medical grounds for a blood transfusion. In support of that proposition he cited a statement in a publication of the American Society of Anaesthesiologists published in 2006 ("Practice Guidelines for Perioperative Blood Transfusion and Adjuvant Therapies" in Anaesthesiology, 2006: 105: 198-208) "that red blood cells should usually be administered when the hemoglobin level is low (e.g. less than 6 g/dl in a young healthy patient), especially when the anaemia is acute". Extrapolating from the haematological results on the following day, 22nd September, Dr. Loughrey was prepared to express an opinion that the actual nadir of Ms. K's haemoglobin on the 21st might have been around 4 g/dl. Dr. Platt declined to express an opinion on that point.

181. In addition to addressing the risk of a substantial re-bleed, which was the primary concern, Dr. Loughrey also addressed the evidence afforded by the clinical notes of ongoing bleeding. Although he found some reassurance in the notes that it was not substantial, he expressed concern that cumulatively over time, if Ms. K had not received a transfusion, she could still reach a critical level of haemoglobin which would result in cardiac arrest and death, if untreated. Notwithstanding that NovoSeven was administered at 12.16 p.m. and resulted in an improvement of Ms. K's coagulation parameters, Dr. Loughrey noted that at approximately 12.45 p.m. Ms. K's haemoglobin was still at 5.1 g/dl. He was of the view that the substantial risk to Ms. K at that stage was the risk of a re-bleed and that there was still a risk to her life if she was not transfused. He was of the view that the position remained the same at 2.30 p.m. While Dr. Loughrey considered that assessing the risk of a re-bleed was an obstetric call, he concurred in Dr. Boylan's view that the risk was of the order of 15% or thereabouts.

Expert haematologists
182. Dr. Martlew did not concur in the view that the nadir of Ms. K's haemoglobin was below 5.1 g/dl or could have been, as it was put, in the low 4s. While she did not discount the practice of doing a back calculation from the haemoglobin results on the following day, she did not see that one could use that approach as any basis of evidence of what actually happened in Ms. K's case on the day for two reasons: the infusion of plasma products would have had a dilutional effect; and there was a margin of error of half a gram in the measurement. Dr. Martlew took from Dr. Conneally's note that Ms. K was haemodynamically stable at around 1 p.m. Although, she noted subsequent references in Ms. K's chart to minimal pv (*per vaginum*) loss and minimal ooze, she pointed to the fact that the haemoglobin had not gone down substantially and she was of the view that Ms. K remained stable. She found the coagulation results at 12.48 p.m. to be encouraging although, in cross-examination, she recognised that there was an underlying coagulopathy after the administration of NovoSeven.

183. Dr. Martlew's opinion was that, once Ms. K was stabilised and her blood pressure and pulse rate remained stable, a transfusion was not necessary to save her life. Specifically she opined that the treatment was not necessary for the purposes of life saving at 2.35 p.m.; it was indicated and not essential. However, she made the same distinction as Dr. Platt made, in that she accepted that the appropriate medical course would have been to transfuse Ms. K had she consented to transfusion. The medically-indicated course of action was transfusion unless Ms. K was objecting. Dr. Martlew's approach at 2.35 p.m. would have been to adopt a "watch and

see" approach provided Ms. K was haemodynamically stable and there was no increased overt bleeding. When it was put to Dr. Martlew that such an approach would have carried the risk that, if there was a sudden loss of blood pressure or a sudden re-bleed, a blood transfusion might be too late, she acknowledged the existence of that risk but made the point that Ms. K was prepared to deny herself all the benefits of blood transfusion in the first place. Likewise, she accepted that a transfusion was clinically indicated at 12.45 p.m. to restore oxygen-carrying capacity, but did not accept that a transfusion was necessary because necessity had to be balanced against the wishes of the individual. It seems to me that, like Dr. Platt's evidence, Dr. Martlew's evidence begs the question the court has to answer.

184. Dr. Martlew was not prepared to quantify the risk of a re-bleed. The outcome of a re-bleed, in her opinion, depended on how much Ms. K bled. If she bled to the extent that she had prior to 10 a.m., she would not have survived. She was of the view that Ms. K would probably have survived the loss of a half a litre but it was difficult to say whether she would have survived the loss of a further litre of blood.

185. In his evidence, Dr. Connaghan laid the groundwork for understanding, insofar as a lay person can do so, the haematological evidence. He estimated Ms. K's blood loss from the haemorrhage in the range of 60% to 70%. Using the back calculation methodology which Dr. Martlew thought was not altogether apt, he estimated that at its nadir Ms. K's haemoglobin was "in the low 4s", which he considered increased the necessity for a transfusion.

186. As an aside, while I think I am correct in stating that the article entitled "Guidelines on the management of massive blood loss" published in the British Journal of Haematology (2006, 135, 634-641) was canvassed during the testimony of the expert haematologist in the context of platelet transfusion, not red cell transfusion, it was canvassed during the testimony of the expert obstetricians in the context of red cells transfusion. That article records the British Committee for Standards in Haematology Blood Transfusion Task Force 2001 as recommending that red cells are almost always indicated when the haemoglobin is below 6 g/dl.

187. Dr. Connaghan deferred to his obstetrician colleagues on the question of the risk of a re-bleed. His opinion was that the outcome of a re-bleed was likely to be fatal without a transfusion and he laid particular emphasis on the fact that, notwithstanding the administration of NovoSeven, at 12.48 p.m. Ms. K still had a major coagulation defect which increased the risk of mortality in the event of a re-bleed. In this connection, both expert haematologists, Dr. Martlew and Dr. Connaghan, were of the view that the coagulation results at 12.48 p.m. did not show that Ms. K's coagulopathy had been arrested, contrary to views expressed by other experts. As has been adverted to, Dr. Conneally was of the same view as Dr. Martlew and Dr. Connaghan.

188. Dr. Connaghan's opinion was that, applying the standard of care advocated by any of the professional bodies and on the basis of his own experience, it was clear that at 2.35 p.m. Ms. K should be given a blood transfusion. In his view, the risk of re-bleeding was not negligible. Indeed, he went so far as to suggest that a delay of hours in instituting blood product would not meet the standard of care required in the management of a normal patient, which I understand to mean a patient who was not refusing treatment, having regard to the degree of the bleed and he suggested that, in the absence of good justification, there would be a case to answer. While deferring to the obstetricians, he stated that a range of somewhere between 15% and 30% as representing the risk of a re-bleed accorded with what he understood from the literature. In the event of a re-bleed, he would have concerns as to the efficacy of NovoSeven.

189. There was some divergence of opinion between Dr. Connaghan and Dr. Martlew as to the significance of the fact that Ms. K's platelet level, according to the 12.44 p.m. haematological results, had fallen to 69. Dr. Connaghan's opinion, which he based on the British Journal of Haematology Guidelines was that one should transfuse platelets where the platelet count was less than 75. Insofar as I understand the divergent views of the experts, it seems that the consideration of the platelet count on its own and whether Ms. K required to be given platelets is only a small part of the bigger question, which I understand to be whether a transfusion of red cells in conjunction with the other products she was ultimately given, fibrinogen, in the form of cryoprecipitate and platelets to correct her haemoglobin and clotting deficits, was medically indicated. I understand both Dr. Martlew and Dr. Connaghan to be of the view that it was medically indicated, even though Dr. Martlew suggested that "one might have got away without platelets".

Expert obstetricians

190. I have already alluded to the fact that Dr. Griffiths estimated Ms. K's blood loss at around 5 litres, representing about half her circulating volume. He did not agree that a reliable back calculation could be made which would show the nadir of Ms. K's haemoglobin at significantly below 5 g/dl.

191. Dr. Griffiths' evidence, on the basis of Ms. K's medical notes, was that at 1.40 p.m. she did not seem to be suffering from clinically significant haemorrhage. His view was that at that time, with the pack in situ and the situation under control, with no current active bleeding, and the blood clotting appearing to normalise (which he clarified later) the likelihood of a re-bleed if the pack was left in place until the following day was extremely remote. His view was that there was not going to be a re-bleed unless there was a dramatic deterioration in Ms. K's clotting status.

192. Apropos of the situation at 1.40 p.m., Dr. Griffiths was of the view that it would have been easier for the clinicians to have included in their repertoire of therapies a blood transfusion, but he saw that as more a matter of convenience than of necessity. Ms. K would be better off, would recover more quickly and would build up her blood count more quickly with a blood transfusion. Dr. Griffiths opined that, in the absence of a blood transfusion, unless there was a re-bleed, Ms. K as a fit, healthy woman whose situation had pretty well stabilised would almost certainly have survived and in time recovered if Dr. Conneally's plan had been implemented.

193. During cross-examination, Dr. Griffiths was asked whether there are any circumstances in which a patient with a haemoglobin of less than 6 g/dl in an acute situation does not require a blood transfusion. His response was that it is generally more convenient and expeditious from the clinician's point of view to use blood transfusion as part of the treatment along with other measures, but in his view "necessary" assumes that the patient is accepting the treatment. Dr. Griffiths made it clear that, in his opinion, from a clinical perspective the only reason why, while her haemoglobin was recorded at 5.1 g/dl, Ms. K would not be transfused was that she had refused a transfusion. He stated that, if a patient in her condition presented on his delivery suite, his team would almost always be advising that she should have a blood transfusion, and in most cases the advice would be accepted and a transfusion would be given.

194. In re-examination, Dr. Griffiths was once more asked to address the necessity for a blood transfusion, specifically after the *ex parte* order was made. He was asked whether the essential core of the issue of necessity was that a blood transfusion was not clinically necessary, and, therefore, should not have been administered. His answer was: "yes", adding "because it is a permissive order and because there wasn't a team decision that it was necessary". In his examination in chief, Dr. Griffiths had stated, in the context of expressing the view that at 1.40 p.m. a blood transfusion was not necessary, that it was his own practice that such a decision would be made in consultation with his anaesthetic and haematological colleagues, because management of a major

haemorrhage in obstetric practice calls for a team approach. While, on the evidence, the desirability of a multi-disciplinary approach to a problem such as the problem Ms. K presented is obvious, I cannot accept that the absence of a team decision could be determinative of whether a particular treatment is clinically indicated. Even when a multi-disciplinary approach is desirable, ultimate responsibility for the decision must lie somewhere. In Ms. K's case it lay with the Master, as he accepted.

195. On the key question as to what constitutes appropriate treatment for a patient in Ms. K's condition, in my view, there was a *non-sequiter* inherent in Dr. Griffith's evidence, in his differentiation between advice on treatment and its implementation where a blood transfusion was accepted and where it was refused. On the basis of his answers in cross-examination, in my view, the proper inference to be drawn from his evidence is that his opinion was that, aside from her refusal, a blood transfusion was clinically indicated while Ms. K's haemoglobin was at 5.1 g/dl.

196. Dr. Griffith's opinion was that at 2.30 p.m. the risk of mortality in Ms. K's case attached largely to the possibility of a re-bleed, which he considered to be remote. When pressed to quantify what he meant by remote he indicated that the risk was somewhere less than 5%. Risks associated with a re-bleed would inevitably depend on the degree of the re-bleed. In the event of a re-bleed the risk of Ms. K dying was significant, but would depend on the volume of blood lost.

197. In relation to what the coagulation results at 12.48 p.m. indicated, I did not understand Dr. Griffith's evidence to differ significantly in substance from the evidence of the haematological experts and Dr. Conneally as to the existence of an underlying coagulopathy. Looking at the whole picture, the three tests results (PT, APTT and Fibrinogen), his conclusion was that they did not indicate normalisation, although there was a trend towards normalisation.

198. As with the evidence of Dr. Platt and Dr. Martlew, my analysis of the evidence of Dr. Griffiths on whether a blood transfusion was necessary to save Ms. K's life is that it begs the question the court has to answer, because it is predicated on the patient's acceptance or refusal of the treatment.

199. Digressing from the issue of the necessity of a blood transfusion, Dr. Griffith's evidence does help on another point. That is whether Ms. K should have been told that an application was going to be made to court for authority to transfuse her. He was quite emphatic that, because of her condition, she could not have been present at the hearing, but he pointed to the fact that she could have been represented by a solicitor and counsel. Dr. Boylan was also of the view that Ms. K should have been told and he stated that in similar circumstances he would have told the patient, although his evidence was that to have conducted a bedside hearing in the delivery suite on 21st September was not a realistic proposition. Dr. Boylan, however, was of the view that it was probable that the only instructions Ms. K could have given to her legal advisers was to say that she did not want blood because she was a Jehovah's Witness. She would have been completely exhausted, not alone from the labour and the delivery but from the reduction of her blood volume so significantly. He put it graphically in stating that she would not have been in a position to do much at all except lie there.

200. In assessing the proper management of Ms. K and her prognosis, Dr. Boylan started from the position that she had suffered a catastrophic major haemorrhage and lost approximately half or more of her blood volume in a very rapid period of time. His opinion was that Ms. K was still very much at risk at 1 p.m., even on the assumption that the bleeding had stopped, because, having regard to the volume of blood she had lost, it would not have taken much "to tip her over the edge". Throughout his evidence he emphasised that the concern was that Ms. K would re-bleed. If she did, the likelihood was that she would have died. Dr. Boylan assessed the risk of death from a re-bleed if Ms. K was not transfused conservatively in the range of 10% to 15%, but, as counsel for the plaintiffs pointed out, that view was expressed in circumstances where he did not consider that Ms. K was suffering from an ongoing coagulopathy, a view with which the expert haematologists disagreed.

201. In relation to Ms. K's management after the haemorrhage, Dr. Boylan's opinion was that the appropriate treatment was what was actually done coupled with a blood transfusion. He disagreed with the suggestion that a transfusion was not necessary at 2.30 p.m., making the point that the only way one would have found out whether it was necessary or not would have been not to give it to her which, in his view, would have been negligent and an unacceptably low standard of care.

202. Dr. Boylan's opinion was that a "watch and see" approach from 2.30 p.m. onwards was not an acceptable approach. In his view it would be "playing a very dangerous game of rolling the dice" in the care of Ms. K and would not be acceptable to him or to any reasonable obstetrician with the responsibility for her life. He emphasised that a particular reason why Ms. K needed a transfusion was that the onset of bleeding might not be apparent because of the presence of the pack in her vagina until she collapsed and at that stage she would be unresuscitatable because her haemoglobin level was only 5.1 g/dl, so that the oxygen supply to her tissues would be completely inadequate for her to be able to withstand a cardiac arrest.

203. Dr. Boylan was dismissive of the necessity of a further blood test at 2.30 before the transfusion. As he saw it, the problem was the low level of Ms. K's haemoglobin. His view was that Ms. K's haemoglobin level could not have improved by then and, indeed, it was implicit in the questions put to him in cross-examination that Ms. K's experts were of the same view.

204. There was one aspect of Dr. Boylan's evidence of which counsel for Ms. K was particularly critical, which related not to the necessity for a blood transfusion but to Dr. Boylan's opinion of the rationality of Ms. K's responses on the morning of 21st September, 2006. In his direct evidence Dr. Boylan, when asked whether he would have concerns from what he knew about the case that Ms. K really fully understood what was happening and was in a position to make decisions concerning her welfare, gave the following answer:

> "No, I don't think that she was in a position to make rational decisions because these decisions were not rational. So in fact she wasn't making rational decisions and also the fact that she was suggesting that coco and tomatoes and eggs and so on, shows a complete dislocation from reality, really."

205. Counsel for Ms. K submitted that, in that answer, Dr. Boylan was conveying he own view of a patient who refuses a transfusion and that, in essence, he opined that Ms. K was irrational in her decision. In my view, Dr. Boylan's answer does blur the distinction which should be made in assessing capacity between misunderstanding or misperception of the treatment information in the decision-making process and the irrationality of the decision itself. The Coke and tomatoes episode is symptomatic of Ms. K's lack of understanding of the gravity of her condition. If the totality of the evidence suggested that she understood and believed that a blood transfusion was necessary to preserve her life but, nonetheless, made a decision, on whatever grounds, which most people would regard as irrational, that decision would have to be respected.

Conclusion on necessity for blood transfusion

206. What emerges from the evidence is that her treating clinicians and the experts were unanimous that the appropriate medical

treatment for Ms. K at all material times after the haemorrhage and before 2.35 p.m. on 21st September, 2006 when her haemoglobin was a 5.1 g/dl, leaving aside her refusal of treatment, was transfusion of blood and blood products. The basis on which each of the experts called on behalf of Ms. K contended that a blood transfusion was not necessary or essential, or could be postponed until Ms. K's condition deteriorated, related to her refusal to accept treatment and was not based on clinical considerations, applying normal standards of appropriate practice. Not only does the approach of those experts beg the question the court has to answer but the basis on which it was advanced in support of Ms. K's counterclaim is fundamentally flawed.

207. Similarly, an assertion by Ms. K's counsel in their written submission that, to justify the administration of life-saving treatment where there is a doubt about the validity of the patient's refusal of such treatment, it must be objectively demonstrated that the threat to life at a minimum is such as to mean that death would be likely "beyond reasonable doubt, or as an absolute minimum on the balance of probabilities" if the refused treatment were not administered, is fundamentally flawed. Such a test would place an impossible burden on clinicians.

208. The duty of the clinician caring for a patient in the circumstances which prevailed in relation to Ms. K on the morning of 21st September, 2006 is to advise the patient of, and afford him or her the opportunity to receive, appropriate medical treatment. If, as a competent adult, the patient refuses to accept the treatment and no issue arises as to the capacity of the patient to make that decision, the clinician's duty to provide such treatment is discharged. However, if an issue arises as to the capacity of the patient to refuse treatment, the duty of the clinician to advise on and provide the appropriate treatment remains. As a matter of law and common sense, the duty of care which the clinician owes the patient in those circumstances is no different from what it would be if there was no refusal or if the patient was unconscious. What is required of the clinician is to take the steps to have the capacity issue be resolved, with the assistance of the court if necessary.

209. It follows that the assessment of the patient's capacity to refuse treatment falls to be determined by reference to the clinician's responsibility to give to the patient the relevant information in relation to the appropriate treatment and the risks attendant on the patient refusing the treatment. The *C* case test requires an objective assessment as to whether the patient assimilates, understands and weighs that information in the balance. That conclusion is the basis of the fourth principle outlined earlier by reference to which the capacity of a patient to make a decision to accept or reject medical treatment is assessed.

209. Therefore, in my view, the assumption which underlies the application of the *C* case test, that the treatment is necessary, means no more than that the treatment is the appropriate treatment, that is to say, that it is clinically indicated. By way of example, in this case, the responsibility of the Master and the other clinicians treating Ms. K was to give her the information that the appropriate treatment for her was a blood transfusion, as counsel for Ms. K acknowledged. In layman's terms the message was that the doctors' opinion was that a blood transfusion was necessary and that without it she might die.

210. On the evidence I find as follows:

> (a) at all times after the haemorrhage and until 2.35 p.m. the appropriate medical treatment for Ms. K was a blood transfusion;
>
> (b) the emergency continued until 2.35 p.m., in the sense that until she was transfused Ms. K had not received the appropriate medical treatment; and
>
> (c) insofar as it is necessary to do so in the context of Ms. K's counterclaim, a blood transfusion was "the appropriate medical treatment" for Ms. K on the proper construction of that phrase in the *ex parte* order and, in giving Ms. K a blood transfusion at 2.35 p.m., the Hospital did not exceed the authority thereby conferred.

VII. Capacity question: application of the law to the facts

211. Following on from the finding I have made that a blood transfusion was necessary, in the sense that it was the appropriate treatment for Ms. K, I am satisfied that the Master and the other treating clinicians gave Ms. K the information necessary to enable her to make an informed decision as to whether to accept or refuse a blood transfusion. That information was conveyed through Ms. F, in what I have described as layman's terms; that the doctor's opinion was that a blood transfusion was necessary and that without it she might die. It was language from which a competent adult whose capacity was not impaired should have understood the gravity of the situation.

212. The argument advanced on behalf of Ms. K was that her understanding was not a matter of concern for the Hospital personnel before the *ex parte* application was made. There was what, in my view, amounted to a serious challenge to the *bona fides* of the Master in applying to court for leave to transfuse in the face of Ms. K's refusal. It was suggested that the Master and the Hospital personnel knew that Ms. K was a Jehovah's Witness and acted on that basis. It was also suggested that the Master made a decision that Ms. K should be transfused, notwithstanding her refusal, and that he went to court "willy-nilly" and without ascertaining the level of her understanding.

213. What the evidence shows is that the Master accepted Ms. K's assertion that, as a Jehovah's Witness, she was refusing a transfusion on religious grounds at face value. Consequently, she was not transfused and the Master's evidence was that she would not have been transfused except on the authority of a court order. My understanding, on the evidence, of the Master's position as to Ms. K's capacity when he decided to seek the authority of this Court to transfuse her was that he had neither come to a conclusion that she lacked capacity to make a decision of such gravity as to refuse life-saving treatment on religious grounds, nor had he come to a conclusion that she had such capacity. While he was satisfied that the gravity of the situation had been explained to her, he did not know the level of appreciation she had about what she had been told. In the course of a trenchant cross-examination the Master described his doubts about the quality of Ms. K's refusal in various ways – as issues, as difficulties, as uncertainties, and as "grey areas". The main thrust of his evidence was that, having regard to all of the circumstances, he could not be certain that Ms. K had the capacity to refuse a blood transfusion.

214. It was submitted on behalf of Ms. K that there was a major deficit in the manner in which the Hospital personnel evaluated the quality of Ms. K's refusal. It was contended that Ms. K had not been interviewed for the purpose of ascertaining what she understood. There was no evidence, it was submitted, of any of the Hospital personnel having a discussion with Ms. K. Other factors were pointed to as suggesting that either Ms. K's capacity was not in issue or, alternatively, no proper assessment of her capacity was conducted before the ex parte application. It was suggested that the requirement of para. 17.1 of the Medical Council Guidelines, which I have referred to earlier, was not complied with, in that the Master did not consult with his colleagues in the sense of inquiring what each of his senior colleagues would do in the circumstances. The fact that there is nothing in Ms. K's chart indicating that she

was lacking in capacity and that the notes made by the student midwife, which I have quoted earlier and which it was contended demonstrated that Ms. K had capacity, were relied on in support of the argument that capacity was not in issue. It was suggested that the capacity issue was, in essence, a contrivance which had been created by the Hospital personnel and that the reality was that there was no assessment of capacity because it was accepted that Ms. K was a Jehovah's Witness who would not take blood, the issue being one of religious belief, not of capacity.

215. A feature which is common to all of those allegations is that they fail to have regard to the exigencies of the emergency. While there was no formal evaluation of Ms. K's capacity, the purpose of the interaction of the various clinicians, whose evidence I have outlined, with Ms. K after her initial refusal was to ascertain whether the refusal should be accepted as informed and valid. Each interaction was prompted by concerns that it was not. Likewise, while there was not a formal consultation process between the Master and his senior colleagues on the issue of capacity, the evidence clearly shows that the concerns of the treating clinicians were conveyed to the Master and, on the basis of his own interaction with Ms. K he had similar concerns. The ultimate responsibility for the care of Ms. K, lay with him. I am satisfied that he informed himself of his senior colleagues' views to the extent necessary in the circumstances. In relation to the absence of any reference to doubt as to Ms. K's capacity in her chart, I attach no significance to this. It is quite clear that the plans for Ms. K's management recorded by the Master and Dr. Conneally were based on the situation which prevailed when each was made, when authority had not been obtained to transfuse Ms. K. I have already set out my views on the notes made by the student midwife. Apart from the foregoing, as I have already held, the fact is that the capacity issue was raised on the ex parte application, in that the plaintiffs raised the issue of "the quality of the refusal" and the issue of the extent to which it "was made on the basis of an informed decision". There could be no clearer evidence that the Master had genuine concerns as to Ms. K's capacity on the 21st before the *ex parte* application was made.

216. I now turn to the kernel of the capacity issue, that is whether the evidence demonstrates that the Master and the other Hospital personnel were objectively justified in doubting Ms. K's capacity.

217. Counsel for Ms. K pointed to three specific incidents which he contended should have dispelled any concerns the Hospital personnel had in relation to Ms. K's capacity. The first was the assertion that it was on her initiative that the Hospital Liaison Committee was contacted at 10.30 p.m. I have already found that it is probable that the initiative came from Ms. F, not from Ms. K. Even if that finding is incorrect and the initiative came from Ms. K, this is not something of which the Hospital personnel were aware. The second was the conversation with Ms. Manning before 11.30 a.m. during which Ms. K gave incorrect information to the Hospital as to the whereabouts of the father of her new-born baby. The Hospital personnel had no reason to suspect that Ms. K was concocting a lie. The third is the suggestion made by Ms. K some time after 11.30 a.m. that Coke and tomatoes might be an alternative solution to a blood transfusion. In my view, viewed objectively that suggestion could only ring alarm bells as to Ms. K's appreciation of the gravity of her situation and what required to be done to preserve her life.

218. The level of communication between Ms. K and the Hospital personnel was also pointed to as evidence of Ms. K's capacity. While there undoubtedly was communication, the problem is that the Hospital personnel were not satisfied that what was communicated by Ms. K revealed an understanding on her part that she needed a blood transfusion and that without it she might die, as the evidence of Dr. Russell, Dr. Froese, Dr. Conneally and the Master, which I have recorded earlier, illustrates. In relation to Ms. K's own evidence, her counsel submitted that it illustrates that she knew she was in danger of dying and she believed it. It was submitted that the question one has to ask is whether she knew it was a life and death situation, not whether she knew that a blood transfusion was the solution. In my view, that proposition is incorrect. The essential piece of information which Ms. K had to assimilate and believe was that a blood transfusion was necessary and that without it she might die and the crucial question is whether she did so. Counsel for Ms. K suggested that the question was answered positively on the evidence in that, in stating in cross-examination that she was told at Jehovah's Witness meetings that taking blood was a personal decision "because it is a question of life and death", Ms. K demonstrated that she knew that taking blood could be a question of life and death. However, when the question is posed as to what she understood and believed on the morning of 21st September, 2006, it is not possible to conclude on the totality of Ms. K's own evidence that she understood and believed that without a blood transfusion she might die.

219. Irrespective of that finding on the evidence adduced on the plenary hearing, the capacity question falls to be determined by reference to the evidence which was available to the Hospital personnel and the court on 21st September, 2006. Having regard to the evidence given on the *ex parte* application and the reasons advanced for seeking the *ex parte* order, I conclude that the Master and the Hospital personnel should have doubted, and genuinely did doubt, Ms. K's capacity to give a valid refusal on the morning of 21st September, 2006. It is instructive to reiterate the factors which were outlined to the court on that day: Ms. K's seriously compromised medical status following a long labour, a difficult delivery and a massive haemorrhage; the communications difficulties created by the fact that Ms. K's first language was not English; the fact that she was a young woman in a foreign country whom the Hospital personnel believed had no family members in the State to whom the Hospital could turn for some assurance or confirmation of her religion and her understanding of her need for a blood transfusion; that, if she died, on the basis of what she told the Hospital personnel her new-born baby would have no traceable next of kin and the whereabouts of his father would be unknown; and that by her disclosure, after the haemorrhage, Ms. K told the Hospital personnel for the first time that she was a Jehovah's Witness and would not take blood, which was at variance with the Hospital's understanding that she was a Roman Catholic which was based on the information she gave when booking. All of those matters, in my view, put the Hospital personnel on inquiry as to whether Ms. K's refusal was valid. If the Hospital personnel had ignored them and done nothing and Ms. K had died, the Hospital might well have had a case to answer at the suit of Ms. K's husband and her child.

220. I am satisfied that, in the interactions of Dr. Russell, Dr. Froese, the Master and Dr. Conneally with Ms. K, the Hospital personnel did what was feasible in the context of the emergency to test the validity of Ms. K's refusal. As the evidence shows, they were hampered by the communication difficulties. A question which was explored in the evidence was whether a professional interpreter should have been brought in. The evidence reveals that some efforts were made to obtain a professional interpreter. Even if as professional interpreter had been available, I think it improbable that the Hospital personnel would have obtained any clearer picture of Ms. K's understanding of the gravity of the situation, because obviously the communication difficulties were not limited to linguistic difficulties.

221. If on 21st September, 2006 the Master had been conversant with the C case test and at, say, 12.30 p.m. had applied it in the light of all of the evidence available, carefully assessing the evidence with due regard to the consequences of Ms. K's decision, that it could result in her death, in my view, he should have concluded that –

> (a) Ms. K did not sufficiently understand and retain the information given to her by the Hospital personnel as to the necessity of a blood transfusion to preserve her life,
>
> (b) that she did not believe that information and, in particular, that she did not believe that she was likely to die without a blood transfusion being administered, and

(c) that in making her decision to refuse a blood transfusion, Ms. K had not properly weighed that information in the balance, balancing the risk of death inherent in that decision and its consequences, including its consequences for her new-born baby, against the availability of a blood transfusion which would preserve her life.

222. On the evidence available before the making of the ex parte application, the plaintiffs were objectively justified in doubting Ms. K's capacity to refuse a blood transfusion.

223. In the article in the Judicial Studies Institute Journal to which I have referred earlier, Donnelly refers to the comment of Black J. in *Provincial Bank v. McKeever* [1941] I.R. 471 (at p. 485) that a court "possesses no X-Ray contrivance that can lay bare the workings of the human mind". If true of the context in which it was made, an allegation of undue influence in relation to a banking transaction, that comment is surely true in the context of a refusal of life-saving treatment on religious grounds. I think it is only fair to record that notwithstanding the issues as to her credibility which arose in the course of the hearing and despite some elements of melodrama, for example holding the Bible, in the presentation of her evidence, Ms. K's evidence did not raise any doubts as to the strength of her conviction that to accept a blood transfusion would transgress the law of God.

224. A regrettable feature of this case is that, notwithstanding that the medical emergency which arose was not foreseeable, the intervention of the court probably could have been obviated if Ms. K had not misrepresented the facts as to her religion when booking into the Hospital and had not perpetuated the misrepresentation and compounded it by misrepresenting the position in relation to her family throughout her dealings with the Hospital. At the beginning of his testimony the Master emphasised that the Hospital is a non-denominational hospital which accommodates patients from different ethnic backgrounds and of different religious beliefs. I am satisfied on the evidence that it is a hospital in which the wishes of patients of the Jehovah's Witness faith who do not wish to be transfused are respected. The situation in which Ms. K was transfused against her wishes unfortunately was of her own making.

VIII. Whether balancing of rights question should be considered

225. As I have recorded, there was consensus that the balancing of rights question would only arise in the event that the court were to find that Ms. K had full capacity to make a decision to refuse a blood transfusion. On the basis of the finding that Ms. K did not have capacity to make that decision the balancing of rights question does not arise. For the court to express a view on it would, in effect, amount to an advisory judgment on an issue which has been rendered moot by the decision on the capacity question.

226. One of the US authorities relied on by counsel for the plaintiffs on the balancing of rights question was *Norwood Hospital v. Yolanda Munoz* (1991) 564 Ne 2d 1017. The issue before the Supreme Judicial Court of Massachusetts in that case was whether the trial judge who, following a full evidential hearing, granted a declaratory judgment authorising blood transfusions to be administered to Mrs. Munoz, whom the trial judge found to be competent to make the decision to refuse blood transfusions, on the ground that her minor child would be abandoned if she were to die, had erred. The Supreme Court held that he had erred because the State's interests in protecting the wellbeing of her minor child did not override Mrs. Munoz's right, as a competent adult, to refuse lifesaving medical treatment. The Supreme Court dealt with the issue although it was moot, Mrs. Munoz having recovered without having to be transfused and there being no evidence that her medical problem, a bleeding ulcer, would recur. The Supreme Court invoked an exception to the general rule that the courts will not decide moot questions. In the context of consideration of that decision, counsel for the plaintiffs advanced an argument which I hope I have not misunderstood. He sought to distinguish the situation in this case on the basis that Abbott J. made an *ex parte* interim order the correctness of which was to be for another day, and this being the trial of the action, the issue is not moot. In my view, it is moot having regard to the decision on the capacity question.

227. Apart from the issue of mootness, in my view, counsel for the Attorney General was correct in urging restraint. The balancing of rights question has no foundation in fact now and it never had. I did not understand counsel for the plaintiffs to argue that Ms. K's baby had a constitutionally-protected right to be brought up and cared for by both of his parents, but rather that he accepted the approach adopted by the Supreme Court of Florida in *Public Health Trust of Dade County v. Wons* 341 So.2d.96, to be consistent with our constitutional jurisprudence. In his concurring judgment, Erlich C.J., dismissing the argument advanced by the Public Health Trust asserting the right of Mrs. Wons' two minor children to be reared by two loving parents, stated:

> "I agree with the district court below that '[t]he *parens patriae* doctrine invoked herein cannot … measure increments of love; it cannot mandate a two-parent, rather than a one-parent family; it is solely concerned with seeing to it that minor children are cared for and not abandoned'. … Absent evidence that a minor child will be abandoned, the state has no compelling interest sufficient to override the competent patient's right to refuse treatment. Sweeping claims about the need to preserve the lives of parents with minor children have an emotional appeal that facilely avoids both the constitutionally-required scrutiny of the state's authority to act and the search for less restrictive alternatives."

228. The plaintiffs' submissions that Ms. K's baby's constitutionally-protected rights would take precedence over Ms. K's constitutional rights to autonomy, self-determination and free practise of her religion were predicated on the proposition that the voluntary death of Ms. K leaving her baby without a parent in the State and without any family member being available to care for him would constitute abandonment. It is obvious now that in the unfortunate circumstance of Ms. K's death her new-born baby was not going to be left parentless. Although the Hospital personnel were misled by Ms. K on this point for the duration of her stay in the Hospital, the baby's father was in the State and, indeed, visited the Hospital both before and after the baby's birth. Therefore, as regards the plaintiffs' claim, the balancing of rights question is wholly hypothetical and should not be decided. For the same reason, although it will be necessary to refer to some of the arguments made by counsel for Ms. K on that question in addressing the reliefs sought on behalf of Ms. K in her counterclaim to set aside the *ex parte* order, it would not be appropriate to make a decision on Ms. K's defence of the plaintiffs' case founded on the balancing of rights question.

IX. Manner in which ex parte order sought and made and reliefs claimed in respect of the order

Claim and Counterclaim

229. The validity of the order of 21st September, 2006 is in issue because of the respective claims of the plaintiffs and Ms. K. The plaintiffs have sought a declaration that they were entitled to apply for the injunction and that the court was entitled to or, alternatively, obliged to grant the relief sought. Ms. K in defending the proceedings has asserted that the order should not have been applied for and that it should not have been made and that it should be set aside pursuant to O. 52, r. 3 of the Rules. She has claimed a declaration that the plaintiffs acted in violation of her constitutional rights in purporting to proceed against her by way of *ex parte* application, in addition to an order that the proceedings be struck out and dismissed as an abuse of process or pursuant to O. 52, r. 3. As the striking out or dismissal of the proceedings would not achieve Ms. K's objective, I am treating that aspect of the counterclaim as a claim to set aside the *ex parte* order either under the court's inherent jurisdiction or O. 52, r. 3. It was also argued at the hearing, although not pleaded, that the order should be set aside on the grounds of material non-disclosure to the court on 21st September, 2006.

Nature of the ex parte order
230. It was submitted on behalf of Ms. K that the order was a "nullity" and that it had "no validity". Counsel for the Attorney General submitted that those propositions are not correct, in that an order of the High Court cannot become a nullity or lose its validity save in circumstances where it has been overturned or set aside by the Supreme Court. While it was recognised that there are certain circumstances in which a High Court order may be varied by the High Court, it was submitted that that does not have the effect of rendering the order which is set aside a nullity or invalid. In the light of that submission, it is necessary to consider this Court's jurisdiction in relation to the *ex parte* order.

231. The jurisdiction of this Court depends on the nature of the *ex parte* order and, in particular, whether it was an interlocutory order or a final order. The submission made on behalf of Ms. K that it was in the nature of a final order, in my view, is not correct. It is true, as I have already pointed out, that its effect was not limited in time and it did not envisage an interlocutory application on notice to Ms. K and there was none. It is also true that, while it was permissive in nature, its immediate implementation was irreversible in the sense that the administration of the blood transfusion could not be reversed. As against that, counsel for the plaintiffs made the point that if the order had not been granted the outcome might have been irreversible, in that Ms. K might have died. The essential question in distinguishing whether the order was an interlocutory order or a final order is whether it was intended finally to determine the rights of the parties. It is quite clear from the observations of Abbott J. that he regarded it as an interlocutory order and that the rights of the parties would be subject to further consideration and, if appropriate, a different determination following a plenary hearing. Therefore, the order was an interlocutory order.

Jurisdiction to set aside ex parte order
232. Counsel for Ms. K specifically invoked the jurisdiction given by O. 52, r. 3. Order 52 deals with the procedural aspects of motions and other applications to the court. Rule 2 provides that, save as otherwise provided by the Rules, all such applications "other than such as under the existing practice are made *ex parte* or are authorised by these rules to be so made" shall be made on notice to the parties concerned. Rule 3 provides:

> "In any case the Court, if satisfied that the delay caused by proceeding by motion on notice under this Order would or might entail irreparable or serious mischief, may make any order *ex parte* upon such terms as to costs or otherwise and subject to such undertaking, if any, as the court may think just; and any party affected by such order may move to set it aside."

233. *Prima facie*, the application made on 21st September, 2006 came within rule 3 because it clearly related to a situation that would or might entail irreparable damage if there was delay in bringing it. What rule 3 seems to envisage is that a party affected will move to set aside an *ex parte* order by motion on notice to the party who has obtained it, grounded on affidavit. The application to set aside in this case follows a plenary hearing and is grounded on oral evidence. Even if the procedure followed here does not come within rule 3, I am satisfied that the court has an inherent jurisdiction to set aside an order made *ex parte*. Although they were not cited by counsel, I think it is useful to consider two recent decisions of this Court to that effect.

224. In *Voluntary Purchasing Groups Inc. v. Insurco Limited* [1995] 2 I.L.R.M. 145, McCracken J. was concerned with an application to set aside an *ex parte* order made pursuant to s. 1 of the Foreign Tribunals Evidence Act, 1856 directing that a firm of accountants be represented before an examiner to give evidence in aid of the execution of a default judgment granted by a court in the United States in a civil matter. In dealing with the question of jurisdiction, McCracken J. in his judgment (at p. 147) pointed out that, while O. 39, rr. 33 – 34 dealt with the procedures under the 1856 Act and provided for an *ex parte* application, it made no provision for any further application to set aside the *ex parte* order. He also concluded that the application did not come within O. 52, r. 3, so that the application to set aside could not be made under that provision. He went on to say:

> "In my view, however, quite apart from the provisions of any rules or statute, there is an inherent jurisdiction in the courts in the absence of any express statutory provision to the contrary, to set aside an order made *ex parte* on the application of any party affected by that order. An *ex parte* order is made by a judge who has only heard one party to the proceedings. He may not have had the full facts before him or he may even have been misled, although I should make it clear that is not suggested in the present case. However, in the interests of justice it is essential that an *ex parte* order may be reviewed and an opportunity given to the parties affected by it to present their side of the case or to correct errors in the original evidence or submissions before the court. It would be quite unjust that an order could be made against a party in its absence and without notice to it which could not be reviewed on the application of the party affected."

225. The reasoning of McCracken J. in that passage was followed by Kelly J. in *Adams v. Director of Public Prosecutions* [2001] 2 I.L.R.M. 401. That was a public law case in which the applicant had been extradited from the United Kingdom to the State in respect of charges, *inter alia*, under the Larceny Act, 1915 and was subsequently charged with a number of counts of rape and sexual assault. Because of the rule of speciality contained in s. 39 of the Extradition Act, 1965, which provides that a person extradited to the State shall not be proceeded against for any offence committed prior to his surrender other than that for which he was surrendered, except, *inter alia*, with the consent of the requested country signified under the seal of the requested country, it would not have been possible to prosecute the sexual offences without the appropriate consent. The Home Secretary for the United Kingdom had issued the relevant certificate of waiver. The applicant brought an application in the court for leave to commence proceedings by way of judicial review seeking to prohibit the continuance of the prosecution of the sexual offences. The Home Secretary was named as a respondent and the relief sought against the Home Secretary was an order quashing the certificate purporting to waive speciality. Leave was granted. The matter before Kelly J. was an application by the Home Secretary to set aside the order granting leave and dismiss the proceedings against him. In addressing an argument made that it was not open to the Home Secretary to make an application to set aside the order granting leave and that the only remedy available to the Home Secretary was by way of appeal to the Supreme Court, Kelly J., having quoted the passage from the judgment of McCracken J. in *Voluntary Purchasing Groups Inc. v. Insurco Limited* which I have just quoted, stated as follows:

> "I have no hesitation in following that line of reasoning. It is in my view both good law and good sense. It would be most unjust to deny a party against whom an *ex parte* order had been made the opportunity of applying to court to set it aside and instead to insist that the only remedy was one of appeal to the Supreme Court."

226. Kelly J. then went on to deal with a further argument made on behalf of the applicant to the effect that the only judge who could hear the Home Secretary's application to set aside the order was the judge who made the *ex parte* order. He rejected that argument on the basis that it was completely inconsistent with the established practice of the court and that, in situations where the Rules permit applications to set aside (for example under O. 52, r. 3 and O. 12, r. 56), no such stricture applies. Kelly J. also pointed to the absurd results which could flow from such a stricture, in that the *ex parte* order could never be set aside if the judge who made it had retired or died. An appeal against the decision of Kelly J. was dismissed by the Supreme Court but without reference to

the observations of Kelly J. on those two arguments.

227. An interesting aspect of the judgment of Kelly J. in the *Adams* case for present purposes is that it is recorded in the judgment (at p. 415) that, in response to a question querying whether there was authority to support the proposition that only the judge who heard the *ex parte* application could hear the application to set aside, Kelly J. was referred to the decision of the Court of Appeal in *St. George's Healthcare N.H.S. Trust v. S*. It was on this decision that counsel for Ms. K primarily relied in support of their contention that the plaintiffs' approach in applying to court *ex parte* for an order authorising the administration of a blood transfusion to Ms. K was improper and that the *ex parte* order was a nullity.

228. The order made at first instance in that case was in the form of a declaration that St. George's Hospital have leave to carry out such treatment to S and the foetus as might be deemed necessary, including Caesarean section by general anaesthetic. The Court of Appeal considered the nature of a declaration, in contradistinction to an injunction. Delivering the judgment of the court, Judge L.J. stated (at p. 965) that a declaration ought not to be made on an interim basis, or without adequate investigation of the evidence put forward by either side, and that a declaration (especially one affecting the individual's personal autonomy) ought not to be made on an *ex parte* basis. He stated that apart from the injustice and other more obvious objections, it would simply be ineffective to achieve its purpose to protect the doctor or doctors who performed the operation from subsequent adverse criticism or claims. This is because, while a declaration operates by creating an estoppel *per rem judicatam* between the parties and their privies, no estoppel can be created by a judgment pronounced in a party's absence without the party having been given notice of the proceedings or any opportunity to be heard. It seems to me that, in point of principle, that must be the case in this jurisdiction also. Judge L.J. then went on to consider the manner in which an interim injunction is granted *ex parte* stating (at p. 966):

> "An interim injunction is granted *ex parte* only in exceptional circumstances, and then only subject to the triple safeguard of (i) the duty of full and frank disclosure, (i) the cross-undertaking in damages which is required as a matter of course and (iii) the right of the party enjoined to apply to vary or discharge the ex parte order. If an interim declaration were a remedy known to English law it would hardly be obtainable without the same safeguards being put in place."

229. Kelly J. quoted that passage in the *Adams* case and went on to consider the duty of disclosure on the part of an applicant on an *ex parte* application in the following passage (at p. 416):

> "On any application made *ex parte* the utmost good faith must be observed, and the applicant is under a duty to make full and fair disclosure of all of the relevant facts of which he knows, and where the supporting evidence contains material misstatements of fact or the applicant has failed to make a sufficient or candid disclosure, the *ex parte* order may be set aside on that very ground. …
>
> The obligation extends to counsel. There is an obligation on the part of counsel to draw the judge's attention to the relevant Rules, Acts or case law which might be germane to his consideration. That is particularly so where such material would suggest that an order of type sought ought not to be made."

230. The Court of Appeal in the St. George's Healthcare case, in considering whether a purported declaration made on an *ex parte* basis was "void" or "voidable", set out what Lord Diplock had said in delivering the Privy Council's advice in *Isaacs v. Robertson* [1985] A.C., 97, at p. 102 – 103, wherein Lord Diplock stated that, in relation to orders of a court of unlimited jurisdiction, it is misleading to draw distinctions between orders that are "void", in the sense that they can be ignored with impunity by those persons to whom they are addressed, and orders that are "voidable" and may be enforced unless and until they are set aside. Having referred to dicta in opinions given by the Judicial Committee of the Privy Council in two appeals, he continued:

> "… but in neither of those appeals nor in any case to which counsel has been able to refer their Lordships has any order of a court of unlimited jurisdiction been held to fall into a category of court order that can simply be ignored because they are void ipso facto without there being any need for proceedings to have them set aside. The cases that are referred to in these dicta do not support the proposition that there is any category of orders of a court of unlimited jurisdiction of this kind; what they do support is a quite different proposition that there is a category of orders of such a court which a person affected by the order is entitled to apply to have set aside *ex debito justitiae* in the exercise of the inherent jurisdiction of the court without his needing to have recourse to the rules that deal expressly with proceedings to set aside orders for irregularity and give to the judge a discretion as to the order he will make."

231. The decisions of McCracken J. and Kelly J. referred to earlier, which were implicitly approved of by the Supreme Court in *Adam v. Minister for Justice, Equality and Law Reform* [2001] I.R. 53, are consistent with that statement. Therefore, if the *ex parte* order was improperly obtained, it was not a nullity or invalid, but the court has jurisdiction to set it aside either under O. 52, r. 3 or under the court's inherent jurisdiction.

Grounds for setting aside the ex parte order?

232. Various stages are discernible in Ms. K's challenge to the propriety of the conduct of the plaintiffs on 21st September, 2006 and why they should not be allowed rely on the *ex parte* order.

233. First, it was submitted that the circumstances were not such as justified an application to court. In this connection, it was submitted that the eighth proposition enunciated by Lord Donaldson in Re T, that, in cases of doubt, where failure to treat threatens the patient's life or threatens irreparable damage to his health, the treating physicians should not hesitate to apply to the courts for assistance has been modified by the guidelines laid down by the Court of Appeal in its later decision in the *St. George's Healthcare* case. It is certainly the case that in the later case the Court of Appeal was more focused on ensuring that only appropriate applications were brought to court. While I would not disagree with the submission made on behalf of Ms. K that the better legal approach is to proceed in the terms outlined in the *St. George's Healthcare* case, nonetheless, I am of the view that given the circumstances which prevailed, the assessment carried out by the Master would have met the requirements stipulated by the Court of Appeal and his doubts as to Ms. K's capacity and the seriousness and complexity of the issues to which the peculiar facts of the case gave rise justified the plaintiffs in seeking the assistance of the court.

234. Secondly, it was submitted that the plaintiffs should have put Ms. K on notice that it was intended to make an application to court for leave to transfuse. I think Ms. K should have been told that an application was to be made, and I will return to the implications of that. However, there is no doubt that neither her attendance at court nor a bedside hearing was a realistic proposition.

235. Thirdly, it was submitted that the application should not have proceeded on an ex parte basis. Counsel for Ms. K pointed to the common law position as dealt with in the guidelines of the Court of Appeal in the *St. George's Healthcare* case where it is stated that

the hearing before the judge should be *inter partes*. More importantly, counsel for Ms. K. invoked the proposition stated in Kelly on The Irish Constitution, 4th edition, at p. 640, that in this jurisdiction the common law rule of natural justice*, audi alteram partem*, has been given – to a greater or lesser degree – "a constitutional status and protection" and is also embodied in article 6(1) of the Convention. That, of course, means that O. 52, r. 3 must be construed and applied in a manner which is consistent with the Constitution and compatible with the Convention. The decision of the Supreme Court in *D.K. v. Crowley* [2002] 2 I.R. 744 in my view, gives a clear indication of what that requires.

236. In that case, the issue was whether s. 4(3) of the Domestic Violence Act, 1996, which empowers a District Court to grant an interim barring order on an *ex parte* application was invalid having regard to the provisions of the Constitution. An argument made by counsel for the respondents, the District Court judge who made the barring order and Ireland and the Attorney General, was outlined in the following passage of the judgment of the court, delivered by Keane C.J., (at p. 752):

> "Counsel for the respondents urged that it was legitimate to depart from established principles of natural justice, including *audi alteram partem*, where there was an immediate risk of significant harm. There were well established procedures under our law enabling court orders to be made either of a restrictive or a mandatory nature without the persons affected being afforded an opportunity to be heard. The procedures under the Domestic Violence Act, 1996, for the granting of interim barring orders on an *ex parte* basis reflected the procedures established by Order 52, rule 3 … for the granting of injunctions on an *ex parte* application. He cited, in this connection, the decisions of this Court in *O'Callaghan v. Commissioners of Public Works* [1985] I.L.R.M. 364, *The State (Lynch) v. Cooney* [1982] I.R. 337 …"

237. The Supreme Court rejected that submission, pointing out that there were significant differences between the statutory jurisdiction conferred on the District Court to grant barring orders and the jurisdiction traditionally enjoyed by Courts of Chancery to grant injunctions in civil cases where damages would not be an adequate remedy. Some of those differences were highlighted in the following passage (at p. 758):

> "The mandatory nature of the interim barring order, even when granted on an *ex parte* application, is in sharp contrast to the nature of the interim or interlocutory injunctions typically granted in civil proceedings. Such injunctions are normally intended to do no more than preserve the status quo pending the determination of the parties' rights in plenary proceedings. While they may on occasions be mandatory in nature, that is unquestionably the exception rather than the rule. It is even rarer for mandatory injunctions to be granted on an interim basis on the *ex parte* application of the plaintiff.
>
> Even more strikingly, although an interim injunction may be granted on an *ex parte* application in the absence of the defendant, the courts have always been concerned to ensure that the interference thus effected with what may very well be a right which the defendant is entitled to exercise without such interference, is as limited in its duration as is practicable. In the High Court, the injunction will not normally last beyond the next motion day and, in many cases, the court will abridge the time for service of a notice of motion so as to ensure that the defendant is heard in a matter of days. With the hearing of the notice of motion, the interim injunction automatically expires."

238. The Supreme Court pointed to other differences: that of breach of a barring order constituted a criminal offence, whereas a person who fails to comply with an injunction commits no offence, although the plaintiff may put in train the process of attachment for contempt in order to obtain compliance with the order; and where the District Court concludes that the interim order should never have been granted, it can do no more than discharge the order and the applicant cannot be required to compensate the respondent, whereas, in stark contrast, an interim or an interlocutory injunction will only be granted where the plaintiff has undertaken to pay any damages to which the defendant may be entitled in the event of it being held that the injunction should not have been granted.

239. The decision of the Supreme Court on the issue before it was that s. 4(3) was invalid having regard to the provisions of the Constitution in that the procedures thereby prescribed, in failing to prescribe a fixed period of relatively short duration during which an interim barring order made *ex parte* was to continue in force, deprived the person against whom such application was made of the protection of the principle of *audi alteram partem* in a manner and to an extent which was disproportionate, unreasonable and unnecessary.

240. The position adopted by the Attorney General on Ms. K's contention that the application ought not to have been dealt with *ex parte* was that, as a matter of principle, a person against whom an order of the type which the plaintiffs sought had a right to be heard, but there may be exceptional circumstances in which it is not possible to afford such person the right. Ms. K's case may have been such a case and whether it was is tied into the findings of fact in relation to the emergency. The question was whether time was available to give notice. If time was available, it was unarguable that notice should have been given.

241. I have already stated that, in my view, Ms. K. should have been told. With the benefit of Ms. F's evidence and a considerable degree of hindsight, I believe that Ms. F, who was Ms. K's designated birth partner and designated "next of kin" could have, through her family connections, procured legal assistance for Ms. K. While Ms. K's capacity to give instructions to a solicitor was limited, again with the benefit of hindsight, I think she had the capacity to instruct a solicitor to defend an application for an injunction, in the sense that she would have been able to tell the solicitor she did not want to be transfused and the solicitor could have decided how best to act on those instructions. Even at this remove, one can only speculate as to whether legal representation for Ms. K could have been put in place as speedily as the urgency of the situation required. In the context of the emergency in which the Hospital personnel and Hospital's legal advisers were operating on 21st September, 2006, and having regard to what they knew of Ms. K's circumstances on that day on the basis of the information she had given them, I think it would be unfair to find that failure to tell Ms. K of the intended application to court constituted a breach of her constitutional rights.

242. Not only would it be unfair on the basis of the facts to so find, but it would also be unfair because there was no State established and funded guidance in place to assist the Hospital personnel and their advisers in the dilemma with which they were faced and there was no designated officer of the State to whom they could have recourse to assist in having Ms. K's interest represented. In the Donnelly article in the Judicial Studies Institute Journal it is noted that in *In re a Ward of Court* Lynch J. appointed the General Solicitor to act as guardian *ad litem* for the ward with a specific function of contradicting the case being made by the ward's family ([1996] 2 I.R. 79 at 89). Later, Donnelly suggests that, in developing an appropriate procedural approach to hearings in relation to capacity issues and independent representation at such hearings, it is useful to begin by looking at the Practice Direction (Declaratory Proceedings: Incapacitated Adults) issued by the Official Solicitor for England and Wales ([2002] 1 W.L.R. 325), which is based on the guidance issued by the Court of Appeal in *St. George's Healthcare N.H.S. Trust v S.* Donnelly suggests there are a number of aspects of the procedure which could usefully be adopted in this jurisdiction and continues (at p. 163):

> "Of particular importance is the fact that it ensures that the individual always has some form of independent legal

representation. If she does not have her own counsel, she is represented by the Official Solicitor. In this jurisdiction, this could be provided through the adoption in the capacity context of Lynch J.'s recommendation in *In re a Ward of Court* that a guardian *ad litem* be appointed to act for the individual involved unless she has her own legal representation. Even in an emergency situation, the person whose rights are at stake should have independent representation."

243. While I agree with those observations, on a practical level, as things stand, it is difficult to see how independent representation could be arranged in an emergency.

244. While I am of the view that the court had jurisdiction to hear the application *ex parte* and that it was proper that the application be proceeded with on an *ex parte* basis, it has to be acknowledged that the process was fundamentally defective. The observations of the Supreme Court in *D.K. v. Crowley* make it absolutely clear that the proper application of O. 52, r. 3 in a manner consistent with the principle of *audi alteram partem* and the constitutional rights of a person in the position of Ms. K, and in a manner compatible with the Convention, requires that an interim order granted on an *ex parte* basis should be as limited in duration as is practicable, which means that the interlocutory application on notice to the party affected should be heard as soon as reasonably practicable. The *ex parte* order made no provision for an interlocutory application. Further, it requires that two of the triple safeguards identified by the Court of Appeal in the *St. George's Healthcare* case should be conditioned into an interim injunction granted on an *ex parte* basis. That was not done in this case, in that, apparently, no undertaking as to damages was given by the plaintiffs and the "liberty to apply to both parties" provision fell short of recognising the right of Ms. K to apply to court to vary or discharge the *ex parte* order. Further, if it is the case that the plaintiffs failed in their duty of full and frank disclosure in making the application, which was the final stage in Ms. K's challenge to the *ex parte* order, this Court has jurisdiction to set it aside.

Failure of duty of full and frank disclosure?
245. It was submitted on behalf of Ms. K that the plaintiffs did not make full and frank disclosure in moving the application on 21st September, 2006. Two complaints were made: that the plaintiffs did not apprise the court of all the relevant facts; and that the court's attention was not drawn to the relevant legal authorities.

246. It was submitted by counsel for Ms. K that, in determining whether to set aside the *ex parte* order on the ground that there had been non-disclosure of factual matters, the court should apply the test set out by Clarke J. in *Bambrick v. Cobley* [2005] IEHC 43 by reference to which the court should exercise its discretion to discharge an interim injunction granted on an *ex parte* basis (in that case a Mareva injunction) and to refuse to grant an interlocutory injunction for failure to disclose on the *ex parte* application. Clarke J. formulated the test as follows:

> "It is necessary to consider, in general terms, the criteria which the court should apply in the exercise of such discretion. Clearly the court should have regard to all of the circumstances of the case. However, the following factors appear to me to be the ones most likely to weigh heavily with the court in such circumstances:-
>
> 1. The materiality of the facts disclosed.
>
> 2. The extent to which it may be said that the plaintiff is culpable in respect of a failure to disclose. A deliberate misleading of the court is likely to weigh more heavily in favour of the discretion being exercised against the continuance of an injunction than an innocent omission. There are obviously intermediate cases where the court may not be satisfied that there was a deliberate attempt to mislead but that the plaintiff was, nonetheless, significantly culpable in failing to disclose.
>
> 3. The overall circumstances of the case which lead to the application in the first place."

247. Earlier in his judgment, having considered some of the authorities on what constitutes lack of candour on an *ex parte* application so as to give rise to the type of consequence he was considering, Clarke J. stated:

> "Taking those authorities it would seem that the test by reference to which materiality should be judged is one of whether objectively speaking the facts could reasonably be regarded as material with materiality to be construed in a reasonable and not excessive manner."

248. Those observations were made in the context of a commercial transaction and following the observation that "in heavy commercial cases the borderline between material facts and non-material facts can be a somewhat uncertain one". In my view, this case is fundamentally different from a commercial transaction. There must be a very onerous duty of candour on a plaintiff making an *ex parte* application to court for authority to conduct an invasive medical procedure which, without such authority, could only be conducted with the consent of the patient.

249. Counsel for Ms. K analysed the attendance note of the proceedings on 21st September, 2006 and listed matters of which Abbott J. was not, but should have been, apprised. It is true that the court was not given a detailed account of what happened between 10.00 a.m. and 12.30 p.m. and, in particular, that the number of times Ms. K's permission to transfuse had been sought and refused was not outlined. However, it is not true to say that the court was not told that the Hospital thought that Ms. K lacked capacity to make the decision. While different terminology was used, references to "the quality of the refusal", and "informed decision", as I have already held, the issue of Ms. K's capacity was introduced. It is also true that the court was not explicitly told that neither Ms. K nor the Attorney General had been notified of the intention to apply for a court order. Whether Ms. K had been told or not, she was not present at the hearing, or legally represented, facts of which Abbott J. was acutely aware. It is not true that the court was not told that there was a programme of non-blood management in place and being followed. While the court was not given details of the non-blood treatment, for example, it was not explained that NovoSeven had been administered at 12.16 p.m., the court was told that the Hospital had managed to stabilise Ms. K using a number of artificial products, including products which were deemed suitable for Jehovah's Witnesses.

250. Some of the matters adverted to by counsel for Ms. K would appear to be designed more as an attack on the credibility of the Master and other Hospital personnel than as being illustrative of material non-disclosure. It is true that, notwithstanding the Master's evidence, as reflected in his 12.30 p.m. retrospective note, that Ms. K was "oozy via pack again", the court was not told that Ms. K was bleeding again. However, the court was told that the major concern was a re-bleed. Another fact, that Abbott J. was told that it would be unsafe to administer a sedative so as to facilitate the administration of the transfusion, was also adverted to but I have difficulty in understanding its relevance in this context. As is clear from the form of the order made, Abbott J. left it to the Hospital personnel to take the appropriate steps to facilitate the administration of the blood transfusion. I have already held that the sedation of Ms. K before the blood transfusion was administered was not clinically inappropriate. Therefore, while what was stated about sedation at the hearing of the *ex parte* application, taken at face value, appears to be in conflict with what was done later, it does

not support an argument that there was material non-disclosure.

251. When one takes into account the exceptional circumstances in which the *ex parte* application was made, even applying the more rigorous standard of candour which, in my view, the nature of the order being sought required, I cannot find that there was any failure by the plaintiffs of their duty of full and frank disclosure of the facts. From the commencement of the emergency to the time the Master left the Hospital for the High Court, the Hospital personnel had two and a half hours in which to deal with the emergency and stabilise Ms. K, assess her medical condition and what they referred to as the "quality of her refusal" (meaning her capacity to make an informed decision to refuse life-saving treatment), consider alternative strategies to blood transfusion and put in place such as they thought were appropriate, decide to apply to court and collate the evidence. The Master had no more than ten or fifteen minutes in which to instruct the Hospital's solicitors and counsel. There was about half an hour in which to put the evidence before Abbott J. and inform him of the relevant law. On the basis that a blood transfusion was the appropriate medical treatment for Ms. K up to 2.35 p.m., those time constraints were objectively indicated. Against those time constraints the plaintiffs' presentation of the facts to Abbott J., in my view, was as full and frank as could have been expected. A significant factor influencing that conclusion is that proper emphasis was laid on the fact that Ms. K was *sui juris* and was not *non compos mentis*.

252. I have already quoted the passage from the judgment of Kelly J. in the *Adams* case dealing with the duty to inform the court of the relevant legal principles on an *ex parte* application. I agree with what is stated in it. Counsel for Ms. K submitted that the case law to which Abbott J. was referred was not "on point" and could not have properly informed the court as to the applicable law. It was submitted that among the authorities that should have been put before the court were the decisions of the Supreme Court in *In re a Ward of Court* and in *A.O. & D.L. v. Minister for Justice* [2003] 1 I.R. 1, and the relevance of the provisions of the Convention to the issues.

253. There is no doubt that the fundamental rubric which must be the starting point of the consideration of an issue as to the capacity of an adult to refuse medical treatment is the recognition by the Supreme Court in *In re a Ward of Court* that a competent adult has the right to refuse medical treatment. Although that decision was not expressly referred to, there is no doubt but that, as regards the capacity question, the plaintiffs' application was founded on that principle. The court accepted that Ms. K was a competent adult and, notwithstanding the submissions made on the issue of the quality of her refusal, implicitly accepted that she had capacity to make the decision to refuse a blood transfusion.

254. Therefore, the contention that on 21st September, 2006 the court's attention was not drawn to the case law which was germane to its decision, on a correct analysis of the *ex parte* application and its outcome, goes to what the court was told about the jurisprudence on the balancing of rights question. This is illustrated by some of the submissions made on behalf of Ms. K on the balancing of rights question on the plenary hearing.

255. In advancing their argument on behalf of Ms. K that the rights of Ms. K's baby could not operate to defeat her right to refuse a blood transfusion, counsel for Ms. K submitted that, insofar as the plaintiffs' case to the contrary was founded on the decision of the Supreme Court in the *PKU* test case, that decision has no proper application to the circumstances which prevail here. What that case was concerned with was the refusal of the parents to allow their child to be subjected to the screening test. It was a parental decision concerning the welfare of the child, unlike Ms. K's decision which related to herself but might have a bearing on her baby. Therefore, it was submitted, when Murphy J. spoke of a "parental decision" constituting a "virtual abdication" of parental responsibility (at p. 733), he was referring to a parental decision concerning the welfare of the minor.

256. Moreover, it was submitted that the judgments of the Supreme Court in the *PKU* test case could not be taken as authority for the proposition that, where a parent makes a decision to refuse life-saving treatment for religious reasons, that could be said to constitute "a virtual abdication" of parental responsibility, notwithstanding that the decision may have ramifications for a child who may be deprived of the company of one, perhaps his or her only, parent. It was pointed out that it is not to be inferred from the decision of the Supreme Court in *In re a Ward of Court* that the right of refusal of medical treatment is limited to an individual who does not have a dependent child.

267. To explain the criticism of the failure to refer to the decision of the Supreme Court in *A.O. & D.L. v. Minister for Justice*, it is useful to start with the concise summary of the submission made on behalf of the applicants in that case, which was rejected by the Supreme Court, in the following passage of the judgment of Keane C.J. (at p. 36):

> "In effect, the case made on behalf of the applicants is that, where a married couple arrive in Ireland in circumstances which render them illegal immigrants and the wife gives birth to a child, the entire family are entitled to remain in Ireland at least until such time as the child reaches his or her majority, that this right derives from the Irish citizenship of the newly born child and the constitutional rights of such a child to the society and care of its parents and that arises irrespective of the length of time which elapses between their arrival in the State and the birth of the child. It is claimed that the only qualification to which the exercise of those rights is subject is the liability of the non-national members of the family to be deported from the State where the respondent is of the opinion on reasonable grounds that they are engaged in activities inimical to the common good or likely to be so engaged."

268. That case involved the balancing of the constitutional right of the Irish born applicant child to the company, care and parentage of its parents within the State, which the Supreme Court held was not absolute and unqualified, against the State's inherent right, in the interests of the common good, to control immigration. The latter right obliged the Minister for Justice, Equality and Law Reform, when considering the deportation of a non-national, including the parent of a child who was an Irish citizen, to consider whether there were grave and substantial reasons associated with the common good which required deportation.

269. Counsel for Ms. K submitted that the practical effect of that decision was that it envisaged that the State could forcibly separate a child whose rights were constitutionally protected from his or her parents if the parents were deported or, more correctly, if the parents were deported and did not bring the children with them. It was submitted that it would be at odds with that decision to hold that a parent who chooses to refuse life-saving treatment for religious purposes must be compelled to accept treatment in the interests of his or her child. Counsel for Ms. K posed the question whether, had she wished to leave the State without her baby, the State would have compelled Ms. K to remain within the jurisdiction in order to provide mothering for her baby.

270. If the balancing of rights question was properly an issue in the plenary action, in my view, serious consideration would have to be given to whether the fact that those two decisions of the Supreme Court, which are patently germane to that question, were not opened to Abbott J. should constitute ground for setting aside the *ex parte* order, notwithstanding the exigencies of the situation. However, the balancing of rights question is not properly an issue now and, for the reasons I have outlined earlier, I have concluded that it should not be addressed. Moreover, it should not have been in issue before Abbott J. because it had no foundation in fact, and would not have been but for the fact that Ms. K told lies to the Hospital personnel in relation to the whereabouts of her husband.

Therefore, there is a certain absurdity in the court having to consider the argument advanced on behalf of Ms. K in relation to non-disclosure of the relevant law.

271. In summary, even though the process which led to the *ex parte* order and the form of the order were flawed, in my view, Ms. K has not made out a case to have it set aside. Apart from that, as I have found, notwithstanding that the plaintiffs' application for the *ex parte* order, insofar as it was based on lack of capacity, was implicitly rejected by Abbott J., there was a basis in law and in fact on 21st September, 2008 for concluding that Ms. K lacked capacity to give a valid refusal to accept a blood transfusion, so that an order could properly have been made authorising the Hospital to transfer Ms. K on that ground. The fact that the *ex parte* order was made on a different ground, which should not have arisen, does not render the actions of the Hospital personnel in transfusing Ms. K unlawful.

X. Form of order

272. There are certain matters which arose at the plenary hearing on which it has not been necessary to express any view, namely:

> (a) Ms. K's invocation of her rights under the Convention, which, having regard to the decision on the capacity question, does not arise, and the plaintiffs' counsel's argument that in this context the substantial guarantees afforded by the Convention match almost completely the constitutional protection invoked by Ms. K, and that, in any event, no entitlement to damages could arise against the Hospital under s. 3 of the Act of 2003, on the basis, supported by counsel for the Attorney General, that the Hospital is not an "organ of the State" as defined in the Act of 2003; and
>
> (b) The Attorney General's argument that, if the factual issues were to be determined in favour of Ms. K and the court were to conclude that the Hospital acted unlawfully in administering life-saving treatment to Ms. K, as a matter of public policy damages should not be awarded against the Hospital, because it would be invidious to do so (citing the judgment of Kelly J. in *Byrne v. Ryan* [2007] IEHC 207).

273. The main elements of the conclusions I have reached on the issues which determine the form of the order to be made are as follows:

> 1. I have found that there was objective evidence during the relevant period, that is to say between 10 a.m. and 2.35 p.m. on 21st September, 2006 that during that period Ms. K's capacity was impaired to the extent that she did not have the ability to make a valid refusal to accept the appropriate medical treatment which was proffered to her, a blood transfusion.
>
> 2. Therefore, the administration of a blood transfusion to her at 2.35 p.m. was not an unlawful act and did not constitute a breach of Ms. K's rights under the Constitution or under the Convention.
>
> 3. As Ms. K's refusal of a blood transfusion was not a valid refusal, the question of balancing rights of her new-born baby under the Constitution against her constitutional rights of self-determination and free practise of her religion does not fall to be considered. In any event, that question has no foundation in fact and never had and arose only because Ms. K misrepresented the facts about her family circumstances to the Hospital personnel.
>
> 4. Having regard to the gravity of Ms. K's medical condition on 21st September, 2006 and the risk of a probable irreversible outcome if she should re-bleed, which gave rise to extreme urgency in making a decision as to whether Ms. K be transfused notwithstanding her refusal of a blood transfusion, no basis exists for setting aside the ex parte order either –
>
> (a) on the ground that there was less than full and frank disclosure on the part of the plaintiffs in applying for it, or
>
> (b) on the ground that absence of notice to, and legal representation of Ms. K, constituted a breach of her rights at law, under the Constitution or under the Convention.

274. In the light of the foregoing conclusions the order of the court will not grant any of the reliefs sought by the plaintiffs, because injunctive relief is no longer necessary and declarations in the terms sought would not be appropriate. However, under the claim for further and other relief a declaration will be made that the plaintiffs acted lawfully in sedating and administering a blood transfusion and other blood products to Ms. K subsequent to the making of the *ex parte* order. Ms. K's counterclaim will be dismissed.

XI. Guidance for the future

275. While recognising the importance of the issue which this case raised, it has to be said that it took up an inordinate amount of court time. Clinicians and medical personnel whose time and energy might be more usefully deployed elsewhere had to spend a considerable amount of time in court waiting to give evidence and giving evidence. The case was stressful not only for Ms. K and Ms. F, but also for some of the Hospital personnel who testified. Although the facts of this case are unlikely to be replicated, it would be unfortunate if the lessons to be learned from it did not make it easier for medical and legal personnel to cope better with the type of crisis to which Ms. K's circumstances gave rise in the future.

276. It would be helpful if guidance and assistance of the type suggested in general terms below were put in place:

> 1. If every maternity hospital had documented guidelines for the management of obstetric haemorrhage in women who refuse blood transfusion. I note that there is a template in existence in the Guidelines of the Rotunda Hospital dated 11th May, 2006, which were put in evidence, but I express no view on their adequacy in relation to legal issues.
>
> 2. If the information sought when a woman is booking into a maternity hospital specifically addressed whether the patient would accept a blood transfusion in the case of emergency.
>
> 3. If the Medical Council Guidelines specifically addressed how capacity to give a valid refusal to medical treatment is to be assessed and, given the inevitability that it will arise in the future, the issues which may arise relating to the giving effect to advance directives to refuse medical treatment.
>
> 4. If, pending the implementation of the recommendations of the Law Reform Commission in legislative form, the State were to designate a legal officer to perform functions of the type performed by the Official Solicitor in England and Wales in relation to patients who refuse medical treatment where an issue as to capacity arises.

5. If a practice direction were put in place in the High Court setting out the procedure to be followed in relation to urgent applications in case of medical emergencies for authority to administer blood transfusions and other medical procedures, distinguishing the three situations which may arise:

(a) where an adult patient is incompetent;

(b) where the patient is a minor and the parents are refusing consent, and

(c) where the patient is an adult and competent but a doubt arises as to his or her capacity to refuse treatment.