Neutral Citation Number: [2014] EWHC 132 (Fam)

IN THE HIGH COURT
FAMILY DIVISION

IN THE MATTER OF THE INHERENT JURISDICTION
AND IN THE MATTER OF AA

Royal Courts of Justice
Strand
London, WC2A 2LL

Date: Tuesday, 28 January 2014

B E F O R E:

MR JUSTICE HAYDEN

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GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST **Applicant**

and

(1) AA **Respondents**
(A Protected Party, by her litigation friend, the Official Solicitor)
(2) BB
(3) CC
(4) DD

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Mr Michael Horne (instructed by Bevan Brittan Solicitors) appeared on behalf of the Applicant
Mr Alastair Pitblado (The Official solicitor) appeared on behalf of the 1st Respondent

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J U D G M E N T

The judge gives leave for this judgment to be reported in this anonymised form. Pseudonyms have been used for all of the relevant names of people. The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them may be identified by his or her true name or actual location and that in particular the anonymity of the child and the adult members of their family must be strictly preserved.

1. MR JUSTICE HAYDEN: I am concerned here with an application by the Great Western Hospitals NHS Foundation Trust to invoke the inherent jurisdiction of the High Court for declaratory relief in relation to serious medical treatment for AA.

2. AA is 25 years of age and she is pregnant with her first child. During the course of her pregnancy, she has been able to comply with the antenatal care offered to her. She asserts, and I accept, that she welcomed that pregnancy and her compliance with antenatal care seems to me to be evidence of it. The pregnancy is also welcomed by her partner, BB, and the couple plainly have the support of AA's parents, CC and DD.

3. AA is now at 38 weeks gestation. Sadly she has a history of affective bipolar disorder. She is prescribed a battery of antipsychotic medication for that condition, including lithium and Depakote for mood disorder and olanzapine and quetiapine and ablify for psychosis.

4. AA also has a history of substance and alcohol abuse, that likely represents her efforts to self-medicate, particularly in the early days of her illness. She has, historically, been admitted to an establishment in Swindon following a mental health assessment in 2011. It is clear that AA, like so many who suffer from this sad and debilitating condition, has only limited insight into it and to its consequences, and so she has from time to time intermittently discontinued her medication when the medication makes her feel well. She has further to progress in the understanding of her condition and of the importance of a strict medication regimen. That will be particularly important when she is a mother.

5. AA is now symptomatic, suffering from hypomania and puerperal psychosis. During the course of the application today, I heard from a number of witnesses, about whom I will say more shortly, but I note that AA's father, who has been with her throughout on this long journey of mental ill-health, has described her present condition as the worst he has seen. He has described her to me as very agitated, "violent" was a word he used, and "exhausted by lack of sleep."

6. On the evening of 26 January, AA presented to the Great Western Hospital in a confused and disoriented state, having, it was suspected, suffered a seizure prior to admission. At the initial assessment at around 8.30 pm, it was noted that her membranes had ruptured. Quite when they had ruptured it was difficult to tell, but it seemed likely that that was not very long before her presentation at the hospital. She was admitted to the labour suite and there she remains, although she has not as yet gone into labour. At 7 am the following morning, on 27 January 2014, she was detained under section 5(2) of the Mental Health Act 1983. She remains highly agitated and is largely uncooperative with almost every aspect of her obstetric care. Her father in his evidence confirmed that position.

7. Because AA is pregnant, it has not been possible to administer the full range or indeed the requisite dose of medication, including the antipsychotic medication, that her present florid condition would otherwise require. The dilemma for the treating clinicians, and the reason why this application comes before me today, is that rupture of the membranes gives rise to a significantly increased risk of both maternal and foetal infection until delivery. In such circumstances, the management plan would ordinarily and almost automatically move to induction of labour by the administration intravenously of Syntocinon. Such administration requires continuous CTG monitoring, both of the mother and of the foetus. The treating team is entirely clear that AA would be unable to co-operate with this type of management. Indeed, AA's father told me that she has already removed intravenous lines on more than one occasion.

8. I heard today from Dr Kevin Jones, a consultant gynecologist and obstetrician. He took over AA's care first thing this morning, although he has not hitherto had any dealings with her. Yesterday evening at about 9.30 pm, the Trust made an emergency application to the out-of-hours judge, who last night was Moor J. At that stage, Mr David Griffiths was the consultant obstetrician and gynecologist on duty, Moor J heard oral evidence from Mr Griffiths over the telephone. As AA had not yet entered into labour, the judge did not think it was appropriate to grant the declaratory relief that the Trust sought on a telephone application. The position could be held over, he considered, until this morning when the matter was to be listed before me. However, had AA gone into labour or begun to show signs of infection, Moor J then gave the Trust the declaratory authority it sought.

9. AA did not go into labour, but she had a bad night and has, if anything, become more distressed. Her father, who was obviously and understandably upset himself, told me that there had been an incident in the night where AA had run at the window and tried to get out. She was telling her father that she wanted to go to heaven.

10. There are broadly speaking two, at least theoretical options, in respect of AA's ongoing care. Firstly, the hospital could attempt to induce labour medically via the administration of intravenous Syntocinon. That would result in a natural labour. However, the research, as Mr Jones told me in evidence, confirming the observation of Dr Anita Sinha, the consultant gynecologist and obstetrician who prepared a statement in this application and who is part of the gynecological team, establishes that between one third and a quarter of patients who require medical inducement (particularly, Dr Jones said, in the case of a first child) require an emergency cesarean. That, he considered, would be particularly dangerous in this case. It could lead to infection and sepsis, the consequence of which for the foetus could be brain damage or death and with an increased risk of shock or haemorrhage to the mother. Given it requires the administration of intravenous medication, in the mother's present condition, it is plainly an unsuitable course.

11. Mr Jones, and in reality the whole of the clinical team, considers that it would be in AA's best interest to have what is termed an "elective cesarean" under general anaesthetic, chiefly because she has, as I have said, demonstrated non-compliance with the intravenous regimes during her admission so far. AA has to date permitted only one episode of electronic foetal monitoring during her admission, and she is simply unable to appreciate that such monitoring is part and parcel of a safe delivery for her baby. Indeed, she appears unable to comprehend any aspect of her treatment.

12. The clinical team has been concerned that, even if she were to comply with intravenous medication to begin with, that compliance would of itself not be sufficiently long standing to administer the medication safely. Rather, it is thought that her distress and agitation would increase were she to be subjected to the kind of prolonged treatment plan which is a very real prospect of induced labour. Also, whilst still fully conscious, she is at the moment unlikely to remain still or calm enough to comply.

13. The proposed treatment plan provides that AA will be delivered by a team of clinicians which would include the anaesthetist and obstetrician undertaking cesarean section, under general anaesthetic. She will receive ongoing treatment to include continuous observation by midwifery and mental health nurses and will also be reviewed regularly by a psychiatric team. It may be necessary to restrain her prior to the general anaesthetic, and indeed after delivery, if she becomes agitated. I am told in Dr Sinha's statement that she will remain, throughout her recovery from the caesarean section, in the delivery suite or the maternity unit prior to onward transfer to the mother and baby unit. She will require regular blood tests, ECG and monitoring of maternal observations, temperature checks and monitoring of any vaginal bleeding.

14. It is understood that cesarean section is a major surgical procedure, but there is unanimity amongst the treating clinicians that it is, by some distance, the safest option for AA. The longer that she remains untreated, the greater the risk of her developing sepsis, a further complication requiring an emergency cesarean or ultimately an obstructed labour, which has the risk of uterine infection associated with severe haemorrhage which could be life-threatening.

15. I have addressed here the disadvantages to the mother in this process conducting a balance of the positives and negatives in the competing alternatives. I do so because I am not in this application concerned with the welfare of the foetus. It must be said however that the alternative to the elective cesarean plainly carries significant risks to the foetus or to the baby and the real clinical prospect of foetal distress.

16. When I consider the best interests of AA here, I do so by evaluating the clinical alternatives keeping her medical interests in focus. But a best interests decision requires a broader survey of the available material. I am perfectly satisfied that this is a wanted baby in a supportive family unit. I have listened carefully to what the family has said, particularly what AA's partner, BB, has said. He was not always consistent or indeed logical. If I may say so, at such a stage in his life in these difficult circumstances I would hardly expect him to be so. He communicates to me that AA is extremely anxious, extremely distressed, but he also says she is tired and he believes in some way she now wants to get on with the delivery. I believe that he was telling me that if AA were not florid, if she were not suffering this profound psychotic episode, and if she were in a position to reason her situation objectively, she would follow the recommendation of the doctors.

17. Her father told me that the doctors and the nurses have been "fantastic" and he supported them "100 per cent". I believe, through the filter of his evidence and that of BB, that were AA herself rational at the moment she would adopt this course. That is the wider context to this case which I weigh alongside the compelling medical evidence. Best interests declarations are never grounded exclusively in medical issues: the wider context is frequently just as illuminating. I draw upon the observations of Hedley J in NHS Trust v X (A Child) [2012] 1 FLR 225; and Wall LJ, as he then was, in Wyatt v Portsmouth NHS Trust [2006] 1 FLR 554.

18. It seems to me self-evident from what I have said and described that AA lacks the capacity to take this medical decision for herself. When the application was made last night before Moor J, it had not been possible to secure AA the services of the Official Solicitor, but today at this hearing he appeared on her behalf in person. He had had the opportunity to consider, as have I, the report of Dr Nicholas Best, a consultant psychiatrist, whose opinion, I was told by Dr Jones, had been reviewed and confirmed by a further consultant psychiatrist only this morning.

19. On 27 January, Dr Best assessed AA's capacity to make decisions regarding the safe delivery of her baby. That assessment took place in two parts as AA needed a break in the process. As part of Dr Best's assessment, he had discussions with AA, her partner, her parents, her treating team on the labour suite, which included consultant obstetrician and gynecologists and midwives and anaesthetists. He reminds me that bipolar disorder is to be regarded as an impairment of disturbance in the functioning of the mind or brain, and therefore satisfies the diagnostic test under the Mental Capacity Act. In AA's case, that disturbance or impairment means that she is unable to make decisions regarding the safe delivery of her baby. He states in his report that AA simply does not believe that she has in fact begun the labour process. She is under the delusion that she can only give birth on or after her due date, which is on or around 9 February 2014. This was amplified by Dr Jones, who told me that she believes that the baby can only be born on her own birthday which falls around that time. Dr Best describes that belief as strong and fixated. Subsequently, AA cannot comprehend the concerns that are being expressed to her by the variety of health care professionals or by her family. Much of this is due to the high and intense level of agitation.

20. The father communicated that level of agitation to me by the almost palpably distressed tones of his own evidence. It brings to life what is said in Dr Best's report: such was the level of agitation that it was almost impossible to engage AA or indeed to gain her attention at all to discuss concerns with her. It certainly prevents her from absorbing or retaining or processing any of the information provided to her and consequently makes it impossible for her to make decisions about the safe delivery of her baby.

21. It is necessary to add a few further remarks about the appropriate legal framework for this application, the Trust recognising that the treatment envisaged involves a facilitative deprivation of liberty.

    The power under the Mental Capacity Act 2005 for the Court to make orders for AA's welfare [the declarations sought under s.16(20(a) and 17(1)(d)] include the power to make an order that deprives her of her liberty, subject to the qualifications set out in s.16A, entitled 'Section 16 powers: Mental Heath Act patients etc'. In short, a welfare order cannot authorise a deprivation of liberty if AA is ineligible to be deprived of her liberty under paragraph 17 of Schedule A1 of the MCA. That provision stipulates that Schedule 1A of the MCA applies for the purpose of determining whether or not she is ineligible.

    The treating team view the obstetric care not as treatment for AA's mental illness, which could be provided under the MHA, but as physical treatment. Paragraph 2 is the central provision in determining whether 'P' is ineligible. Because she is detained under s.2 of the MHA, AA falls within Case A of paragraph 2 as she is both subject to and detained under a hospital treatment regime.

In **A NHS Trust v Dr A [2013]** EWCH2442 (COP), Baker J endorsed the view that "Case A is clear indication of the primacy of the MHA 1983 when a person is detained in hospital under the hospital treatment regime and it would seem that when it applies P cannot be deprived of liberty under the MCA in a hospital for **any purpose**." (§87) and held that force feeding (which was not treatment for P's mental disorder) could not be ordered under the MHA or MCA. The inherent jurisdiction provided the route by which treatment in the patients best interest should be authorised. The Applicant Nhs Trust contends that the same analysis applies here. The Official Solicitor agrees and so do I.

22. In all the circumstances, therefore, it is perfectly clear that AA, at the moment, lacks capacity to take these crucial decisions, and that the case made by the Trust for elective cesarean is, as the Official Solicitor observed, compelling. For the avoidance of doubt, the Official Solicitor has supported every aspect of the Trust's case.

23. Although BB and DD were both highly supportive of the actions of the clinicians, BB told me that he was concerned by even the short delay in this case in bringing the matter to court. These issues he considered ought to be resolved in the clinical situation at the hospital. How, he asked politely and genuinely, could a judge be better placed than a doctor to take these decisions? I hope that in analysing my reasoning in the way that I have, I have already to some extent answered that question. But I would add this: the decision to restrain and compel medical procedures on those who do not have the capacity to take them themselves is an onerous one. The declaratory relief is sought for two purposes: firstly, the legal purpose, which is to cloak the Trust with the legal authority to carry out the procedure and to provide them with a defence to any allegation of criminal or tortious liability for trespass to the person (see Re W (a minor) (Medical treatment: Court's jurisdiction) [1993] Fam 64); secondly, the clinical purpose, which stems from the fact that in many instances the co-operation of a patient, or at least a patient's confidence in the efficacy of a treatment, is a major factor contributing to the treatment's success. Failure to obtain the consent of a patient not only deprives the patient but the medical staff of this advantage. The court has the jurisdiction over the legal purpose; it does not have jurisdiction over the clinical one, and its approval helps to ameliorate that disadvantage.

24. During the course of submissions by Mr Horne, Counsel who is acting on behalf of the Trust, I have considered with him the extent of the restraint that I would be prepared to permit, should it be necessary, in delivering the general anaesthetic and to ensure the safety of mother and baby throughout delivery. Those discussions are concluded in the terms set out in paragraph 2 of the declaratory order, and, in its anonymised format, I propose to annex the declaratory part of the order to this judgment.

Appendix

IT IS DECLARED THAT:

1. AA lacks capacity to:

(a) Make decisions in relation to the serious medical treatment at issue in this application. In particular she lacks capacity to decide whether to undergo a caesarean section and to make decisions generally about her care and treatment in connection with her ongoing pregnancy.

(b) Litigate these proceedings.

2. Notwithstanding AA's lack of capacity to consent thereto it is lawful being in her best interests for AA to continue as an in-patient at the Applicant Trust's Hospital and for the medical and midwifery practitioners attending AA to carry out such treatment as may in their opinion be necessary for the management of AA's present pregnancy and delivery, including if in their professional opinion it is necessary in her best interests:

(a) a formal examination and diagnostic assessment;

(b) monitoring both the condition of AA and the foetus;

(c) the taking of blood samples for testing;

(d) the insertion of needles for the purpose of intravenous infusions;

(e) the administration of anaesthesia including general anaesthesia;

(f) delivery by caesarean section;

(g) pre-, peri-, and post-operative medical care associated with such treatment.

3. It is lawful being in AA's best interests for staff employed by the Applicant NHS Trust and / or those staff from the NHS Trust responsible for AA's clinical care to use reasonable and proportionate measures, including those which constitute a deprivation of AA's liberty

(a) to achieve the interventions referred to in paragraph 2(a) to (g) above; and/or

(b) ensure that she does not leave the ward at the Applicant's hospital during the course of such interventions and/or post-operatively until it is clinically appropriate for AA to be discharged from the hospital after those interventions.

PROVIDED THAT:

(i) anaesthesia and sedation may be used as far as necessary as prescribed by a consultant anaesthetist in consultation with a consultant obstetrician and is to be administered by a registered medical practitioner or registered nurse as appropriate;

(ii) such physical restraint or force that may be used to administer such treatment/anaesthesia/sedation and/or to prevent AA from leaving the ward at the Applicant's hospital shall be the minimum necessary reasonable force; and

(iii) all reasonable steps are taken to minimise distress to AA and to maintain her greatest dignity.

AND IT IS FURTHER ORDERED AND DIRECTED THAT:

4. Any restraint used shall be the minimum deemed necessary by those applying that restraint (having consulted with the treating clinical team) in order to facilitate the assessment and treatment of AA and shall be used in a manner to ensure she suffers the least distress and retains the greatest dignity possible in the circumstances.

5. This hearing is in public.

6. Any subsequent hearings in this matter shall be in public.

7. As the matter involves issues of serious medical treatment and deprivation or possible deprivation of liberty, an anonymised version of the judgment in this application shall be published.

8. There be no order for costs, save that the Applicant shall pay half the costs of the Official Solicitor of this application, to be subject to detailed assessment if not agreed.

9. This order shall have effect notwithstanding that it does not bear the seal of the court.

10. There shall be liberty to apply in relation to the terms or implementation of this Order.