IN THE COURT OF PROTECTION
N/C NO: [2021] EWCOP 33

No. COP 13748761

Royal Courts of Justice
Strand
London, WC2A 2LL

Thursday, 13 May 2021

Before:

MR JUSTICE HOLMAN

(sitting throughout in public)

B E T W E E N :

(2) A NHS FOUNDATION TRUST
(1) A NHS FOUNDATION TRUST — Applicants

- and -

AN EXPECTANT MOTHER — Respondent

(Expectant mother suffering from agoraphobia)

REPORTING RESTRICTIONS APPLY

MISS K. GOLLOP QC appeared on behalf of the applicants.

MS S. ROPER appeared on behalf of the Official Solicitor acting as litigation friend for the respondent.

J U D G M E N T

(a s a p p r o v e d b y t h e j u d g e)

MR JUSTICE HOLMAN

1 This case concerns a pregnant mother who suffers from severe agoraphobia, such that she may not be able to bring herself to travel to hospital for the birth of her baby even if that became medically imperative. In this judgment, I will refer to her as "the mother"; to her partner, who is the father of the baby, as "the partner"; and to her own mother as, for convenience, "the grandmother".

2 I have heard the whole case at the Royal Courts of Justice in London in an ordinary court room open to the public, and indeed, a journalist has attended from time to time during the hearing, and is currently present as I deliver this judgment.

3 The mother and her family live far away from London, as, of course, do the treating medical team. In the case of the mother, there is the additional feature that, because of her agoraphobia, she would have found it impossible to travel to London, or, indeed, to any court room, to attend the hearing. For those reasons, the family have participated by video link, and the four medical witnesses gave their evidence by video link. That does not detract, however, from this hearing being an ordinary hearing in open court, open to the public who could, indeed, have watched all the evidence on the large video screen in the court room if they wished to do so.

4 The mother is represented by the Official Solicitor, to whom I am very grateful for the very thorough way in which she and her staff have investigated this case in a short space of time.

5 By the conclusion of the hearing and all the evidence, there is a large measure of agreement, such that I can summarise the facts and the issues very briefly.

6 The mother is now aged 21. The best estimate of her gestational EDD is around the first week of June, today being 13 May 2021. The mother had certain behavioural problems as a child and young person which it is not necessary to elaborate. From the age of about 17, she has clearly suffered from severe agoraphobia. During the last several years, she has only left her home at all on a very small handful of occasions. When she does do so, she experiences overwhelming sensations of anxiety, shortness of breath, dizziness and palpitations. As a result, she does not work, travel, or socialise or shop (except online), or engage in any leisure activities outside her small flat.

7 The medical evidence, including that of Dr Tyrone Glover, the consultant psychiatrist instructed by the Official Solicitor as an expert witness, is clear that the mother does suffer a severe form of agoraphobia, which is a classified mental illness, and an impairment of, or disturbance in, the functioning of her mind or brain within the meaning of section 2(1) of the Mental Capacity Act 2005.

8 The mother's agoraphobia is so overwhelming that it exerts a significant effect on her ability to weigh matters in the balance if the activity in point entails her leaving her home. Further, in the opinion of Dr Glover, the mother has short-term memory problems which limit her capacity to manage and process complex, multifaceted information.

9 For these reasons, Dr Glover and the consultant perinatal psychiatrist for the applicant trusts both agree, as do I, that the mother lacks capacity to make decisions about whether her baby should be born at home or in hospital. Put simply, she is so overwhelmed by her agoraphobia that she is unable to weigh and process relevant considerations and unable to make any sort of decision about it. I am, accordingly, quite satisfied - and the Official Solicitor on her behalf now agrees - that the mother lacks capacity to make decisions about the location of the delivery of her baby, and also lacks litigation capacity in relation to that issue, and I will so declare.

10 The agoraphobia is longstanding and deep seated and there is no prospect of the mother's capacity improving in the relevant time scale of the next two to three weeks. The Court of Protection is, accordingly, both entitled and required to make the necessary decisions for her, applying a test of her best interests. As the mother dearly wishes to give birth to a healthy baby, undamaged by the process of birth, the safety and wellbeing of the expected baby, as well as her own safety and wellbeing, are relevant to the consideration of the mother's own best interests.

11 At the outset of that consideration of her best interests, I wish to make crystal clear that this case is **not** about the advantages or disadvantages of hospital birth or home birth, or vice-versa, upon which capacitous women may have different views and about which a capacitous expectant mother normally has autonomous and complete freedom of choice. But in this country that choice is normally made in the knowledge that if, during a home birth, a medical emergency arises which may imperil the wellbeing or even the life of the mother or the baby, the mother can be fairly rapidly transferred to a hospital if required. The nub of this case is the potential difficulty of transferring this particular mother to hospital if a medical emergency arose, but she was so overcome by her agoraphobia that she would not go. That, of course, could potentially occur at any time of day or night, or during a weekend, when far fewer resources might be available than if the mother is taken to hospital, not in labour, in a planned way so as to give birth there.

12 Unfortunately, due to her agoraphobia, the mother several times failed to attend hospital for scans, and the data in relation to the baby is less reliable than it otherwise would be. But, on the basis of a very recent home scan (less reliable than a hospital scan) carried out this week, on 10 May 2021, it is believed that the baby is entirely normally developed and on about the 50th centile, with an EDD, as I have said, of around the first week in June. The mother is physically healthy, and currently there are no specific indicators that she may not have an

uneventful, spontaneous labour and vaginal delivery. When I use the word "uneventful", I do not in any way underestimate the physical and psychological demands and pain of a first birth upon a young mother, but there is no case specific indication that any particular medical emergency will arise in this case.

13 However, although child birth is the most natural of human events, it is not risk free. There are statistics which indicate that, in about 45 per cent of cases in which a young, healthy, primigravida mother embarks on a home birth, she will be transferred to hospital before the birth occurs. Of that 45 per cent, about one quarter are for urgent medical emergencies. The remainder are for important but less urgent reasons, such as a failure to progress, pain relief, or repairing tears. On that basis, about 10 per cent of all such home births require an urgent transfer to hospital for serious medical emergencies, threatening the mother and/or the baby. Professor James Walker, the consultant obstetrician instructed as an expert witness by the Official Solicitor, considered that what he called "urgent blue light ambulance transfers" occur during about one to two per cent of home births.

14 There is an overall statistic that about one in 200 hospital births tragically result in a still-born or otherwise seriously damaged baby. In cases which start as home births, that figure doubles to about one in 100. The difference between the two figures is largely, if not wholly, attributable to delays in effecting a transfer from the home to the hospital. In the present case, the medical witnesses do not in any way predict that there will be any emergency; but, on the basis of those known statistics, they must, appropriately and responsibly, anticipate the possibility that there may be.

15 A recent case in the Court of Protection, in which MacDonald J handed down an after-the-event judgment on 5 March 2021, vividly illustrates the dilemma which may (I stress, may) arise: *East Lancashire Hospitals NHS Trust v. GH* [2021] EWCOP 18. In that case, a woman aged 26, in her second pregnancy, had been in labour at home for nearly 72 hours

and was suffering an obstructed labour. There was considered to be an urgent need for transfer to hospital and urgent inpatient treatment, including a possible emergency Caesarean section. But, like the mother in the present case, that mother suffered from acute agoraphobia and was refusing to go. In this emergency, an application was made to MacDonald J, the hearing of which is reported to have lasted from about 10 p.m. until shortly before midnight. At the end of it, the judge made an order declaring and authorising that the mother could, in her best interests, be transported to hospital using reasonable and proportionate force if necessary. A postscript to the published judgment, which, as I have said, was delivered three days after the event, describes that, in the event, the labour had begun to progress quickly after the hearing, and the baby was in fact delivered at home before the arrangements authorised by the court could be implemented.

16 It is, of course, possible to draw conflicting messages from that case and judgment. It could be said to illustrate that, even when doctors consider that there is an acute emergency, it may yet pass and the birth may take place at home without (apparently) long-term damage. It could be said to illustrate the capacity in some situations for a hospital to obtain an urgent hearing and an order, even in the middle of the night, when an emergency has actually arisen. But the hearing will have taken time to set up, and itself lasted nearly two hours, far too long if there had been what Professor Walker described as “a blue light ambulance emergency”.

17 Overall, the case illustrates, in my view, the need to anticipate problems of this kind and to face up to them as best one can in advance, even if that involves speculation and/or reliance upon statistics. In my view, therefore, it was entirely justifiable and appropriate that the hospital trusts in the present case have made the present application. Amongst other advantages, it has enabled a thorough and informed investigation to take place, as well as a fair and transparent hearing, lasting many hours, in which to test out the issues and the

evidence, all of which is impossible in any kind of emergency out-of-hours situation. Further, the mother herself has been able to participate, and has participated, throughout the hearing, at a time when she is not in labour, pain or distress.

18 The judgment of MacDonald J in *East Lancashire Hospitals NHS Trust v. GH* contains a very thorough analysis of the relevant law at paragraphs 19 to 28. I have read it during this hearing. I agree with it, and I incorporate it into this judgment by reference as my narrative as to the applicable law.

19 Based on the above statistics, the hospital trusts and the treating doctors correctly and justifiably anticipate that a need may (I stress, may) arise for an urgent transfer to hospital during any home labour. Based on the mother's known agoraphobia and her almost total refusal ever to leave her home, they correctly and justifiably anticipate that at that time she may refuse to leave her home or to be transported to hospital with, potentially, very grave consequences for herself and/or her baby. The expert psychiatrist, Dr Glover, expressed at paragraph 6, under the heading "Opinion", in his report dated 11 May 2021 a "suspicion" that, should serious harm be a possibility during labour at home, "the mother's ability to co-operate and grudgingly accept hospital transfer would be significantly enhanced", but he added that "her co-operation or acquiescence could not however be guaranteed."

20 The expert witness obstetrician, Professor Walker, likewise expressed that, if she was in labour at home and in severe pain and/or a medical emergency arose, the mother might become more compliant with a hospital transfer. But this, too, is speculative, and is expressed in paragraph 6 of the note of the joint (online) meeting between the obstetricians on 11 May 2021 as no more than what "he would suspect".

21 All the doctors who gave evidence in this case agree, the Official Solicitor now agrees, and I agree, that, for all the above reasons, it is preferable, and in the overall best interests of this particular mother and her baby, that she should give birth in hospital in a planned way

around the EDD, but before she goes into spontaneous labour. The mother's partner, who is the father of the baby, would also prefer, if it can be achieved, a hospital birth, as does the grandmother, who has herself given birth to five children, all in hospital. The considered views and preferences of the partner and the grandmother are relevant, both as falling within section 4(7)(b) of the Mental Capacity Act 2005 and, importantly, because they are the family support network for the mother. She wishes them both to be present at the birth, or, if only one is permitted to be, then her mother to be there. If any question does arise, whether in an emergency or in a pre-planned way, of transporting the mother to hospital, then the partner and the grandmother (who lives nearby) will be very key people in the process. They will be giving maximum encouragement, help and support to the mother to overcome her agoraphobia, because they themselves do each consider that she should travel to hospital and give birth there.

22 The mother herself says that she would prefer to give birth at home, but she clearly expresses that that is due to her agoraphobia and fear of going out. I am satisfied that, but for her agoraphobia, the mother herself would opt for a hospital birth, as encouraged by her mother and partner.

23 If the mother is successfully transported to hospital to give birth there, then the birth may either be induced or by Caesarean section. The mother does have the capacity to make an informed choice between those methods, and unless there is a significant medical contraindication, the hospital will respect and be guided by her choice on the day. Similarly, if she elects a Caesarean section, she has the capacity to make an informed choice between a local or a general anaesthetic. Currently, she has clearly said that, if she is to have a Caesarean, she would prefer a general anaesthetic and to wake up when it is all over. But, of course, she has the right and capacity to change her mind about that until the last moment.

24 For the above reasons, it is now agreed by the Official Solicitor, who represents the mother, that I should declare that it is in the best interests of the mother to be transferred to the hospital for a planned delivery. She would be attended by an experienced community midwife and a community psychiatric nurse, who are familiar to her, as well as by her partner and her mother.

25 It is also agreed, in the light in particular of the consensus between the psychiatrists, that it is in the best interests of the mother that sedation may be administered to her, probably 2 mg of Lorazepam, so as to calm her and help her cope with the transfer. That may be administered orally or by intramuscular injection. She does not like needles, but she accepts the need for injections and is not, as such, resistant to them. Indeed, moments before I commenced this judgment, she told me that the visiting midwife had just taken blood samples from her with no problem. All forms of reasonable encouragement and persuasion can be used, as can light physical guidance, such as the midwife or nurse taking her by the arm to assist and encourage her into the vehicle.

26 The issue which remains between the hospital, on the one hand, and the Official Solicitor, on the other, is as to the extent of additional force or restraint which could lawfully be used on a pre-planned transfer and admission, if she was not actually in labour and no actual acute medical emergency has actually arisen. In the latter eventuality, should it arise, the Official Solicitor has, herself, agreed and accepted that force and restraint could, if it became necessary, be used. But she submits that, short of an actual current emergency, it is not justifiable or proportionate to use force or restraint for a pre-planned admission, however desirable such an admission might otherwise be.

27 The hospital trusts wish to include provision and authorisation in an order, and attached care plan, for the use of reasonable force (but always the minimum necessary) even in the case of a pre-planned, non-emergency admission.

28 All the medical witnesses have said that this is a finely-balanced decision. Both psychiatrists have agreed that, if force is used, that may (this again is speculative) have a damaging psychological effect on this already agoraphobic person. It may entrench her agoraphobia. It may damage or impair her bonding with her baby. It may give her long-term flashbacks. It may compromise her attitude to future pregnancies, or her dealings with persons in authority. On behalf of the Official Solicitor, Ms Sophia Roper submits that these are known risks from the use of force or restraint which outweigh the more speculative and statistical risks, if the mother goes into labour at home but may then require an urgent transfer to hospital.

29. Specifically, the hospital trusts wish to have two personnel trained in restraint techniques discreetly available on the occasion of the planned, but not in labour, transfer to hospital, who should be permitted, if necessary, to use physical force and restraint to her arms and upper body (but **not** lifting or handling her by her legs) so as to get her into the vehicle and get her from the vehicle to the maternity area of the hospital. The hospital trusts make clear that in no circumstances would so-called mechanical restraint be used. There would be no handcuffs and no straps or belts, apart from a necessary normal maternity safety belt in the vehicle. She would not be placed in a prone position, and no pressure would be applied to her diaphragm or abdomen.

30. It is, of course, an unattractive scenario and, on the face of it, if resorted to, a severe infringement of the mother's personal autonomy and liberty. But, on the other side of the balance here, there is the known, if small, risk that, if a pre-planned birth cannot be achieved, some acute emergency may (I stress, may) arise in the home from which the mother cannot be rescued before some catastrophe occurs to either her or her baby. The risk may be low, but that which is at risk could not be potentially more grave. The mother is very, very clear that she does not want that to happen.

31. Having very anxiously weighed and considered all the factors in this case, I am, on balance, satisfied, albeit in disagreement with the Official Solicitor, that it will be in the overall best interests of this mother if - if the necessity for it arises on the day - some trained and professional force and restraint are used to transport her to hospital, and I will so declare. The declaration will incorporate the final "care plan for delivery" of the baby, which has been amended by me and counsel during the course of the hearing. An official transcript will be made as soon as possible of this judgment, and an anonymised version of the care plan and the order will be annexed to it.

32. During this hearing, I have much appreciated my interaction with the mother, her partner, and her mother, even with the severe limitation of it being by less than perfect video links. I sincerely wish the mother and her partner the very best of good fortune with the birth, which must soon take place, and that they will soon be the proud parents of a very healthy baby.

POSTSCRIPT

The judge was later informed that on 22 May 2021 the mother went into spontaneous labour at home. She contacted the hospital and travelled there with the support of her partner and mother and the community midwife. While still at home, she received 2mg of Lorazepam orally. Although initially resistant, she was guided by staff and her family into the ambulance and no restraint was required or used. A few hours later she was safely delivered of a healthy baby boy with a good birth weight. She returned home with the baby within the next day or two.

CERTIFICATE

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

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IN THE COURT OF PROTECTION **CASE No. 13748761**
IN THE MATTER OF THE MENTAL CAPACITY ACT 2005
IN THE MATTER OF AN EXPECTANT MOTHER
B E T W E E N : -

(1) A NHS FOUNDATION TRUST
(2) A NHS FOUNDATION TRUST

Applicants

and

AN EXPECTANT MOTHER
(by her litigation friend, the Official Solicitor)

Respondent

ORDER

BEFORE Mr Justice Holman sitting in public in the Royal Courts of Justice in London but with family members and witnesses participating and giving evidence by CVP

UPON reading the documents in the bundle, the Position Statements of the parties, and the notes of the discussions between the obstetric and psychiatric witnesses

AND UPON hearing oral evidence from: Dr X (treating obstetrician), Professor Walker (obstetrician), Dr Y (treating perinatal psychiatrist), Dr Glover (psychiatrist)

AND UPON hearing from the respondent and her mother

AND UPON hearing leading counsel for the applicants, Miss Katie Gollop, and counsel for the mother on the instruction of the Official Solicitor, Ms Sophia Roper

AND UPON the court having made a separate reporting restrictions order prohibiting the publication of any information that could lead to the identification of the respondent and her treating clinicians in connection with these proceedings

IT IS HEREBY DECLARED AND ORDERED PUSUANT TO SECTIONS 15 AND 16 OF THE MENTAL CAPACITY ACT 2005 THAT:

1. The respondent lacks capacity:
    a) to conduct these proceedings;
    b) to make decisions about the location of the delivery of her baby.

2. It is lawful and in the respondent's best interests for the medical, nursing and other healthcare practitioners with responsibility for her care and treatment to transfer her to X Hospital for a planned delivery in accordance with the Care Plan appended to this order.

3. In the event that the respondent becomes agitated or distressed and refuses to attend the hospital voluntarily, it is lawful, being in her best interests, for the medical and nursing practitioners with responsibility for her care and treatment to use such chemical and/or physical restraint as is consistent with the Care Plan in order to facilitate her transfer to hospital, the delivery of her baby and the provision of all ancillary care and treatment.

4. Insofar as the above measures amount to a deprivation of the respondent's liberty, they are authorised as being in her best interests.

5. Any restraint used pursuant to the Care Plan and paragraph 3 of this order shall be the minimum necessary in order to safeguard the respondent, the baby and those involved in her transfer and treatment and shall be provided in such a way as to ensure that, as far as practicable, the respondent retains the greatest dignity and suffers the least distress and discomfort.

6. In the event that the respondent's pregnancy continues past 3 June 2021 (her estimated due date) the applicants shall file and serve evidence containing an update and a summary of the risks of pregnancy continuing beyond 9 June 2021 (estimated 42 weeks' gestation) together with a draft order and Care Plan by 12 noon on 7 June.

7. The applicants must place a copy of this order, the Care Plan appended to it and the judgment in the respondent's medical records.

8. The applicants shall provide a copy of this order and the Care Plan appended to it and a copy of the judgment to X County Council within three working days of receipt of the sealed order.

9. The applicants must very urgently obtain an approved court transcript of the judgment.

10. No order for costs, save that the applicants shall pay one half of the costs of the Official Solicitor of these proceedings, to be subject to detailed assessment if not agreed.

Dated 13 May 2021

Care Plan for Delivery of Baby X

There has been a court hearing about the delivery of Baby X. On 13 May 2021 the judge gave a judgment and made an order.
Please look at the court order and the judgment.

M is the mother to be of Baby X.
M lives in the community. She has a diagnosis of agoraphobia.

The court has determined that as a result of her agoraphobia and linked anxiety, M lacks capacity to make decisions about whether to have her baby at home or at hospital.

A plan of care is required to ensure that M's baby is delivered in a manner that is safe for M, the baby and members of staff.

The following plan has been authorised by the court as being in M's best interests.

The plan takes account of the principles of least restriction and patient choice as far as possible, but ultimately decisions have been taken to ensure clinical safety. Liaison between services including the local authority and safeguarding teams is vital, as is regular communication with the family.

M booked late and has been unable (because of agoraphobia) to attend hospital for scans. As a result, her due date is uncertain and there is a margin of error of +/- 7 days. The working due date is 3 June 2021 when it is estimated that M will be 40 weeks. However, because of the uncertainty about the due date, she could be 39 weeks or she could be 41 weeks.

The treating team would like her to attend hospital on Tuesday 1 June 2021 for delivery when M will be 39 weeks + 5 days.

A pregnancy becomes high risk at 42 weeks because of the risk of injury from placental failure (the risks are brain damage from lack of enough oxygen to the brain and stillbirth).

After 42 weeks, for the very small number of women who chose not to have birth induced, the hospital would do a scan in hospital and twice weekly monitoring of the baby with CTG in hospital. It would be technically very difficult to do a CTG at home because of the size of the machine. If an abnormality is detected then immediate delivery by caesarean section is required.

The earliest that M might be at 42 weeks would be Thursday 10 June.

Planned Transfer to Hospital

1. M's Community Midwife (CM) and Community Psychiatric Nurse (CPN) will attend M's home at [time] on [date]. M and her partner will be in the property and M's mother may be there. If her mother is not at the property, she will meet M at the hospital to support her daughter through the birth.

2. CM will ensure that staff will ensure M's maternity notes are transported with her and that an accurate record of any medication administered is kept in order to handover to the hospital team.

3. Upon arrival at the hospital, CPN and CM will remain with M until care is handed over to the hospital team, including a midwife who is known to M and a Registered Mental Health Nurse (RMN) who will be present on the labour ward. In the event that Secure24 is utilised to facilitate the transfer, staff from Secure24 will support M onto the ward if required.

4. Support to assist M to attend hospital will be provided in a graded approach. The clinical team have evidence that M can become more anxious if attempted interventions are protracted and as such it is envisaged that the team will move fairly swiftly through the steps outlined below:

    a) CM and CPN will provide verbal support to encourage M to attend hospital and will provide transport for M and her partner via a hospital pool car. Verbal support and encouragement will be attempted for up to 30 minutes;
    b) If M fails to respond to verbal support, she will be offered Lorazepam 2mg. If this is successful in managing M's anxiety then the transfer will proceed in line with point a) above;
    c) The CM and CPN may use such force or restraint as they have been trained to use and the partner and mother may (should they chose) use moderate, physical force or restraint to achieve the transfer;
    d) If M declines medication, CM will contact Secure24 and proceed to point 5 below.

5. Two members of staff trained in Prevention and Management of Violence and Aggression (PMVA) techniques appropriate to M's clinical presentation will be supplied by Secure24. If M is not able to accept transfer, as a final and last resort and for the minimum term possible, such techniques will be utilised to transport M safely to hospital in secure transport. On the date of planned delivery, Secure24 will attend the property at a pre-arranged time but will stay in the background unless it is communicated to them by CM or CPN that assistance is required.

    a) In these circumstances M can be given Lorazepam 2mg intramuscularly (only if no oral

Lorazepam has been given);

b) Pulse, blood pressure, respiratory rate and oxygen saturation levels will be monitored at a minimum of every 15 minutes until transfer to hospital is complete and M is admitted to the maternity ward;
c) Physical restraint will be used with the minimum force necessary (the reasonableness of such force being assessed by reference to M's pregnancy and obstetric condition), commencing with arm holds and following appropriate escalation as required.

BUT the force/restraint used must not include:

a. Mechanical restraint (other than vehicle safety belt);
b. Use of a prone restraint position;
c. Any techniques that would apply pressure to the diaphragm or abdomen
d. Handling M's legs.

Planned Delivery

1. M has been inconsistent when expressing her wishes and feelings on mode of delivery in hospital. Three options are currently available to the clinical team:

   a. induced vaginal delivery;
   b. caesarean section with spinal block;
   c. caesarean section under general anaesthetic.

   These will be discussed with M on her arrival at hospital and her wishes and feelings will be followed in so far as is practicable. Although labelled options a, b and c these labels have been applied for clarity only: they are not intended to suggest a graded approach or order of preference.

2. The maternity unit has single en suite rooms. M will be allocated a member of midwifery staff to whom she will have been introduced in the community prior to the planned delivery date. A Registered Mental Health Nurse will be present outside of M's room and will be available to support M and midwifery staff in anxiety management.

3. M will be greeted by the midwifery team and a joint assessment will be carried out with the Obstetrics registrar/consultant to determine M's presentation, level of compliance and her wishes and feelings regarding mode of delivery. If not already present, the outcome of the assessment will be fed back to the obstetrics consultant who will make the decision as to the clinically available options for delivery. It is envisaged that M will be able to choose between those available options. The clinical team will only depart from M's views in the event that it is clinically necessary to do so in order to prevent harm to M or her unborn baby.

Option A: Induced Vaginal Delivery

The ability to carry out this plan is dependent on M's views, presentation and compliance on arrival at the hospital.

1. Vaginal delivery will require the following interventions:

   a. Administration of vaginal prostaglandins to induce labour (up to three doses 6 hourly

until able to rupture membranes)
   b. Artificial rupture of membranes to induce labour
   c. Routine observations including blood pressure, pulse, temperature and urine analysis
   d. Abdominal palpations and continuous fetal heart monitoring via CTG plus or minus intermittent auscultation of fetal heart and palpation of contractions
   e. Vaginal examination as required (minimum of 4 hourly) once in established labour
   f. Pain relief as required in the form of entonox, pethidine, diamorphine, epidural
   g. Episiotomy and associated perineal repair may be required
   h. IM injection of syntometrine or oxytocin

2. Complications associated with delivery may require the following interventions:

   a. Oxytocin infusion to augment labour
   b. Fetal blood sampling
   c. Manoeuvres by the clinical team to deliver the baby should shoulder dystocia occur
   d. Necessity for instrumental delivery including use of forceps/ventouse
   e. IV access for fluid/bloods
   f. Need for emergency caesarean section
   g. Management of abnormal MEWS (Maternity Early Warning Score) and/or PPH

Options B & C Caesarean Section (Spinal Block or General Anaesthetic)

In the event that M expresses a wish for caesarean section a plan for caesarean section will be implemented, unless the clinicians consider that a caesarean carries an unjustifiable risk.

1. A joint decision between the obstetrics team and the anaesthetist will be taken as to whether a spinal anaesthetic or a general anaesthetic is required. This will depend on M's wishes and feelings and the level of M's distress and risk at that time. In the event that M is given a spinal anaesthetic in the first instance but her cooperation deteriorates, a general anaesthetic will be given.

2. M may require restraint for the anaesthetist to be able to deliver the appropriate intervention.

3. Once M is under general anaesthetic, the planned staffing team do not need to remain with her but will remain within the maternity unit in order to provide support and assistance on M's transfer from theatre back to her room.

4. M will be taken to the recovery suite following surgery and then back to her single room.

Emergency Plan

In the event that:

1. M experiences contractions or what feels like the onset of labour when she is not in the hospital, and hospital admission is clinically required for the safety or wellbeing of M or the baby; or

2. Hospital admission is otherwise clinically required for the safety or wellbeing of M or the

baby (otherwise than in circumstances where the concern arises solely from the fact that M has gone past her EDD without going into labour);

the team will follow the steps set out in the transfer section of this care plan. If delivery is indicated, the steps outlined in the delivery section of this plan will be followed.

In the event that hospital admission is required out of hours:

1. Triage midwife at hospital to inform birthing centre co-ordinator/consultant obstetrician if M doesn't attend hospital as clinically advised

2. Continue plan with unknown staff to avoid delays in hospital attendance/seeking medical attention

3. Call 999 to seek assistance for ambulance transfer if required

Post-delivery Care

1. Once the baby is delivered, clinical staff will follow the child protection plan from Children's Services

2. M will remain at hospital until she is medically fit for discharge. In the post natal period, further assessment of M's mental state will be carried out to determine whether the ongoing support of mental health staff on the ward is required.

3. The current plan is for M to return to home following discharge subject to further examination of her mental state. If M becomes distressed or anxious about returning home, the MDT will consider implementing a transfer plan in accordance with the steps outlined above.

Family contact

1. M has indicated that she would like to be supported by her partner and her mother to be present during the delivery.

2. COVID guidance has been relaxed to ensure M can be supported by two asymptomatic birth partners (one of whom can remain throughout her admission following birth).

3. It is important at the time of transfer that we balance the need for M to feel supported by family against the need for a calm and appropriate environment in which the transfer plan can be implemented.

4. If, at any stage in the labour, clinicians form an impression that the presence of any family member may be increasing the agitation, staff may advise the family to step away for periods to allow de-escalation.

5. Hospital staff will exclude any person who is thought to be posing a risk to staff, patients or visitors on the wards in accordance with Trust policies.