Neutral Citation Number: [2023] EWCOP 23

Case No: 1408575T

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 8 June 2023

Before :

THE HONOURABLE MRS JUSTICE ROBERTS

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Between :

(1) NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST **(2) BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST**	**Applicants**
- and –	
MB **(by her litigation friend, the Official Solicitor)**	**Respondent**

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Mr Conrad Hallin (instructed by Capsticks LLP) for the Applicants
Ms Elizabeth Fox (instructed by the Official Solicitor) for the Respondent

Hearing date: 22 May 2023

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JUDGMENT

Mrs Justice Roberts:

1. MB is a 26 year-old woman who is 37 weeks pregnant and due to give birth to her first child within the next fortnight. She is currently detained in Hospital A pursuant to section 3 of the Mental Health Act 1983 having been admitted there on 14 March 2023. These proceedings concern an application in relation to serious medical treatment, namely the birth plan which is to be put in place to ensure the safety and wellbeing of both mother and baby during the delivery process. As part of that plan the court is being asked to authorise a planned Caesarean section should that become necessary at any stage of MB's labour. It is agreed in this case that MB currently lacks capacity to make informed and considered choices about how her unborn child is to be brought into this world. Since that proposed surgical intervention and the administration of anaesthesia would potentially represent an interference with fundamental human freedoms and the right to choose whether to consent to serious medical treatment, the court is being asked to authorise that course as being in MB's best interests.

2. This application was issued by the Trusts on 16 May 2023. The matter came before Knowles J on 18 May 2023 when it was listed for an urgent hearing before me today. The issues to be determined were stated to be (i) whether MB lacks capacity to make decisions regarding her obstetric care, and, if so, (ii) what care plan is in her best interests.

3. On behalf of the respondent, Ms Fox has criticised the manner in which this application has been brought. In my view, those criticisms were justified. When the application was issued on 16 May, it was envisaged that MB's child would be delivered by Caesarean section the following week on Wednesday, 24 May. There was no supporting witness statement to explain the background, context or urgency of the application. MB had by then been a patient at Hospital A for almost nine weeks. It was clear to those charged with her ante-natal care that this was a rapidly evolving situation both in terms of evaluating capacity and deciding upon an appropriate birth plan. It is not clear to me why this application was made without sufficient notice to enable the Official Solicitor to carry out her enquiries with proper information and without the pressure of court deadlines. This was not a case of a genuine medical emergency. As it was, the Official Solicitor was obliged to instruct Dr M to assess, and report on, MB's capacity both to conduct court proceedings and make decisions about the birth of her child within the space of 48 hours. Dr M was able to attend Hospital A last Friday and prepared her report over the weekend. She has attended court today to assist the court, as have two professional witnesses for the Trusts. Whilst the evidence of all three medical witnesses has been of assistance to me, I can see no good reason why this application could not have been issued much sooner and in accordance with the clear guidance set out in *NHS Trust 1 and NHS Trust 2 v FG* [2014] EWCOP 30, [2015] 1 WLR 1984.

The Law

4. Since capacity is not an issue before the court today for reasons I shall explain, I propose to deal with the legal framework in relatively short order.

5. The starting point is the legal presumption that a person should be entitled to make decisions about his or her medical treatment even if those decisions are contrary to medical advice and/or likely to lead to harm or even death. A doctor is not entitled to administer treatment or operate upon an adult patient of sound mind without that patient's consent since it is that consent which makes lawful what would otherwise amount to an assault: see *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

6. That presumption of capacity now has a statutory basis in law: see s. 1(2) Mental Capacity Act 2005 ("MCA").

7. There are three circumstances in which adults can have treatment imposed upon them without first securing their consent. The first arises where that person lacks capacity to make the relevant decision under the MCA. The second is where a person is detained under the Mental Health Act 1983 and the proposed course of treatment is designed to address the mental disorder from which he or she is suffering[1]. The third arises where a person is categorised as "vulnerable" for the purposes of the engagement of the High Court's inherent jurisdiction: *A Local Health Board v JK* [2019 EWHC 67 (Fam).

8. The statutory code is now embodied in sections 1 to 3 of the MCA 2005 which provide as follows:-

> **1. The principles**
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> ….

[111] For these purposes there is an embargo on surgical treatment which destroys brain tissue or brain functioning (s. 57) and on certain specified types of treatment which require a second opinion (s. 58 MHA 1983).

2. People who lack capacity

(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

(2) It does not matter whether the impairment or disturbance is permanent or temporary.

(3) A lack of capacity cannot be established merely by reference to –

(a) a person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

….

3. Inability to make decisions

(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable –

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of –

(a) deciding one way or another, or

(b) failing to make the decision.

9. Determination of capacity is both 'decision specific' and 'time specific'. Where a person's capacity to make decisions may fluctuate over a period of time with episodes, or 'snapshots', of lucidity, the issue of capacity must always be assessed in relation to the specific decision which the court is considering at the specific time when the decision needs to be made.

10. In relation to s.3(1) MCA, an inability to undertake any one of these four aspects of the decision making process is sufficient for a finding of incapacity provided that the court is satisfied that such inability arises as a result of an impairment of, or a disturbance in the functioning of, the mind or brain. Thus it must be the mental disorder captured within s. 2 of the Act which is the cause of a person's inability to make the relevant decision for himself or herself.

Best interests

11. In circumstances where the court reaches a conclusion based upon expert medical or other evidence that a person lacks the necessary capacity to make autonomous decisions for him- or herself, it must then consider whether the proposed course of treatment, as here, is in that person's best interests. For these purposes, s. 4 of the MCA provides the statutory framework to guide and shape that determination. For the purposes of the present application, and MB's particular circumstances, these specific matters will be engaged:-

(i) the extent to which MB will at some time have capacity in relation to the matter in question and, if it appears likely that she will, when that is likely to be: s. 4(3) MCA. The MCA Code of Practice makes provision for the postponement of a decision if capacity is likely to be regained in the foreseeable future (para 3.14) but that is qualified by para 4.27 which confirms that an assessment of capacity must be determined in relation to a particular decision at the time when it needs to be made;

(ii) MB's past and present views, her wishes and her feelings will be a relevant factor in any best interests decision. In particular, any written statements or consents made, or given, at a time when she had capacity may carry weight in a best interests determination: s.4(6)(a) MCA;

(iii) So far as reasonably practicable, and where the court considers it appropriate, MB must be permitted and encouraged to participate in any decision which affects her: s.4(4) MCA. In this case, I am satisfied that every opportunity has been afforded to MB to date, including an invitation to attend this hearing remotely. Whilst the link was set up in a private space in Hospital A, she has declined to take any part in today's hearing.

12. Two further points need to be made in relation to the legal principles which are engaged in this case. First, this court has no jurisdiction in relation to MB's unborn child: *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276 as affirmed by the ECtHR in *Paton v United Kingdom (1981) 3 EHRR 408*, and confirmed by MacDonald J in *North Bristol NHS Trust v R* [2023] EWCOP 5 at para 75. Thus the focus of any best interests decision in relation to MB's birth plan, and whether it should include provision for an elective or emergency Caesarean section, must be solely on MB and MB alone.

13. Second, in the context of depriving MB of her liberty where it is necessary in accordance with the proposed birth plan, MB is entitled to the preservation of her rights under the European Court of Human Rights. In the present case, each of Art 3 (prevention of inhuman or degrading treatment), Art 5 (the right to liberty) and Art 8 (the right to a private family life) is engaged. Before approving any birth plan which represents a restriction upon, or interference in, those fundamental rights, I have to be satisfied that such interference is justified, necessary and proportionate. In reaching conclusions about these issues, I am obliged to adopt "the least interventionist approach": per Keehan J in *NHS Trust 1 v G: Practice Note* [2014] EWCOP 30 at para 49.

Circumstances of MB's admission to Hospital A

14. Details about MB's background, or such of it as can be extracted from the evidence which is currently before the court, are somewhat limited. She emerges from the history she was able to give to her doctors as an isolated individual who has travelled through the care system from the age of 11 following many years of severe neglect as a younger child. She appears to have little ongoing involvement with her parents and, as an only child, her family and social network in terms of ongoing support appears to be limited. She has lived alone in a one-bedroom flat in north London for the last five years. The father of her unborn child is, as yet, unknown and she does not appear to be in an ongoing relationship with any partner. That said, she has no medical history of note and, significantly, no evidence of any previous mental health difficulties. It is agreed that this is likely to be the first presentation of psychosis and it is a condition which has responded well to the medication she has received since becoming an in-patient at Hospital A.

15. MB first presented at the hospital for which the first applicant is responsible on 14 March 2023 and reported that she was pregnant. She was complaining of abdominal pain and vaginal bleeding. Her presentation on that occasion caused concern to the obstetric team in that she claimed to be hearing voices and was expressing an interest in the babies of other patients. Following assessment by the psychiatric liaison team, she was detained under s. 2 MHA and admitted to a psychiatric ward at Hospital A. At that point in time she was exhibiting paranoid delusions and had little or no insight into her presentation.

16. Once on the ward, she was prescribed quetiapine, an antipsychotic medication. Whilst initially reluctant to take it, she later co-operated with the medical staff and was compliant with the treatment. At that point she was testing negative for all substances related to illicit drug use which appeared to rule out addiction as a cause of the psychosis. When she was first admitted to the ward, she became increasingly chaotic, violent, aggressive and irritable with the result that she had to be placed in seclusion (per Dr N, her consultant psychiatrist). She was treated with lorazepam and, on returning to the ward after 24 hours, remained compliant in terms of her medication.

17. Various attempts to engage her in ante-natal care were unsuccessful and she absconded on two occasions from the transport which had been arranged to take her to these appointments. After one such absconsion she was returned to the hospital "heavily drunk and thought disordered". Dr N examined her at the time and found her to be floridly psychotic as a result of having stopped her medication. She was put back on lorazepam and quetiapine which gradually restored her equilibrium. As at 18 May 2023 when he signed his witness statement, Dr N's view (para 18) was that:

> "The current risk of her now absconding remains quite high because she is very unreliable, she says she will attend appointments but then absconds. In my view there is a risk of her not being able to take care of her baby because of her mental health problems. Risk of suicide is low and risk of harm to others is moderate because at times she can be very aggressive when she is psychotic. In terms of risk from others outside, it is hard to say because she is very vulnerable. She needs the right support and the friends she keeps use substances."

18. However, he goes on to record that over the course of the last week, she has been taking her medication and is calmer.

Capacity assessments

19. On 11 May 2023, some five days before this application was issued, Dr N, together with MB's consultant obstetrician, Dr L, and her consultant midwife, FL, carried out an assessment of MB's capacity. That assessment confirmed

she was experiencing episodes of psychosis but that her capacity to make decisions was fluctuating. A subsequent assessment on 18 May 2023 confirmed that she was much more settled. In Dr N's opinion, she was able on that occasion to understand the nature and purpose of the proposed birth plan which then involved an elective planned Caesarean section. He felt she was able to retain the information he was giving her and she signed a consent form to that effect. Her adherence to the medication programme had restored a significant element of her mental stability although he considered that she remained at risk if she stopped taking quetiapine as she had threatened to do once her baby was born. There appears to have been an entirely lucid conversation on that occasion between MB and her two consultants when various options were discussed and MB was able to express her personal preferences in terms of a birth plan. At that stage she was keen to embark on a normal vaginal delivery but accepted that a Caesarean section may be required if she or the baby were in difficulties during labour. Whilst her capacity to retain information at that stage was limited, both consultants were of the view that she was then capacitous in relation to her obstetric care although she lacked capacity to "follow court proceedings".

20. That was where matters stood when the application came before the court for the first time on 18 May 2023 although the report of that assessment was not then available. By her order, Knowles J permitted the Official Solicitor to obtain an independent capacity assessment in advance of this hearing. I have already referred to the work which was required in order to ensure that report was available for this hearing.

21. Dr M saw MB on the hospital ward last Friday evening (19 May 2023). She has recorded in significant detail her observations of MB during that meeting. By that stage, she had no independent recollection of the information which had been given to her the previous day by Drs N and L in relation to the various options relating to her obstetric care. She had no insight into why she was in hospital and told Dr M that it was because she had a stomach-ache and this was the only place which had a bed available. She had no recollection of any of her presenting symptoms which led to her detention under the MHA.

22. She was nevertheless able to communicate to Dr M that she would prefer to have a spontaneous vaginal delivery although she knew this was not then the recommendation of her obstetric team. She confirmed that she was in agreement with their plan for delivery by a planned Caesarean section.

23. In terms of her professional opinion, Dr M has reported that:-

> "[MB] remains at risk of deterioration in mental state due to poor insight and limited compliance with her treatment plan, with consequent

vulnerability to others, and she is at increased risk of postpartum depression and postpartum psychosis."

"As [MB] is currently recovering from a first episode of psychosis her risk of a further relapse in labour or in the early postpartum period is elevated though difficult to quantify exactly because of a lack of information about her psychiatric family history. Postpartum psychosis usually entails a rapid and severe deterioration in mental state and initial symptoms include intense anxiety, sleep disturbance. This illness presents usually with a strong affective component. Further symptoms are perplexity, alteration in the pattern and content of speech, altered energy levels, psychotic symptoms such as delusions and hallucinations, erratic behaviour that can result in self harm or suicide attempts. Typically, there will be a breakdown in childcare and the infant is often incorporated in the mother's delusional beliefs, with consequent risks to the infant's safety either through neglect or accidental/non accidental harm."

24. Dr M's conclusions were clear. Whilst there was evidence of fluctuating capacity,

    (i) MB did not have capacity to make decisions about her mode of delivery; and

    (ii) MB did not have capacity to instruct a solicitor for the purposes of court proceedings.

25. That is where the evidence stood when the matter came before me today. Dr N, MB's treating consultant psychiatrist, did not challenge that assessment during the course of his oral evidence.

26. In addition to hearing from Dr M, Dr N and Dr L, I have also read statements from Dr W (a consultant anaesthetist) and from Ms V, a solicitor employed by Bindmans, who went to see MB at Hospital A to ascertain her wishes and feelings about her obstetric care before the report of Dr M was available.

27. I have taken all this evidence into account in reaching my conclusions about the issues which are engaged in this case.

28. In terms of capacity, there is clear agreement between counsel that, on the basis of the evidence which is now available to the court and against the background of what has been a fluctuating capacity, MB currently lacks capacity to make decisions about her obstetric care and/or to litigate on her own behalf in these proceedings which she now conducts through her litigation friend, the Official Solicitor. In these circumstances, the applicants no longer seek anticipatory declarations or orders in relation to the authorisation of treatment for MB. In the course of closing submissions, Mr Hallin addressed me on what he accepts

to be an area of law which remains controversial. In this context I was referred to previous decisions of Sir Mark Hedley in *Cheshire West and Chester Council v PWK* [2019] EWCOP 57 and Hayden J in *Guys and St Thomas's NHS Foundation Trust and another v R* [2020] EWCOP 4, [2020] 4WLR 96. The latter concerned an application by the applicant trusts for anticipatory declarations concerning obstetric treatment of a vulnerable adult who had a diagnosis of bipolar affective disorder characterised by psychotic episodes and whose pregnancy was almost at term. All the treating clinicians in that case agreed that she had capacity to make decisions in relation to her ante-natal care but, given the substantial risk she might lose capacity during labour, they sought advance approval from the court that any decision to perform a Caesarean section would be lawful, including any necessary deprivation of R's liberty which would be necessary to achieve that outcome. R had consistently stated that she did not wish to have a Caesarean section.

29. That factual matrix is different from the case with which I am dealing and in which there is a unanimous position that MB lacks capacity in both domains. At para 33 of his judgment in the *Guys and St Thomas* case, Hayden J identified that distinction in these terms:-

> "It is important here to restate that which is obvious in order to identify the clear parameters of this application. I am not being asked to authorise medical intervention in relation to a capacitous adult. I am being invited to determine whether, if the adult in question loses capacity, a medical intervention can be authorised which is contrary to her expressed wishes, whilst capacitous."

30. In this case the birth plan for MB's, as yet unborn, child is now in its third iteration. Mr Hallin has this afternoon produced an amended version of earlier plans dated respectively 18 and 20 May 2023. Significantly, the current plan now reflects the views and wishes which MB herself has expressed during the currency of these proceedings. The plan to carry out an elective Caesarean section on Wednesday of this week has now been superseded by a revised plan which anticipates a vaginal waterbirth in accordance with the views expressed by MB on 18 May when she was considered to be expressing capacitous views about the available options. Subject to ultrasound scans confirming normal amniotic fluid indices between now and MB's delivery date at 39 weeks (7 June 2023), she will be allowed to move to spontaneous labour and a natural vaginal delivery. The birth plan includes detailed provision for how MB is to be transferred from Hospital A if she goes into spontaneous labour before her due date and the care she will receive on arriving at the hospital where she will give birth to her child. If surgical intervention is required during the course of labour to protect either MB or her child, the birth plan envisages an elective Caesarean section under spinal anaesthetic. Because of the need to ensure a still and

compliant patient in order to administer the spinal anaesthetic, it will only be as a last resort that MB undergoes this procedure under general anaesthetic, unless she expresses a wish or preference for general anaesthesia and it is considered in her best interests to do so.

31. The birth plan also provides for a potential escalation or dysregulation in MB's presentation and/or a further episode of psychosis in the postpartum period. MB is aware that her baby will need to be transferred to the neonatal unit following birth because of the medications she has taken during the latter stages of her pregnancy. The infant's exposure to quetiapine and lorazepam, in particular, is likely to cause sedation and drowsiness and may in the early stages affect the baby's alertness and ability to breastfeed. MB has been made aware of these concerns. The birth plan makes specific provision for MB to be "treated like any other mother". She will be taken to the neonatal unit to visit her baby unless she is either medically unfit to leave her bed or she is in a state of florid psychosis.

Conclusions in relation to capacity and best interests

32. On the basis of the evidence before me, I am satisfied that MB lacks capacity to make decisions about her obstetric care and treatment. The jurisdiction of the Court of Protection is fully engaged and, subject to the statutory framework provided by the MCA 2005, the court is thereby enabled to make the declarations and orders which are set out in the draft order which is currently before the court.

33. In terms of whether the relief sought is in MB's best interests, there are a number of factors which lead me to the clear conclusion in this case that the applicants are entitled to the orders they seek. Whilst it is clear that MB has at times expressed ambivalence towards her pregnancy, in lucid moments when she has been communicating clearly with those charged with her care she has expressed a wish to deliver a healthy baby through as natural a process as possible. I regard the safe delivery of her child as an intrinsic factor in a consideration of her own best interests. The current iteration of the birth plan which I am being asked to approve in this context is aligned with MB's own expressed wishes. I accept that cases involving Caesarean sections offer particular challenges to courts who must intervene to preserve the fine balance which exists between preserving what has often been referred to as "the inviolability of a woman's body", a vital aspect of her fundamental freedom, and the legal protection sought by those responsible for her care and that of her unborn child when their safety and wellbeing requires medical intervention which, without her informed and capacitous consent, would be unlawful.

34. In the context of this particular case, as both counsel accept, I am not required to make anticipatory, or contingent, declarations as to the lawfulness of any

proposed treatment. MB lacks capacity. Her safety and wellbeing requires the formulation and approval of a clear way ahead given that she may go into spontaneous labour, or her unborn child may become distressed and require medical intervention, at any point prior to 7 June which is her due date. Whilst it is not impossible that between now and then she may have moments, or even periods, of lucidity, the preponderance of the evidence is that such periods are unlikely to be sustained. No court can reach important decisions in relation to an individual's capacity from a single 'snapshot' or event isolated from a trajectory or continuum of medical presentation. The statutory framework of the MCA 2005 is designed to support and enable individuals to achieve personal autonomy in terms of their decision-making capabilities. I very much hope that, with the right support and treatment, that outcome will be achieved for MB. However, for present purposes, she is not in that position. I have already referred to the circumstances and timing of this application. I might have found myself in the territory of contingent or anticipatory relief had this matter not come before the court with possibly days or, at most, two weeks, before MB's delivery date. I have concluded that, in the circumstances which are presented to this court, and for so long as the applicants act in accordance with their current birth plan, reflecting, as it does, MB's seemingly capacitous wishes, they will be acting lawfully should surgical intervention be required.

35. That is my order in relation to the mainframe applications which are currently before the court.

Order accordingly

Notification to MB of the local authority's current intention to apply for an interim care order involving the separation of mother and child

The issue

36. There is a final issue in this case which is not agreed and which I need to determine. MB is presently unaware of it although Ms Fox, on behalf of the Official Solicitor, has made representations on her behalf. The local authority has given notice of its intention to apply for an interim care order once MB's child is born. In the context of future public law proceedings, the local authority's current plan is to seek the court's approval for the immediate separation of mother and child. Whilst the final plan is yet to be formulated, although it has been advertised as one of placement and adoption, it is reasonable to suppose that in the interim the local authority will seek authorisation for the immediate placement of the child with short-term foster carers. MB has not been made aware of these plans. The issue I have to determine is whether she should be told in advance of her labour and/or the delivery of her child that this is what is proposed. I understand that the local authority has expressed a willingness to be guided by the applicant trusts in terms of whether this information is disclosed to MB prior to the birth of her child.

37. In this context there is a clear divergence between the experts' views.

38. Dr M's evidence in relation to the impact on MB of being told that the baby will be removed from her care is set out in para 9 of her report. She confirmed that, notwithstanding MB's earlier ambivalence towards her pregnancy, a separation immediately after the birth would be traumatic for her. It would be likely to add to existing traumas with consequent increased distress and a possible deterioration in her mental state. Dr M foresaw a significant escalation in the risk that MB would abscond from Hospital A once she became aware of the proposal. She was likely to cease taking medication which, in turn, would put both her and the pregnancy at risk.

39. When Dr M gave her oral evidence, she was asked by Ms Fox about the potential benefits of telling MB prior to the onset of labour whilst she was being cared for in a controlled psychiatric setting. She told me that giving this mother an opportunity to bond with her child in the hours and days following his or her birth without imparting the knowledge that there was likely to be a separation could have more significant long-term consequences. Dr M accepted that there were clear risks of telling her now but she was concerned about informing MB at a time when, post-delivery, the risks of postpartum psychosis would be heightened. If she was told before the onset of labour, Dr M considered that she would be able to process the information and would be more prepared for what would happen. She would have an opportunity to speak to a solicitor about the

options. During cross-examination Dr M accepted that she would need very close monitoring if a decision was made to tell her before the birth. She accepted that it was a very difficult decision either way and the significant risks involved would need to be mitigated. She accepted that, if MB were to abscond at this very late stage of pregnancy and thereby put the viability of the pregnancy at risk, the damage to her mental health could be life-long. She accepted that she did not know MB well having only met her once and thus her reactions were not easy to predict.

40. Dr N has been MB's treating consultant for several weeks. He has seen her on the ward on a regular basis since her admission in March this year. He saw a significant escalation in the risk of MB absconding from the hospital before she delivered her baby if this information was given to her prior to the child's birth. He foresaw a likelihood that she would disengage from her current treatment programme and abandon the medication which was controlling, or partially controlling, the psychotic symptoms which she was exhibiting both on admission to hospital and after previous disengagements with her treatment plan. Were she to abscond and stop taking her medication, she would put her unborn baby's health at risk as well as her own. Dr N acknowledged the increased risk of postpartum psychosis following delivery as well as the risk that, if told after the birth, MB may well try to abscond and take her baby with her. He acknowledged that it was a very difficult decision either way and that the risks were significant and would need to be managed. On balance, he was clear in his professional view that the risks of informing MB before delivery in terms of the potential safety and wellbeing of both mother and child were too great. In the context of managing those risks, he told me that there would be ongoing psychiatric liaison between the medical team at Hospital A and the obstetric team in the hospital where MB will give birth. That team will be available to provide support when she is told about the proceedings concerning her child and his or her potential removal.

Analysis

41. My starting point is this mother's entitlement to know about matters which have the potential to infringe her basic rights which, here, include the right to a family life with her child (Art 8). MB is an individual who is in an advanced state of pregnancy, who lacks capacity to make decisions about her medical treatment and/or to engage in litigation, and who has only recently achieved a degree of mental stability following a period of florid psychosis. That position is being maintained by a carefully controlled regime of medication. I agree with Mr Hallin's description of MB's current mental health as 'extremely fragile'. I also agree that any relapse would have potentially devastating consequences both for her and her unborn child. Both experts agree that the risk of her discontinuing her medication is high if she attempts to abscond on learning that her child is to

be removed from her care at birth. The use of increased sedation during this critical pre-birth period is not an answer to mitigating that risk because part of the rationale for telling her now is to provide her with an opportunity to process the information and seek advice on her options. Quite apart from questions about her current ability to process information and options at this particular point in time, even with appropriate psychiatric support, she will not be in a position to take up this opportunity if she is being medicated to prevent her leaving the hospital.

42. In the event of a Caesarean section and in the absence of medical complications, MB is likely to be on the labour ward for approximately 48 hours before discharge back to Hospital A. Dr N anticipated that the best course for MB and her baby would be to allow them to bond for a period before any attempt to remove the child. I have no evidence about the practical options which might be available to enable this to happen. I do not know whether the local authority's application for an interim care order is likely to be dealt with in a time frame which would permit the immediate removal of the child who, following delivery, will need to spend time in the neonatal unit in any event.

43. Having weighed matters carefully in the balance, I have reached a clear conclusion that it is in MB's best interests to protect her from the consequences of further trauma and distress in the remaining days of her pregnancy. The process of labour will be challenging enough for her in any event given her extreme vulnerability. Dr N, who is very familiar with the evolution of her presentation, is quite clear that the risks of further deterioration in her mental health are greater if she is told before the birth of her child. As matters stand, she is on what Mr Hallin has described as a constructive and collaborative path to labour where she is engaging with her medical team. She is focussed on the amended birth plan which will now allow her to attempt delivery by a normal and spontaneous vaginal water birth. That was her stated wish when she was last considered to have capacity to make decisions in relation to these matters. She has seen the facilities which the hospital will provide to enable that to happen. To the extent that she can be, she appears to be focussed on that plan. I regard maintaining that stability as being entirely in accord with her best interests. I know not what position she may take in response to the local authority's advertised application. Her ability to care for this child in the future will be a crucial question for the court in any future proceedings. This is a first presentation of psychosis with no discernible history to inform a future finding of chronic or recurring mental illness. These are not matters for this court but MB's ability to present whatever case she chooses to advance in future proceedings is a relevant factor in deciding how to mitigate the risks of a further deterioration in her health in what is likely to be a relatively short period before her child is delivered.

44. In my judgment, the postponement of informing MB about the local authority's current position this close to her likely delivery date represents a potential interference with her Art 8 rights but it is an interference which is necessary, justified and proportionate. She should not be informed of those matters prior to the birth of her child.

45. That is my judgment.