Neutral Citation Number: [2022] EWCOP 56 Case No. COP1401683T

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Friday, 18 November 2022

Before:

MR JUSTICE COBB

B E T W E E N :

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST — Applicant

- and -

SM — Respondent

ANONYMISATION APPLIED

_____

MR P MANT (instructed by Browne Jacobson LLP) appeared on behalf of the Applicant.

MR M WENBAN-SMITH (instructed by Simpson Millar Solicitors) appeared on behalf of the Respondent.

_____

J U D G M E N T
(Hybrid Hearing)

(Transcript prepared without the aid of documentation)

MR JUSTICE COBB:

1 This is a short *ex tempore* judgment given at the conclusion of a short hearing of an urgent application before the Court of Protection. The application was issued in fact only two days ago, on 16 November 2022. It concerns SM, who is a 16-year-old young woman. SM is a looked-after child within the meaning of section 20 of the Children Act 1989. She is in an extremely advanced stage of pregnancy (over 39 weeks).

2 The application has been issued by the Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust ("the Trust"). The applicant seeks the following relief: (1) a declaration that SM lacks capacity to make decisions regarding her obstetric care and treatment; (2) that the court's authority lawfully to proceed with delivering SM's baby in line with the proposed plan which the treating professionals unanimously agree is in her best interests; (3) authorisation to deprive SM of her liberty in order to achieve the safe delivery of her baby.

3 It is accepted that this is a complex and finely balanced case engaging the exquisitely sensitive issues of medical treatment, but a decision is required, and it is required *urgently*. It is agreed that SM has capacity to conduct these proceedings. The Official Solicitor has, accordingly, declined to act as a litigation friend. The Official Solicitor also declined a request from the Trust's solicitor to consider acting as an advocate to the court. SM has instructed her own lawyers. Indeed, I am most grateful to Ms Varey from Simpson Millar, Solicitors, for accepting instructions at the very last minute and for taking instructions from SM and participating in a hearing in that way; and to Mr Wenban-Smith for appearing for SM at court this morning.

4 For the purposes of determining this application, I have read the statements of: Ms Lindsay Banks, dated 15 November 2022; Dr NP, anaesthetist, dated 16 November 2022; Dr PA, consultant obstetrician, from whom I also heard some limited oral evidence, dated 16 November 2022; Dr ZS, consultant perinatal psychiatrist, dated 17 November 2022; Ms Speakman, social worker, Child in Care team, dated 15 November 2022; and also Dr PK, a consultant liaison psychiatrist. I heard, as I say, brief evidence from Dr PA during the course of the hearing this morning before adjourning briefly to allow him to consult with the medical team. He did so, following which I heard further oral submissions. I wish to pay tribute to the ability of counsel instructed in this case to present their cases both economically and effectively given the pressures of time.

5 I propose, unusually, to announce the outcome of my deliberations at the outset before going into a little more of the background because I am conscious that time is of the essence. In reaching my decision in this case, I bear very much in mind what Hayden J, the Vice-President of the Court of Protection, said in the case of *GSTT v SLAM and R* [2020] EWCOP 4 at [67]:

> "... The inviolability of a woman's body is a facet of her fundamental freedom but so too is her right to take decisions relating to her unborn child based on access, at all stages, to the complete range of options available to her. Loss of capacity in the process of labour may crucially inhibit a woman's entitlement to make choices. At this stage the Court is required to step in to protect her, recognising that this will always require a complex, delicate and sensitive evaluation of a range of her competing rights and interests. The outcome will always depend on the particular circumstances of the individual case."

6 On all that I have read and heard in this particular case, I am satisfied that the longer that the current situation goes on with this pregnancy at its extremely advanced stage, the greater is the risk of stillbirth of the baby, an outcome which would have a seriously deleterious effect on SM herself, particularly given her fragile mental health. I am further satisfied that ongoing distress for SM over the uncertainty of this current situation is not in her interests. I am also concerned about the situation that would arise should SM go into spontaneous labour in circumstances in which the medical support around her would not immediately be available. It is plainly in SM's best interests for a healthy baby to be born as soon as possible as the impact upon her psychological well-being, and the trauma that an unhealthy baby would create, would have a significantly detrimental and longer-term impact on both her and the baby. It is plainly in SM's best interests that she is able to exercise a high degree of autonomy over the manner in which her baby is born. In this particular case, and having heard the evidence that I have heard and read the evidence that I have read, I regard it as not only proportionate but also in SM's short and long-term best interests that the hospital attempts one final administration of vaginal induction of the baby. This should begin straightaway in order to give SM the best chance to deliver the baby vaginally and while she is alert and awake, something which she (and I understand this completely), wishes to achieve in her first experience of childbirth.

7 I am satisfied, however, from all that I have heard that there have been times in the last few days when SM has lost capacity in what has been described as "the heat of the moment", when anxiety and stress has overwhelmed her, and she has not been able to make a capacitous decision in relation to the appropriateness of submitting to Caesarean section. Should that situation arise in the hours ahead and if, in the opinion of the treating clinicians, she loses capacity again, as she has in the recent past and as described in the reports before me, and if the welfare of the mother or child is compromised or is likely to be compromised such that a caesarean section is indicated as an emergency, I confirm that it is in SM's best interests for the baby to be delivered by Caesarean section performed under general anaesthetic; it will accordingly be lawful for the hospital to perform that procedure in those circumstances. I recognise that this is not what the applicant NHS Trust wishes me to order in this particular case, at least in part, because they have assembled (no small feat) a dedicated and expert team this afternoon to perform the Caesarean section. However, with warning and due notice that the process of delivery of the baby is now to begin within the next few minutes or hours in the manner in which I have described, I very much hope that the clinical team that has been assembled can, either in its current form or in a substituted form, be on stand-by over the next few hours and days in the event that a Caesarean section is required.

8 I propose, now, to deal very briefly with the background to the case and a little of my analysis. SM is a looked-after young person. She resides in supported living in Wigan and receives care from a team of carers. She has no consistent relationship with her own parents. She has a history of sexual exploitation and suffers from a complex post-traumatic stress disorder as a result of childhood trauma, anxiety and emotional dysregulation. She has had multiple admissions to hospital as a result of her mental ill-health. She also has recorded instances of visual and auditory hallucinations, recalling a figure called 'Greg' who visits her. She is declining all psychotropic medications through fear she will become "like her brother", who it is said suffers from paranoid schizophrenia.

9 Not insignificantly, in my judgment, SM's antenatal care has been generally good. She has had the benefit of an enhanced midwifery team, who provide care to women with vulnerabilities, with whom SM has engaged well. She has seen the team every two weeks and has engaged well with obstetric care and ultrasound scans. Aside from her mental

ill-health, SM's pregnancy has been uncomplicated. Although SM has been mainly compliant with appointments, she has repeatedly changed her mind regarding her choices for birth planning. SM has, during her pregnancy, shown distress and fear of giving birth. The local authority has been making plans to issue care proceedings in relation to her unborn child and this information has, unsurprisingly, caused SM distress and, at times, she has reportedly punched her stomach in an act of self-abuse.

10 On 7 November, SM was placed on section 5(2) Mental Health Act 1983 provision (compulsory admission for 72 hours) as a result of her stating that she was at risk to herself.

11 On 10 November, at a routine ultrasound scan, a raised or abnormal PI ('Pulsatility Index') was detected on umbilical artery Doppler studies. PI is a surrogate marker for increased placental vascular resistance. It denotes potential utero placental insufficiency and, hence, constitutes a foetal risk. This was plainly a matter of concern to the clinicians and it indicated to them that the delivery of the infant should not be delayed.

12 On Friday 11 November, SM agreed to be induced for vaginal delivery. On the following day, the first drugs were administered and within a very short time SM refused to carry on with the induction, refusing a vaginal examination, allegedly because of discomfort; she was not, apparently, coping with the contractions at the point when her cervix was one centimetre dilated, about 10 per cent of the required dilation for the purposes of delivery. Her anxieties increased.

13 On 12 November, SM agreed that her baby could be born by elective Caesarean section and this was planned for the following day. On that day, two attempts were made, involving several anaesthetists, including a consultant anaesthetist on the second occasion, to perform the procedure. This delivery would have been by local anaesthetic. On both occasions, SM refused to have an anaesthetic at the last minute because of her heightened anxiety over the regional anaesthetic and attempts at anaesthetisation were abandoned.

14 On Monday 14 November, SM agreed to proceed with elective Caesarean under general anaesthetic. On this day, she was calm and assessed to have capacity to make that decision. However, having had the cannula fitted, her dysregulated behaviour escalated rapidly due to anxiety and she became incredibly distressed, throwing objects around her room. She was allowed home for the night.

15 On Tuesday 15 November, SM returned to the hospital and seemed positive about the prospect of a Caesarean section. However, once again, as soon as she sat on the theatre bed, she started crying out loud and became very agitated, screaming and refusing further intervention. She then ran out of the delivery suite and off the hospital grounds with her cannula intact. Greater Manchester Police brought SM back using their powers under section 136 of the Mental Health Act 1983. She was deemed not to be detainable under section 2 of the Mental Health Act 1983, but was assessed then as lacking capacity to make decisions about obstetric treatment at that time due to her intense, and now increasing, anxiety.

16 Thus, it appears that Caesarean section has been attempted by now three times. On all three occasions, SM has been unable to go through with the operation at the last minute because of intense anxiety around the anaesthesia and operation. There is no real dispute now (and this, if I may say so, is important), that, at the point at which the Caesarean section has become an immediate reality, her mental capacity has been so affected that she has been unable to retain or weigh up the relevant information in relation to this form of obstetric intervention. Her agitation and distress, indeed, has been shown over time to have become

progressively worse. The clinical team are, in the circumstances, understandably concerned that the events of the last week have heightened anxiety for SM, leading her to suffer a lack of capacity at the relevant time.

17 The clinical team who have filed evidence have helpfully set out and discussed essentially the three options available: (1) vaginal birth; (2) Caesarean section under local anaesthetic; and (3) Caesarean section under general anaesthetic. It remains the view of the clinical team that Caesarean section under general anaesthetic is the only realistic option for SM.

18 When Dr PA was questioned, he clarified the following points. In relation to the raised or positive PI, he told me that this finding is always a matter of concern. It should never be ignored, even though there are sometimes false positives. Mr Wenban-Smith asked him about a test subsequent to the test in which the raised PI was identified which has been normal; Dr PA told me, in response to that question, that such subsequent tests are intermittently normal and abnormal, but the abnormal PI should never be ignored. Generally, he said, the test is not repeated once a woman is 37 weeks or more pregnant. The fact that the subsequent test on 13 November was negative is, in Dr PA's opinion, of no consolation or reassurance. Once it is positive, he told me, "We generally don't repeat the test. We can't guarantee the health of the baby."

19 It was pointed out to him that other examinations have not indicated any compromise or adverse indicators to the infant. The baby has, apparently, continued to grow *in utero* and there have been no clinical indicators of distress. However, said Dr PA, there may be no such indicators and the outcome may still be bad. He felt that other negative examinations and/or test results were really "neither here nor there". He said that once a raised (abnormal) PI has been revealed, the general advice women receive is to bring their pregnancies to an end, and, on Dr PA's evidence, women invariably accept that advice. Indeed, he told me he has no experience of a woman who has not accepted that advice.

20 Secondly, he was asked about delay. He said that when there is a raised PI, there is no consistent or predictable pattern of deterioration of the foetus. Regular monitoring may not capture a sudden deterioration. The risk of delivering a compromised infant is high and remains high. The longer this goes on, he told me, the greater the risk to the mother's mental health and to the child.

21 Thirdly, what of the practical difficulties? He told me that an emergency Caesarean section now requires one of the senior anaesthetists to be on board, and he could not assure the level of seniority of an anaesthetist in the event of an emergency Caesarean section in the hours or days ahead. He also referred to the fact that some level of restraint may be needed and it may be difficult to maintain the appropriate level of staffing to achieve this.

22 Fourthly, what about spontaneous labour? He told me that it is difficult to know exactly what would happen. He did not think that SM would cope with this, and she would end up asking for a Caesarean section. He told me that it was "unwise" (his word) for the mother at this point to attempt a vaginal delivery following induction, but invited me to allow him to discuss that briefly with his team. I adjourned the hearing briefly and he did so. Having done so, I was advised by counsel that the view that the team had earlier formed remained in place, namely that vaginal induction should not be attempted at this point but that the Caesarean section should be attempted forthwith, this afternoon, in particular because the team had been assembled for that purpose today, and there was no assurance that the expertise or the strength or depth of the team could be maintained on stand-by over the next hours or days. He felt, as indeed did the team, that the chances of SM cooperating with induction for the full duration of the process were so low that it should not be embarked

upon at this stage. He was, as the team are, fearful that induction would cause additional distress to SM.

23 For completeness's sake, I should add that I read a useful report from Dr NP, consultant anaesthetist, who specifically addressed in her report why a spinal anaesthetic would not be appropriate and she, in her report, identified a number of reasons why spinal anaesthesia would not be indicated in this particular case. In short, of course, intravenous administration of spinal anaesthetic was attempted on 15 November and failed as a result of SM withdrawing her cooperation. She felt that if the Caesarean section was to be conducted under spinal anaesthetic, this would require SM to remain calm and cooperative for the length of the procedure, which she did not think would be possible for her. If she were to become too distressed, she would indeed, in turn, have to have a general anaesthetic part-way through the procedure, which was inherently less safe. As it happens, the suggestion of spinal anaesthesia has not really been advanced as a meaningful option in this case.

24 So far as SM's position is concerned, it has been ably summarised by Mr Wenban-Smith and, indeed, I have had advantage of seeing a note taken by Ms Varey from SM directly from instructions taken at the hospital. Most significant perhaps of SM's submissions is her strong wish to be able to deliver her baby with the least intervention and to be aware and awake when her baby arrives. She is able, as I have earlier indicated, to point to a high level of antenatal cooperation with health services and she invites the court to respect her autonomy and her ability today to make a capacitous decision in relation to this way forward.

25 At the outset of the hearing this morning, her primary position was that she should be allowed to proceed to full term, to go into labour spontaneously and have a vaginal delivery. She promised to attend hospital each day for examination, if required. Her secondary position was that she would agree to be induced as a prelude to vaginal delivery. This having been attempted last weekend and failed, there was, of course, scope for Mr Mant (for the applicant) to observe that this showed no real promise once again. But SM says that when the induction was attempted in the past, although it was "really uncomfortable" and she had, she accepted, asked the doctor to remove the pessary, she said that she would now be willing to try it again now that she knows fully what the implications are. She accepted that she had failed to comply with the administration of the spinal anaesthetic in the past. She said that she had been told that she would not feel the needle, but she did feel it. She had flinched and was fearful that if this had been administered wrongly it could have led to paralysis. She said she felt "bullied".

26 Her secondary position by the conclusion of hearing was that she would accept that induction could or should be attempted one more time, now, and that if her health or the health of her infant were compromised or were likely to be compromised and a Caesarean section was indicated, she would be assessed and, if the stress and anxiety was once again found to have deprived her of her capacity, she accepts that, in those circumstances, it would indeed be lawful for the applicant Trust to perform the Caesarean section under general anaesthetic.

Capacity

27 The evidence of the applicant is that SM's anxiety, as a disturbance of the mind, together with her emotional dysregulation, disables SM from being able to use or weigh information to make relevant decisions "in the heat of the moment". In that regard, I have seen the report, as I have earlier indicated, of Dr PK, a consultant liaison psychiatrist at the Royal Albert Edward Infirmary in Wigan where SM is currently a patient. Applying the relevant

criteria from the Mental Capacity Act 2005, he is of the view that: SM is fully able to understand the processes involved in a Caesarean section; she is aware that the procedure would be undertaken in theatre; she will need anaesthesia; and she was aware that an incision would be made to her stomach through which the baby will be delivered. She has, in short, an understanding.

28 Secondly, can she retain information? Dr PK is of the view that SM is able to retain all of the relevant information. She is able to retain information regarding the treatment proposed, which includes induction and Caesarean section.

29 Thirdly, in relation to her ability to use and weigh, when overwhelmed by anxiety and stress, it is Dr PK's view that SM is not able fully then to weigh the pros and cons regarding the treatments, including Caesarean section, due to her intense fear and anxiety. Although when calm she is able to recall the risks and benefits of proposed treatment, at that point she is not able to comply due to her health anxieties about different procedures involved in the treatment, such as anaesthetic, procedures, needles and medication. Even from her own account, she gets extremely anxious and catastrophises things which prevent her from undergoing the proposed treatments. She is, fourthly, able to communicate her views.

30 The concern of the hospital Trust is a real and understandable one for, when SM is lucid, she is able to articulate an optimal form of treatment for herself, for the manner of the delivery of her baby and even can accept the appropriateness of the Caesarean section. However, when the time comes, her heightened anxiety causes her to be unable to use or weigh the information in order to be able to make that decision. At that time, the hospital Trust takes the view, and, if I may say, so I agree, that her capacity becomes compromised and she is unable to use or weigh the relevant information regarding the consequences.

31 I have had regard to the report of the consultant perinatal psychiatrist Dr ZS and addendum which were dated 17 November. They are extremely valuable documents. Dr ZS concludes that SM has what she described as "fluctuating capacity", a phrase which she uses to describe what I myself have described as a capacity which while when SM is capable of being lucid is present, but which she loses in what has been described in this hearing as "the heat of the moment", when stress and anxiety overwhelms her. In Dr ZS's addendum, she expresses the view that it would be inevitable that SM would lose her capacity to decide about the means of delivery of her baby as soon as the obstetric interventions are attempted (i.e., either vaginal induction of labour or a Caesarean section), as her emotional dysregulation means she will become acutely distressed, probably aggressive, and will not be able to weigh up the information regarding delivery of her baby due to this impairment of functioning of her mind or brain.

32 At this point, I am unable to be so satisfied of the inevitability of that loss of capacity, although it is very clear on the evidence that I have heard and read that that is a very real possibility.

33 I agree with Mr Mant that the facts of this case are in many ways analogous to those of *Re MB* [1997] EWCA Civ 3093, where a patient consented to Caesarean section but could not bring herself to go through with it because of an extreme needle phobia. The Court of Appeal said then (this is, of course, a pre-2005 Act case) that temporary factors may completely erode capacity. In that case, as in this, careful scrutiny of the evidence is necessary because fear of an operation can be a reasonable reason for refusing to undergo it. However, fear induced by panic may paralyse the will and thus destroy the capacity to make a decision. That is, in my judgment, this case. If my approach were said to be wrong in relation to that, either because it would not be right to rely on *Re MB* (above) in those

circumstances, or because SM does not currently lack Mental Capacity Act capacity to make decisions about her obstetric care, as I have so found, I would have felt able to exercise the court's powers on the basis of my *parens patriae* jurisdiction on the grounds that:

i) SM is, as I said at the outset of this case, still a child and a vulnerable child at that, and
ii) At the critical moment her ability to make the relevant decisions may be impaired.

34 In conclusion, therefore, I have reached the view that no time can now be lost in embarking upon the process which will lead to the delivery of SM's baby. I think she now understands that. Balancing the competing considerations as firmly and fully as I can in these circumstances, I attach, at this stage, greater weight to SM's wishes and to her sense of autonomy than the Trust currently does, and feel that, given the circumstances, particularly, in which the earlier induction was said to have failed, it is appropriate for that process to be attempted one more time in the hope (if not the expectation) that that can lead to a successful vaginal delivery of SM's baby while she is, as she so earnestly and understandably wishes, alert and awake.

35 SM understands, and I am reassured by this, that there may well come a time, and that time might come quite soon, where her anxiety and her stress so overwhelms her that she loses capacity to make decisions for herself in relation to the appropriate form of obstetric intervention. If that moment arises, and if the clinicians, in the exercise of their clinical judgment, consider that a Caesarean section under general anaesthetic is indeed in SM's best interests, then I am constrained to rule that such an outcome is not only lawful but inevitably also in her best interests in order to achieve the safe delivery of the baby to preserve both the well-being of the baby, but, the subject of my deliberations today, the safeguarding and well-being of SM herself.

36 I hope that the decision and the reasons for it are sufficiently clear that counsel is now going to be in a position to implement that decision and draw up an order which reflects it. But I am conscious, given the pressure under which this hearing has taken place and the judgment has been delivered, that there may be gaps which yet need to be filled.

_____

Post-Script

37. It is appropriate for me to make two further comments by way of post-script:

i) SM was vaginally induced following the hearing, in accordance with the arrangements which I had approved (see in particular §34 above). She progressed safely to deliver a baby girl on the following day; she was entirely compliant and able to breast feed under supervision. It was not in the end necessary for SM to undergo a Caesarean section as the Applicant had proposed.

ii) It is regrettable that, following the hearing, the Press Association published a piece about this case under the headline "Teenager gives birth after Judge approves C-section against her wishes", which may well be thought to have been a partial and potentially misleading account of this decision, and of the actual outcome for SM.

CERTIFICATE

Opus 2 International Limited hereby certifies that the above is an accurate and complete record of the Judgment or part thereof.

Transcribed by ***Opus 2 International Limited***
Official Court Reporters and Audio Transcribers
5 New Street Square, London, EC4A 3BF
Tel: 020 7831 5627 Fax: 020 7831 7737
civil@opus2.digital

(This transcript is subject to Judge's approval)