St George's Healthcare NHS Trust v S
R v Collins and others, ex parte S

COURT OF APPEAL, CIVIL DIVISION
BUTLER-SLOSS, JUDGE AND ROBERT WALKER LJJ
10–13, 17 FEBRUARY, 7 MAY 1998

Medical treatment – Adult patient – Consent to treatment – Right to refuse treatment – Patient 36 weeks pregnant diagnosed with pre–eclampsia and advised she needed to be admitted to hospital for an induced delivery – Patient rejecting advice as wishing her baby to be born naturally – Patient admitted against her will to mental hospital and later transferred to general hospital – Judge on ex parte application disposing with patient's consent to medical treatment and patient delivered of baby by Caesarean section – Patient transferred back to mental hospital and later discharged herself – Whether judge right in dispensing with patient's consent – Whether patient's detention, treatment and transfer lawful – Mental Health Act 1983, s 2.

On seeking to register as a new patient at a local NHS practice, S, who was 36 weeks pregnant, was diagnosed with pre-eclampsia and advised that she needed to be admitted to hospital for an induced delivery. S fully understood the potential risks but rejected the advice as she wanted her baby to be born naturally. She was seen by C, a social worker approved under the Mental Health Act 1983, and two doctors, whose advice she again refused to accept, and, on C's application, was admitted to a mental hospital for assessment under s 2 of the 1983 Act. Subsequently, and again against her will, she was transferred to another hospital, which applied ex parte to the court for a declaration dispensing with her consent to treatment. The judge granted the declaration, and later that evening appropriate medical procedures were carried out and S was delivered of a baby girl by Caesarean section. Thereafter, S was returned to the mental hospital, and two days later her detention under s 2 of the Act was terminated, whereupon, against medical advice, she discharged herself. S appealed against the grant of the declaration dispensing with her consent to treatment, and applied for judicial review of (i) her admission and detention in the mental hospital, (ii) her transfer, detention and treatment at the second hospital, and (iii) her return to the mental hospital.

Held – (1) Having regard to the right of an individual to autonomy and self-determination, an adult of sound mind was entitled to refuse medical treatment, even when his or her own life depended on receiving such treatment. In the case of a pregnant woman, that right was not diminished merely because her decision to exercise it might appear morally repugnant. In the instant case, the declaration involved the removal of the baby from S's body under physical compulsion and that removal amounted to trespass. Moreover, the declaration was made on an ex parte application in proceedings which had not then been instituted by the issue of a summons, without S's knowledge or even any attempt to inform her or her solicitor of the application, without any evidence and without any provision for S to apply to vary or discharge the order. In those circumstances, S was entitled to have it set aside, and accordingly the appeal would be allowed (see p 685 *e* to p 686 *d*, p 692 *a* to *c* and p 702 *a* to *d*, post); *Airedale NHS Trust v Bland* [1993] 1 All ER 821 and *S v S*, *W v Official Solicitor* [1970] 3 All ER 107 considered.

(2) The 1983 Act could not be deployed to achieve the detention of an individual against his or her will because his or her thinking process was unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large; the Act could only be used to justify detention for mental disorder if the case fell within the prescribed conditions. Moreover, a person detained under the Act for mental disorder could not be forced into medical procedures unconnected with his or her mental condition unless his or her capacity to consent to such treatment was diminished. In the circumstances, therefore, S's detention, treatment and transfer were all unlawful. Accordingly, the application for judicial review would be granted and appropriate declaratory relief ordered (see p 692 *d g* to *j*, p 693 *g*, p 697 *f*, p 698 *j* and p 702 *f*, post).

Notes

For consent to medical treatment, see 30 *Halsbury's Laws* (4th edn reissue) para 39, and for cases on the subject, see 33 *Digest* (Reissue) 273–275, *2242–2246*.

For the Mental Health Act 1983, s 2, see 28 *Halsbury's Statutes* (4th edn) (1996 reissue) 852.

Cases referred to in judgment

A-G's Reference (No 3 of 1994) [1997] 3 All ER 936, [1998] AC 245, [1997] 3 WLR 421, HL; *affg in part* [1996] 2 All ER 10, [1996] QB 581, [1996] 2 WLR 412, CA.

Airedale NHS Trust v Bland [1993] 1 All ER 821, [1993] AC 789, [1993] 2 WLR 316, CA and HL.

Anisminic Ltd v Foreign Compensation Commission [1969] 1 All ER 208, [1969] 2 AC 147, [1969] 2 WLR 163, HL; *rvsg* [1967] 2 All ER 986, [1968] 2 QB 862, [1967] 3 WLR 382, CA.

Associated Provincial Picture Houses Ltd v Wednesbury Corp [1947] 2 All ER 680, [1948] 1 KB 223, CA.

B v Croydon Health Authority [1995] 1 All ER 683, [1995] Fam 133, [1995] 2 WLR 294, CA.

Blathwayt v Lord Cawley [1975] 3 All ER 625, [1976] AC 397, [1975] 3 WLR 684, HL.

Brink's-MAT Ltd v Elcombe [1988] 3 All ER 188, [1988] 1 WLR 1350, CA.

Burton v Islington Health Authority, de Martell v Merton and Sutton Health Authority [1992] 3 All ER 833, [1993] QB 204, [1992] 3 WLR 637, CA.

C (adult: refusal of medical treatment), Re [1994] 1 All ER 819, [1994] 1 WLR 290.

C v S [1987] 1 All ER 1230, [1988] QB 135, [1987] 2 WLR 1108, CA.

F (in utero), Re [1988] 2 All ER 193, [1988] Fam 122, [1988] 2 WLR 1288, CA.

F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, sub nom *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 WLR 1025, HL; *affg* [1990] 2 AC 1, [1989] 2 WLR 1025, CA.

Imperial Tobacco Ltd v A-G [1980] 1 All ER 866, [1981] AC 718, [1980] 2 WLR 466, HL.

International General Electric Co of New York Ltd v Customs and Excise Comrs [1962] 2 All ER 398, [1962] Ch 784, [1962] 3 WLR 20, CA.

Issacs v Robertson [1984] 3 All ER 140, [1985] AC 97, PC.

JT (an adult: refusal of medical treatment), Re [1998] 1 FLR 48.

Jefferson v Griffin Spalding County Hospital Authority (1981) 274 SE 2d 457, Ga SC.

MB (an adult: medical treatment), Re [1997] 2 FCR 541, 38 BMLR 175, CA.

McFall v Shimp (1978) 127 Pitts Leg J 14, 10 Pa D & C 3d 90, Allegheny Cty Ct.

MacFoy v United Africa Co Ltd [1961] 3 All ER 1169, [1962] AC 152, [1961] 3 WLR 1405, PC.

Madyyun, Re (1986) 573 A 2d 1259, DC Ct of Apps.
Marsh v Marsh [1945] AC 271.
New Brunswick Rly Co v British and French Trust Corp Ltd [1938] 4 All ER 747, [1939] AC 1.
Oscroft v Benabo [1967] 2 All ER 548, [1967] 1 WLR 1087, CA.
Paton v Trustees of BPAS [1978] 2 All ER 987, [1979] QB 276, [1978] 3 WLR 687.
Patten v Burke Publishing Co Ltd [1991] 2 All ER 821, [1991] 1 WLR 541.
R v Hallstrom, ex p W (No 2), R v Gardner, ex p L [1986] 2 All ER 306, [1986] QB 1090, [1986] 2 WLR 883, CA.
R v Kirklees Metropolitan BC, ex p C [1993] 2 FCR 381, [1993] 2 FLR 187, CA.
R v South Western Hospital Managers, ex p M [1994] 1 All ER 161, [1993] QB 683, [1993] 3 WLR 376.
R v Wilson, ex p Williamson [1996] COD 42.
Riverside Mental Health NHS Trust v Fox [1994] 2 FCR 577, [1994] 1 FLR 614.
S (adult: refusal of medical treatment), Re [1992] 4 All ER 671, [1993] Fam 123, [1992] 3 WLR 806.
S-C (mental patient: habeas corpus), Re [1996] 1 All ER 532, [1996] QB 599, [1996] 2 WLR 146, CA.
S v S, W v Official Solicitor [1970] 3 All ER 107, [1972] AC 24, [1970] 3 WLR 366, HL.
T (adult: refusal of medical treatment), Re [1992] 4 All ER 649, [1993] Fam 95, [1992] 3 WLR 782, CA.
Wallersteiner v Moir, Moir v Wallersteiner [1974] 3 All ER 217, [1974] 1 WLR 991, CA.
Webster v Southwark London BC [1983] QB 698, [1983] 2 WLR 217.
Winnipeg Child and Family Services (Northwest Area) v G (1997) 3 BHRC 611, Can SC.

Cases also cited or referred to in skeleton arguments

Anlaby v Praetorius (1888) 20 QBD 764, CA.
Ashmore v British Coal Corp [1990] 2 All ER 981, [1990] 2 QB 338, CA.
Blakemore, Re (1845) 14 LJ Ch 336.
Bramblevale Ltd, Re [1969] 3 All ER 1062, [1970] Ch 128, CA.
Bray v Ford [1896] AC 44, [1895–9] All ER Rep 1009, HL.
Carl-Zeiss-Stiftung v Rayner & Keeler Ltd (No 2) [1966] 2 All ER 536, [1967] 1 AC 853, HL.
Chester v Bateson [1920] 1 KB 829, DC.
Clay, Re, Clay v Booth [1919] 1 Ch 66, [1918–19] All ER Rep 94, CA.
Cole v Turner (1704) Holt KB 108, 90 ER 958, NP.
Collins v Wilcock [1984] 3 All ER 374, [1984] 1 WLR 1172, DC.
Congreve v Home Office [1976] 1 All ER 697, [1976] QB 629, CA.
Craig v Kanseen [1943] 1 All ER 108, [1943] KB 256, CA.
DSV Silo- und Verwaltungsgesellschaft mbH v Sennar (owners), The Sennar [1985] 2 All ER 104, [1985] 1 WLR 490, HL.
Entick v Carrington (1765) 2 Wils 275, [1558–1774] All ER Rep 41, 95 ER 807.
Guaranty Trust Co of New York v Hannay & Co [1915] 2 KB 536, [1914–15] All ER Rep 24, CA.
Hayes v Malleable Working Men's Club and Institute [1985] ICR 703.
Herczegfalvy v Austria (1992) 15 EHRR 437, ECt HR.
Hunter v Chief Constable of West Midlands [1981] 3 All ER 727, [1982] AC 529, HL.
James v Eastleigh BC [1990] 2 All ER 607, [1990] 2 AC 751, HL.
Khawaja v Secretary of State for the Home Dept [1983] 1 All ER 765, [1984] AC 74, HL.
Knight v Clifton [1971] 2 All ER 378, [1971] Ch 700, CA.
London and Clydeside Estates Ltd v Aberdeen DC [1979] 3 All ER 876, [1980] 1 WLR 182, HL.

Malone v Comr of Police of the Metropolis (No 2) [1979] 2 All ER 620, [1979] Ch 344.
MB (Caesarian section), Re (1997) Times, 18 April, [1997] CA Transcript 564.
Newham v Tate (1838) 1 Arnold 244.
Nixon v A-G [1930] 1 Ch 566, CA.
Open Door Counselling Ltd v Ireland (1992) 15 EHRR 244, ECt HR.
Padfield v Minister of Agriculture Fisheries and Food [1968] 1 All ER 694, [1968] AC 997, HL.
Paul (R & W) Ltd v Wheat Commission [1936] 2 All ER 1243, [1937] AC 139, HL.
Preston v IRC [1985] 2 All ER 327, [1985] AC 835, HL.
R v Comr for Local Administration, ex p Croydon London BC [1989] 1 All ER 1033, DC.
R v Hallstrom, ex p W [1985] 3 All ER 775, sub nom *Ex p Waldron* [1986] QB 824, CA.
R v Inner London Education Authority, ex p Westminster City Council [1986] 1 All ER 19, [1986] 1 WLR 28.
R v Institute of Chartered Accountants, ex p Andreou (1996) 8 Admin LR 557, CA.
R v Islington London BC, ex p Rixon (15 March 1996, unreported), QBD.
R v Newham London Borough, ex p Gentle (1993) 26 HLR 536.
R v Secretary of State for the Home Dept, ex p McQuillan [1995] 4 All ER 400.
R v Secretary of State for the Home Dept, ex p Ruddock [1987] 2 All ER 518, [1987] 1 WLR 1482.
R v Stratford-on-Avon DC, ex p Jackson [1985] 3 All ER 769, [1985] 1 WLR 1319, CA.
R v University of Cambridge (1723) 1 Stra 557, 93 ER 698.
Raymond v Honey [1982] 1 All ER 756, [1983] 1 AC 1, HL.
Ridge v Baldwin [1963] 2 All ER 66, [1964] AC 40, HL.
Rochdale Healthcare (NHS) Trust v C [1997] 1 FCR 274.
Royal Government of Greece v Brixton Prison Governer [1969] 3 All ER 1337, [1971] AC 250, HL.
S (hospital patient: court's jurisiction), Re [1995] 3 All ER 290, [1996] Fam 1, CA.
S (hospital patient: foreign curator), Re [1995] 4 All ER 30, [1996] Fam 23.
Sidaway v Governor of Bethlem Royal Hospital [1985] 1 All ER 643, [1985] AC 871, HL.
Tameside and Glossop Acute Services Trust v CH [1996] FLR 762.
Tavita v Minister of Immigration [1994] 2 NZLR 257, NZ CA.
Thoday v Thoday [1964] 1 All ER 341, [1964] P 181, CA.
Turquand v Strand Union (1840) 8 Dow 201.
Union Pacific Rly Co v Botsford (1891) 141 US 734, US SC.
W v Egdell [1990] 1 All ER 835, [1990] Ch 359, CA.
WEA Records Ltd v Visions Channel 4 Ltd [1983] 2 All ER 589, [1983] 1 WLR 271, CA.
Webb v EMO Air Cargo (UK) Ltd (No 2) [1992] 4 All ER 929, [1993] 1 WLR 49, HL.
Wheeler v Leicester City Council [1985] 2 All ER 1106, [1985] AC 1054, HL.
Winterwerp v Netherlands (1979) 2 EHRR 387, ECt HR.
Y (mental patient: bone marrow donation), Re [1997] Fam 110.

Appeal and application for judicial review

S appealed from the decision of Hogg J in chambers on 26 April 1997 whereby, on the ex parte application of St George's Healthcare NHS Trust, she granted a declaration dispensing with her consent to medical treatment proposed by the trust. S also applied for judicial review of decisions of (i) Louize Collins, a social worker approved under the Mental Health Act 1983, (ii) Pathfinder Mental Health Services Trust and (iii) St George's Healthcare NHS Trust relating to her detention under s 2 of the 1983 Act, treatment and transfer. The facts are set out in the judgment of the court.

Richard Gordon QC, Barbara Hewson and *Robert O'Donoghue* (instructed by *Leigh Day & Co*) for S.

Lord Lester of Herne Hill QC and *Beverley Lang* (instructed by *Jane Ramsey,* Merton) for Louize Collins.

Philip Havers QC and *Monica Carss-Frisk* (instructed by *Bevan Ashford*, Bristol) for Pathfinder Mental Health Services NHS Trust and St George's Healthcare NHS Trust.

Cur adv vult

7 May 1998. The following judgment of the court was delivered.

JUDGE LJ.

Introduction

On 25 April 1996 S, a single woman born in June 1967, working as a veterinary nurse, sought to register as a new patient at a local NHS practice in London. She was approximately 36 weeks pregnant. She had not sought antenatal care. Pre-eclampsia was rapidly diagnosed. She was advised that she needed urgent attention, with bedrest and admission to hospital for an induced delivery. Without this treatment her health and life and the health and life of her baby were in real danger. She fully understood the potential risks but rejected the advice. She wanted her baby to be born naturally.

She was seen by Louize Collins, a social worker approved under the Mental Health Act 1983, and two doctors, Dr Caroline Chill and Dr Siobhan Jeffreys, a duly qualified practitioner registered under s 12(2) of the Act. They repeated the advice she had already been given. She adamantly refused to accept it. An application was made under s 2 of the Act by Louize Collins for her admission to Springfield Hospital 'for assessment'. Dr Chill and Dr Jeffreys signed the necessary written recommendations. That evening (25 April) S was admitted to Springfield Hospital against her will.

Shortly before midnight, again against her will, she was transferred to St George's Hospital. In view of her continuing adamant refusal to consent to treatment, an application was made ex parte on behalf of the hospital authority to Hogg J sitting in the Family Division in chambers, who granted a declaration which, in summary terms, dispensed with S's consent to treatment. Later that evening appropriate medical procedures were carried out and at 22.00 S was delivered of a baby girl by Caesarean section. When she recovered she developed strong feelings of revulsion and at first rejected her baby. Happily the natural bond between them has now been established.

On 30 April she was returned to Springfield Hospital. On 2 May her detention under s 2 of the Act was terminated, and against medical advice, she immediately discharged herself from hospital.

During the period when she was a patient no specific treatment for mental disorder or mental illness was prescribed.

Virtually every step of the medical and legal procedures involving S between 25 April and 2 May is criticised and we have been required to consider important questions about the autonomy of a pregnant woman and the effect of her right to self-determination on her unborn child, the correct application of a number of provisions of the Act, as well as the effect of a declaration, made by the High Court in the course of an ex parte hearing, on the rights of a woman unlawfully detained in hospital in consequence of an order purportedly made under the Act. Relief is sought both by way of appeal from the decision of Hogg J and judicial review of

the decisions: that S should be admitted to and detained at Springfield Hospital under s 2; her transfer, detention and treatment at St George's Hospital; the application to Hogg J itself; the medical procedures which culminated in the birth; and her return to and treatment at Springfield Hospital. Leave to apply for judicial review of these decisions was granted by the full court notwithstanding the substantial delay in the making of the application. Leave was also granted to appeal the decision of Hogg J out of time. It was further ordered that the applications for judicial review should be considered by the Court of Appeal together with the appeal from Hogg J.

The relevant facts

We shall first analyse the relevant facts in the detail necessary to a proper understanding of the issues. The affidavits of witnesses prepared for these proceedings include several important conflicts of recollection and some supplementary material. However the papers include a very substantial body of notes made contemporaneously, or very soon after, any relevant event when the memory of the note-maker was fresh. From these documents, reinforced where necessary by reference to the affidavits, and ignoring any ex post facto attempts at self-justification, a reasonably clear picture emerges.

S attended Dr Chill's surgery on 25 April in the morning. She had never previously consulted or attended at her surgery before. She was 36 weeks pregnant. Her history revealed a termination of pregnancy at nine weeks in 1993 and a miscarriage in December 1995. Her relationship with the baby's father had ended fairly recently. On examination she was suffering from severe pre-eclampsia, severe oedema extending to her abdomen and proteinnuria. Dr Chill advised her that an early delivery was essential. S refused. With her permission, Dr Chill spoke to Dr Keogh, a general practitioner in Surrey, who had seen her two days earlier. He referred to an earlier diagnosis of moderate depression. Dr Chill again repeated her advice, but when S refused to accept it, Dr Chill arranged for her to be seen and assessed by an approved social worker, who arrived at the surgery shortly afterwards, and the duty psychiatrist who came about two hours later. According to the assessment report made later by Louize Collins, Dr Chill 'had initiated the Mental Health Act assessment as she feared S's mental state was affecting her decision making about her own and her baby's health'. In the meantime S waited there for them. S appeared happy to and did wait for their arrival. She then remained at the surgery throughout a prolonged discussion with Louize Collins, Dr Chill and Dr Jeffreys. S adamantly maintained that she did not want treatment for her condition. She appeared to comprehend that if her condition were left untreated her baby would die and she too might die, or become severely disabled. Her position was that nature should take its course. Without setting out the detailed material which emerged during the course of these discussions, a number of contradictions in her position were noted. For example, while refusing admission to hospital she nevertheless had come to and remained at the surgery; although she wanted to have the baby naturally, she was unable to explain how the baby would be delivered. Louize Collins later noted that—

> 'at times she seemed tearful; she acknowledged that she is probably depressed; she has had many difficulties of late with relationships, housing, changing jobs and indeed being pregnant with a child that she says she doesn't want and would give to the father as soon as it is born.'

The advice given to the approved social worker by Dr Chill was that urgent medical attention was needed for S's physical condition and that her 'mental state may be compromising her ability to make decisions'. Dr Jeffreys' advice was that S was 'probably depressed and would benefit from a period of assessment as well as the safety and containment needed to monitor and treat her physical condition'. Both suggested that S needed some form of intervention and that she should not be left to her own devices as she, S, wished.

In the light of the medical advice and her own assessment of the situation, Louize Collins decided that an application should be made under s 2 of the Act. She concluded her assessment:

> 'I had attempted to persuade S of a less restrictive option which would have involved her and myself going to the Obstetric Unit at St George's Hospital where her delivery would have been induced immediately. After many attempts at negotiating this option S continued to refuse therefore I felt I had no choice but to detain her for assessment to a safe place where there would be general nurses as well as psychiatric nurses to monitor her very severe condition. I do not think that a psychiatric ward was the best place for this patient, but I felt the gravity of the situation was such that she needed some sort of safety containment, assessment and immediate treatment when necessary.'

In context the 'very severe condition' is a reference to pre-eclampsia. No express mention was made of treatment for depression. The only treatment S refused was intended to reduce the physical risks to her and her unborn child.

Dr Jeffreys and Dr Chill completed the form prescribed by reg 4 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, SI 1983/893. Both expressed the opinion that S 'is suffering from mental disorder of a nature or degree which warrants detention' in a hospital for assessment and that she 'ought to be so detained' in the interests of her own health and safety 'with a view to the protection of other persons …' The amendment to this part of the form signed by Dr Chill is immaterial. 'Other persons' can only have referred to the foetus carried by S.

As required by the language of the form, and integral to it, each doctor explained the reasons why she believed informal admission was inappropriate. Dr Chill explained:

> 'Patient depressed and self neglectful refusing voluntary treatment. Has pre-eclampsia with potential severe physical complications which needs assessment, monitoring and treatment. Potential risk of self-harm or harm to unborn child if not treated.'

Dr Jeffreys explained:

> 'The patient is refusing treatment and will not accept voluntary admission. She appears to be significantly depressed with low self esteem and a profound indifference to the consequences of refusing treatment for her serious physical condition. She is pregnant and her behaviour is putting her own life and the life of her unborn baby at risk.'

These texts have been closely examined. Dr Chill was concerned for the health and safety of the mother and her unborn child. The focus of her concern was pre-eclampsia and its possible consequences. With Dr Jeffreys, the same immediate concern, the serious physical condition and the risk of death or injury

to S and her baby, is apparent. No reference to treatment for mental disorder or depression is included, but as the application indicates, S was to be admitted for 'assessment'. *a*

On her arrival at Springfield Hospital in the evening of 25 April, when her rights under s 132 of the Act were explained to her, S fully comprehended her position. Another very detailed examination was carried out by a different specialist, Dr Maginn, who diagnosed pre-eclampsia and depression. S remained adamant, *b* refusing any intervention with her pregnancy. At 10.30 pm it was concluded that S needed 'to be on [an] obstetrics ward'. There was a risk to her and the baby. S was saying that she 'would not be bothered if she dies and it would be better for the baby to be dead'. S herself recorded in writing her 'extreme objection to *any* medical or surgical intervention' and made it 'absolutely clear that it is against my wishes and I shall consider it an assault on my person'. *c* In the same articulate letter she explained her intention to seek legal advice at the earliest possible opportunity the next day and commented that she was 'not prepared to consent to admission to St George's Hospital for obstetric treatment'. Nevertheless at just before midnight on the night of 25–26 April, after a stay of no more than a few hours at Springfield Hospital, her transfer to St George's was completed. Those *d* responsible failed to act in accordance with the provisions of the 1983 Act and the 1983 regulations. Through an oversight, almost certainly brought about by what at that time was a very recent change in the arrangements between Springfield Hospital and St George's Hospital, and without any intentional abuse of power, the transfer and subsequent detention were unlawful. At St George's S was not *e* provided with the information prescribed by s 132 of the Act. S was transferred (not granted leave of absence under s 17 nor discharged under s 23) by those responsible for her detention into another place of detention prescribed by them against her wishes. She was not absent without leave for the purposes of s 18 of the Act. She was not at large; she did not absent herself from Springfield Hospital. She continued to be detained in accordance with what was wrongly believed to *f* have been a lawful transfer.

On admission to St George's, the reference letter recorded that S had been sectioned due to 'depressive illness'. She was immediately seen by Dr Green, a registrar in obstetrics. S's attitude was unchanged. She said she wanted to go to Wales where her baby would be born in a barn. When it was pointed out that her *g* baby might die, she responded that she was not interested in the pregnancy or the baby. Dr Green described her as slightly manic, plainly angry at having been detained against her will. She continued to suffer from severe pre-eclampsia.

She was seen very briefly by a consultant obstetrician and gynaecologist, Mr Sultan, before what proved to be a long and unsettled night. In the morning she *h* continued to refuse any examination of the foetal heart. When Mr Sultan saw her at about 8.45 am S was even more determined to refuse treatment or investigation. Her condition caused increasing concern and anxiety to the medical team responsible for her and the unborn child. They consulted Andrea Sutcliffe, the general manager of the hospital. At that time they believed that 'as the *j* psychiatrist has mapped out that treatment cannot be given to [S] due to the fact that the s 2 only allows for assessment', and since her condition 'does not affect her mental health, no further action can be taken. Her wishes need to be respected.' It was thought imperative that legal advice should be sought, and Andrea Sutcliffe contacted Messrs Bevan Ashford, the solicitors to the NHS trust. Among the subjects raised in her discussion with Simon Lindsay of that firm, were S's ability to consent to treatment and whether her condition was life-threatening. At that

stage the response to both questions was affirmative. However those questions having been raised, S was once again examined by Dr Jeffreys, this time at St George's Hospital. The precise time of the examination is unclear but it began at approximately 11.30.

Dr Jeffreys recorded that S appeared 'at times to be sad and distressed' but denied feeling depressed or having suffered any biological symptoms of depression recently. She noted that S continued to be 'profoundly indifferent to the fact that she could die or be severely brain damaged if the pre-eclampsia is not treated'. According to the record of the examination, S provided an inconsistent explanation for her attitude. For example, she had said on 25 April that she was 'terrified' of needles and injections, but during this examination said that she was not. She could not 'adequately explain' to Dr Jeffreys why she cared so little about what happened to her, but continued to assert her belief that pregnancy was a natural process and any intervention was to be avoided. Dr Jeffreys noted that she appeared to 'fully understand' the interventions proposed, the reasons for them and the serious, life-threatening consequences of refusal and at the end of the examination, recorded that S's capacity to consent to treatment 'appears to be intact' and expressed the opinion that her 'mental state is not affecting her capacity to consent'.

S was invited to explain the reasons for her views. She did so, in her own writing, in unequivocal and again highly articulate terms:

> 'At the request of Dr Jeffreys, senior registrar, I am writing in an effort to clarify my views, and reasons for upholding them so strongly, with regard to medical or surgical intervention in the case of illness (specifically at this time; pre-eclampsia). (i) I am a qualified veterinary nurse, and am therefore quite able to comprehend the medical terminology used, and feel happy to ask for clarification if an unfamiliar term is used. (ii) I fully understand that pre-eclampsia is a potentially life threatening condition, ie that the raised blood pressure may lead to haemorrhage, shock and, if untreated, death; or alternatively death due to total organ failure resulting from inability to compensate. (iii) I have always held very strong views with regard to medical and surgical treatments for myself, and particularly wish to allow nature to "take its course", without intervention. I fully understand that, in certain circumstances this may endanger my life. I see death as a natural and inevitable end point to certain conditions, and that natural events should not be interfered with. It is not a belief attached to the fact of my being pregnant, but would apply equally to any condition arising.'

In the meantime S remained extremely angry about her detention and, no doubt, under some stress at the repeated questioning which had taken place. She contacted solicitors by telephone. The hospital records show that between 12.00 and 13.00 she spent half an hour talking to them. Her solicitor, Mr William Bailey, advised her that she was entitled to refuse medical treatment if she wished to do so. This coincided with S's own understanding. It is clear from the hospital records that by 13.00 on 26 April it was appreciated by those responsible for the care and treatment of S that her refusal to consent to any form of interference with her pregnancy was unchanged, and that in accordance with the intention expressed in her letter on 25 April, she had found and consulted her own legal adviser. Furthermore whatever may have happened subsequently, it was still believed by the psychiatrist who had played a significant part in the decision to admit her to hospital under s 2 of the Act, that her capacity to consent was intact.

The application, on behalf of the hospital, to the court, was made by Mr Nigel Pitt of counsel during the lunch-time adjournment. Before making it he had spoken to Joanna Lloyd of Bevan Ashford. He understood from her that S had been in labour for 24 hours and that her life and the life of her unborn child were in danger. He spoke to the medical staff, including those responsible for the care and treatment of the pregnancy, to Andrea Sutcliffe and to Dr Jeffreys herself. According to his recollection Dr Jeffreys advised him that S's 'capacity' for consent 'was intact', adding that 'it could be affected by a mental/psychiatric state'. He was also told that S appreciated the potentially fatal consequences if treatment were refused and 'was not making her decision under the influence of any other person or any wrong assumption or misunderstanding of the facts'. He was advised by Mr Sultan that without investigations or treatment it was 'very likely that the baby would die and probable that S would die', and that 'every minute counted'.

Labour had not started. Quite how Mr Pitt came to be given the information that S had been in labour for 24 hours remains unclear. Dr Jeffreys however, confirms that when they spoke, she told Mr Pitt that in her opinion S was 'capable of consenting or refusing treatment'. She subsequently thought about this problem and discussed it at length with a consultant forensic psychiatrist at Springfield over the telephone and briefly with another consultant psychiatrist at Springfield at a meeting. Later that day she was to discuss the same question with Simon Lindsay, one of the solicitors from Bevan Ashford, and for a short while, to modify her opinion.

Arrangements were made for an ex parte application to be made on behalf of the hospital authority during lunch-time. At the hearing before Hogg J no evidence was tendered. Instead, in accordance with normal practice when an application is very urgent, the formalities were temporarily put on one side. Mr Pitt told the judge that S had been in labour for about 24 hours, thus inadvertently misleading the judge. He said that S was suffering from severe pre-eclampsia and that without treatment, both she and the foetus would probably die. The judge understood him to be saying that, having spoken to the doctor, this was a 'life and death situation and with minutes to spare'. Counsel agreed. The judge's attention was drawn to the fact that S had been admitted under s 2 for an assessment of her mental and psychiatric condition, that the assessment was 'ongoing' and that to date only 'moderate depression' had been diagnosed. The mother was refusing 'any sort of intervention'. Beyond that, the question of her capacity to consent was not addressed. The judge did not ask about it; counsel did not volunteer the information he had recently received from Dr Jeffreys. Mr Philip Havers QC suggested that the topic was not addressed at all because it was assumed throughout the hearing that S was competent. If so, it is, to put it no higher, most unfortunate that no one at the hearing appreciated the fundamental importance of this fact, and as it was, Hogg J knew no more than that S had been admitted for assessment as a Mental Health Act patient.

Mr Pitt drew the attention of the judge to Powers and Harris *Medical Negligence* (2nd edn, 1994) together with the decision of Sir Stephen Brown P in *Re S (adult: refusal of medical treatment)* [1992] 4 All ER 671, [1993] Fam 123 and to the passage in *Powers and Harris* quoting the observations of Balcombe LJ, in *Re F (in utero)* [1988] 2 All ER 193, [1988] Fam 122 in which he pointed out that the exercise of control over the mother of an unborn child affected the liberty of the individual. Hogg J took note of the decision and decided that she should follow *Re S*. Attention was not drawn to the decision of the House of Lords in *F v West Berkshire*

Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545, [1990] 2 AC 1.

The hearing concluded without the judge being informed that S had already instructed solicitors, nor that she and her solicitors were ignorant of the proceedings. No reference was made at the hearing to the possible involvement of the Official Solicitor. At that time no one appreciated that S was not lawfully detained at St George's Hospital.

The judge had asked how far advanced labour had been. When her question was put to the hospital's legal advisers it was treated as irrelevant. As the judge did not take up the question again and made her decision without further reference to it, there is no advantage in dwelling on the discourtesy to the court revealed by this response. At the hearing of an urgent ex parte application, the judge is entitled to be given accurate answers to any questions which she thinks relevant. Furthermore nothing was done subsequent to the hearing to make sure that the proper formalities were complied with. Indeed technically no proceedings ever existed and no affidavit evidence from the hospital confirming what Mr Pitt had said to the judge was filed. These omissions should not recur.

The declaration granted to St George's Healthcare (NHS Trust) was in the following terms:

> 'And notwithstanding the purported refusal to consent of S It is declared that: (1) all necessary investigations for the purposes of diagnosing the cause of and treating her severe pre-eclampsia may be performed (2) all necessary investigations of her foetus for the purpose of deciding upon the most appropriate course of delivery may be performed (3) there be leave to carry out such treatment to mother and foetus as may be deemed necessary following such investigations, including Caesarean section by general anaesthetic.'

Initially the word 'agreed' appeared in the order immediately before 'anaesthetic'; it was subsequently replaced with the word 'general' which accurately reflected what the judge had said.

Costs were reserved. If there was thought to be any difficulty about the welfare of the child when it was born Hogg J indicated that she would be available. She added 'if the mother wishes to appeal this case it means that it has worked', an observation which is difficult to understand, unless perhaps she was a referring to the fact that this would mean that the mother's life had been saved.

In the meantime after her discussions with Mr Lindsay, Dr Jeffreys reconsidered the conclusion she had expressed earlier, that S's capacity to consent was not affected by her mental state. She amended her note to read 'in my opinion her capacity to consent however *may* be affected by her current mental state'. She noted that mental disorder 'cannot be excluded even though diagnosis may not be clear' and recorded this as a late entry based on a revised opinion. The way in which she had expressed herself to Simon Lindsay of Bevan Ashford was that 'she could not exclude the possibility that her mental state might affect her consent. That she could not definitely say that it did. She [meaning S] appreciated the risks'. She [the judge] considered the decision in *Re C (adult: refusal of medical treatment)* [1994] 1 All ER 819, [1994] 1 WLR 290 and added that this was a case of 'profound indifference to whether she ended up alive or dead'.

The declaration having been made, and Andrea Sutcliffe having been notified of it, she made arrangements for the effect of the order to be explained to S by Dr Jeffreys. S reiterated her objection to any form of medical intervention.

Just after 17.00 the copy order made by Hogg J was shown to her [S] by Andrea Sutcliffe, who expressed sympathy with her. S seemed very tired and although she continued to reject any treatment, Andrea Sutcliffe thought that she appeared 'resigned' to it, a view which, according to affidavit evidence, was not shared by others who were present at the time. S queried the wording of the order and asked that the copy order should be faxed to her solicitors. At the time the word 'agreed' was still included. Shortly afterwards S spoke to her solicitor. After the end of the telephone call S made no gesture of 'positive resistance'. In fact she had decided that to struggle physically and be overcome would be undignified. She therefore lay still offering no resistance when, at about 17.20, she was sedated. Shortly afterwards her solicitors telephoned Bevan Ashford.

Some concern arose from the wording of the copy order which S's solicitor interpreted as merely meaning that the anaesthetic had to be agreed with his client. That is consistent with what S said he had advised her. The wording of the order was eventually cleared, but in any event, by the time of this telephone call, the process which ultimately led to the Caesarean section was now underway.

A catheter was inserted at 18.30. The foetal heart was then monitored. Signs of foetal distress became evident. It was decided that an emergency Caesarean section should be performed. At 20.35 when invited to do so, S expressly refused to sign the appropriate consent form. She was anaesthetised. The operation proceeded on the basis of Hogg J's order. Her baby was born by Caesarean section at 22.00.

To the extent that it is suggested that by co-operating with the medical process from just after 17.00, or at any rate by not actively opposing the process, S had consented to the operation, her reaction when asked to sign the appropriate form at 20.35 demonstrates beyond question that her position remained unchanged. Even if that document had not been available the overwhelming impression created by the contemporary documents, which needs no additional support from affidavit evidence, is that she never at any stage consented or appeared to consent. Under the pressures of an exhausting and emotionally charged situation, and faced with the court order, S ceased to offer any resistance. This was not consent but submission.

It is also suggested that the court should now review the evidence relating to S's competence or capacity to give or refuse her consent and to infer from the contemporaneous documents that it was lacking. Even in the light of the material referred to by Mr Havers there is no possible basis for approaching this case differently to the way in which he himself says that it was presented to Hogg J on behalf of his clients. S knew perfectly well what she was doing; without resort to any presumptions, and however the question is tested, there is no sufficient evidence from which to conclude that her competence on 26 April was in question. That conclusion is reinforced by the decision to make one last effort to obtain her consent to treatment at 20.35; if she was not thought competent at that stage, the exercise was a complete waste of time.

After another restless night S woke at 7.15 am. She was very angry that the hospital had gone against her wishes and complained of physical assault. When she was told that it was done for her benefit and that of her baby she remarked that it was 'a matter of opinion'. Throughout 27 April she continued to be very angry and resentful at what had happened and dismissive of the baby which she rejected, at that time seeking her adoption.

S remained at St George's Hospital receiving postnatal care throughout 28 and 29 April. Her attitude was unchanged. On 29 April Dr Jeffreys saw her again and

reviewed the psychiatric situation. She noted that S remained 'extremely angry and upset about the events of the last few days' reiterating the same opinions consistently expressed to Dr Jeffreys on earlier occasions. She held them 'tenaciously', appearing unable to reflect on it and either 'unable or unwilling to think about what might have happened if we had not intervened … or to consider the future welfare of the baby'. The diagnosis remained unclear with '? atypical depression, c strong denial, ? personality factors interacting with life events'.

By the morning of 30 April it was no longer necessary for S to be cared for at St George's Hospital. She was therefore transferred back to Springfield Hospital, leaving St George's at 17.30 by ambulance. She spoke briefly to her solicitor and asked him to appeal to a mental health review tribunal.

On the following day S was examined by her responsible medical officer Dr Fisher, a consultant psychiatrist. Although she was still angry, distancing herself from her baby, he could find no clear evidence of mental illness, at any rate in the sense that there 'were no current abnormalities in her mental state'. In any event S did not represent any significant continuing risk to anyone. By the next day he decided that the s 2 order should be discharged. Although S was encouraged to remain at Springfield she rapidly discharged herself.

We can now consider the issues of principle which arise in this appeal.

Autonomy

Even when his or her own life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination. Lest reiteration may diminish the impact of this principle, it is valuable to recognise the force of the language used when the right of self-determination was most recently considered in the House of Lords in *Airedale NHS Trust v Bland*:

> 'The first point to make is that it is unlawful, so as to constitute both the tort and crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent see *F v West Berkshire Health Authority* (*Mental Health Act Commission intervening*) [1989] 2 All ER 545, [1990] 2 AC 1. Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die.' (See [1993] 1 All ER 821 at 860, [1993] AC 789 at 857 per Lord Keith.)

> '… it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that, if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even … though they do not consider it to be in his best interests to do so … To this extent, the principle of the sanctity of human life must yield to the principle of self-determination … and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified.' (See [1993] 1 All ER 821 at 866, [1993] AC 789 at 864 per Lord Goff of Chieveley.)

> 'Any treatment given by a doctor to a patient which is invasive (i e involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient: it constitutes the crime of battery and the tort of trespass to the person. Thus, in the case of an adult who is mentally competent, the artificial feeding regime (and the attendant steps necessary to evacuate the bowels and bladder) would be unlawful unless the patient

consented to it. A mentally competent patient can at any time put an end to life support systems by refusing his consent to their continuation.' (See [1993] 1 All ER 821 at 881–882, [1993] AC 789 at 882 per Lord Browne-Wilkinson.)

'Any invasion of the body of one person by another is potentially both a crime and a tort … How is it that, consistently with the proposition just stated, a doctor can with immunity perform on a consenting patient an act which would be a very serious crime if done by someone else? The answer must be that bodily invasions in the course of proper medical treatment stand completely outside the criminal law. The reason why the consent of the patient is so important is not that it furnishes a defence in itself, but because it is usually essential to the propriety of medical treatment. Thus, if the consent is absent, and is not dispensed with in special circumstances by operation of law, the acts of the doctor lose their immunity … If the patient is capable of making a decision whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue.' (See [1993] 1 All ER 821 at 889, [1993] AC 789 at 891 per Lord Mustill.)

The speeches in *Airedale NHS Trust v Bland* did not establish the law, but rather underlined the principle found in a series of authoritative decisions. With the exception of one short passage from the observations of Lord Reid in *S v S, W v Official Solicitor* [1970] 3 All ER 107, [1972] AC 24 no further citation is necessary.

In that case the House of Lords considered whether it was right to order blood tests on two infants to help establish whether or not they were legitimate. Lord Reid examined the legal position and said ([1970] 3 All ER 107 at 111, [1972] AC 24 at 43):

'There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will … The real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion; and often it is the first step that counts. So it would be unwise to make even minor concessions.'

The importance of this salutary warning remains undiminished.

There are occasions when an individual lacks the capacity to make decisions about whether or not to consent to treatment. This may arise when he is unconscious or suffering from mental disability. This question will have to be examined more closely in due course, but dealing with it generally for the moment, where the adult patient is disabled from giving consent the medical practitioners must act in his best interests and if appropriate, may carry out major invasive surgery without express consent.

The status of the foetus

Ignoring those occasions when consent may be implied or dispensed with on the ground of incapacity, each woman is entitled to refuse treatment for herself. It does not follow without any further analysis that this entitles her to put at risk the healthy viable foetus which she is carrying. Concern for the sanctity of human life led Lord Donaldson MR in *Re T (adult: refusal of medical treatment)* [1992] 4 All

ER 649 at 653, [1993] Fam 95 at 102 to express a degree of hesitation against making any such assumption.

> 'An adult patient who … suffers from no mental incapacity has an absolute right to choose … one rather than another of the treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable foetus. That is not this case and, if and when it arises, the courts will be faced with a novel problem of considerable legal and ethical complexity.'

(See also *Re S (adult: refusal of medical treatment)* [1992] 4 All ER 671, [1993] Fam 123, where Sir Stephen Brown P granted a declaration that, notwithstanding her refusal of consent on religious grounds, a Caesarean section could be performed on a mother to save her life and that of her unborn child.)

Whatever else it may be, a 36-week foetus is not nothing; if viable, it is not lifeless and it is certainly human. In *A-G's Reference (No 3 of 1994)* [1997] 3 All ER 936, [1998] AC 245 the House of Lords considered the status of the foetus before birth in the context of an allegation of murder arising when a pregnant woman was stabbed and, following premature labour, gave birth to a child who survived for 121 days before dying as a result of the stabbing. The conclusion of the Court of Appeal was that the foetus should be treated as an integral part of the mother in the same way as any other part of her body, such as her foot or her arm. This view was rejected in the House of Lords.

Lord Mustill ([1997] 3 All ER 936 at 943, [1998] AC 245 at 255–256) explained the principle:

> 'There was, of course, an intimate bond between the foetus and the mother, created by the total dependence of the foetus on the protective physical environment furnished by the mother, and on the supply by the mother through the physical linkage between them of the nutriments, oxygen and other substances essential to foetal life and development. The emotional bond between the mother and her unborn child was also of a very special kind. But the relationship was one of bond, not of identity. The mother and the foetus were two distinct organisms living symbiotically, not a single organism with two aspects. The mother's leg was part of the mother; the foetus was not … I would, therefore, reject the reasoning which assumes that since (in the eyes of English law) the foetus does not have the attributes which make it a "person" it must be an adjunct of the mother. Eschewing all religious and political debate, I would say that the foetus is neither. It is a unique organism. To apply to such an organism the principles of a law evolved in relation to autonomous beings is bound to mislead.'

Lord Hope of Craighead agreed with Lord Mustill ([1997] 3 All ER 936 at 945, [1998] AC 245 at 267):

> 'It [the Human Fertilisation and Embryology Act 1990] serves to remind us that an embryo is in reality a separate organism from the mother from the moment of its conception. This individuality is retained by it throughout its development until it achieves an independent existence on being born. So the foetus cannot be regarded as an integral part of the mother in the sense indicated by the Court of Appeal, notwithstanding its dependence upon the mother for its survival until birth.'

Accordingly, the interests of the foetus cannot be disregarded on the basis that in refusing treatment which would benefit the foetus, a mother is simply refusing treatment for herself.

In the present case there was no conflict between the interests of the mother and the foetus; no one was faced with the awful dilemma of deciding on one form of treatment which risked one of their lives in order to save the other. Medically, the procedures to be adopted to preserve the mother and her unborn child did not involve a preference for one rather than the other. The crucial issue can be identified by expressing the problem in different ways. If human life is sacred why is a mother entitled to refuse to undergo treatment if this would preserve the life of the foetus without damaging her own? In the United States, where such treatment has on occasions been forced on an unwilling mother, this question has been described as 'the unborn child's right to live' and 'the State's compelling interest in preserving the life of the foetus' (*Jefferson v Griffin Spalding County Hospital Authority* (1981) 274 SE 2d 457) or 'the potentiality of human life' (in *Re Madyyun* (1986) 573 A 2d 1259). In *Winnipeg Child and Family Services (Northwest Area) v G* (1997) 3 BHRC 611, a decision which will need further examination, in his dissenting judgment Major J commented (at 645): 'Where the harm is so great and the temporary remedy so slight, the law is compelled to act … Someone must speak for those who cannot speak for themselves.' That said however, how can a forced invasion of a competent adult's body against her will even for the most laudable of motives (the preservation of life) be ordered without irremediably damaging the principle of self-determination? When human life is at stake the pressure to provide an affirmative answer authorising unwanted medical intervention is very powerful. Nevertheless, the autonomy of each individual requires continuing protection even, perhaps particularly, when the motive for interfering with it is readily understandable, and indeed to many would appear commendable; hence the importance of remembering Lord Reid's warning against making 'even minor concessions'. If it has not already done so, medical science will no doubt one day advance to the stage when a very minor procedure undergone by an adult would save the life of his or her child, or perhaps the life of a child of a complete stranger. The refusal would rightly be described as unreasonable, the benefit to another human life would be beyond value, and the motives of the doctors admirable. If however the adult were compelled to agree, or rendered helpless to resist, the principle of autonomy would be extinguished.

In *McFall v Shimp* (1978) 127 Pitts Leg J 14 Flaherty J used more dramatic language when sustaining the entitlement of a defendant to refuse to submit to treatment which would save the life of the plaintiff who suffered from a rare bone marrow disease and desperately required a bone marrow transplant from a compatible donor. It was not therefore a case involving a pregnant woman and her foetus. Nevertheless he highlighted the potential tensions:

> 'Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another. Many societies adopt a contrary view which has the individual existing to serve the society as a whole. In preserving such a society as we have it is bound to happen that great moral conflicts will arise and will appear harsh in a given instance … Morally this decision rests with the defendant, and in the view of the court, the refusal of the defendant is morally indefensible. For our law to *compel* the defendant to submit to an intrusion of his body would change every concept

and principle upon which our society is founded. To do so would defeat the sanctity of the individual …' (Flaherty J's emphasis.)

In the particular context of the mother's right to self-determination and the interests of her foetus, this tension was considered in *Re MB (an adult: medical treatment)* [1997] 2 FCR 541, 38 BMLR 175. In this most difficult area of the law, practical decisions affecting the rights of a mother and her unborn child and the position of those responsible for their care, frequently require urgent resolution without the luxury of time to analyse the complex ethical problems which invariably arise. Accordingly, with the advantage of detailed skeleton arguments, the relevant statutory provisions and authorities were closely studied.

Giving the judgment of the court, Butler-Sloss LJ said ([1997] 2 FCR 541 at 561):

> '… a competent woman who has the capacity to decide may, for religious reasons, other reasons, or no reasons at all, choose not to have medical intervention even though … the consequence may be the death or serious handicap of the child she bears or her own death. She may refuse to consent to the anaesthesia injection in the full knowledge that her decision may significantly reduce the chance of her unborn child being born alive. The foetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a Caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.'

As the mother in *Re MB* was found not to have been competent, strictly speaking this question did not arise for decision and, as Butler-Sloss LJ herself recognised, the observation was obiter.

It was however consistent with the reasoning in a line of authorities where a husband had made an unsuccessful application to prevent an abortion being performed on his wife: see *Paton v Trustees of BPAS* [1978] 2 All ER 987, [1979] QB 276 and *C v S* [1987] 1 All ER 1230, [1988] QB 135 and with *Re F (in utero)* [1988] 2 All ER 193 at 200, [1988] Fam 122 at 143, where, refusing an application that the foetus of an unstable pregnant woman should be made a ward of court, Balcombe LJ observed—

> 'there is no jurisdiction to make an unborn child a ward of court. Since an unborn child has, ex hypothesi, no existence independent of its mother, the only purpose of extending the jurisdiction to include the foetus is to enable the mother's actions to be controlled.'

He went on to consider the possibility that the court might be asked to order delivery of the baby by Caesarean section, and commented ([1988] 2 All ER 193 at 200–201, [1988] Fam 122 at 144):

> '… it would be intolerable to place a judge in the position of having to make such a decision without any guidance as to the principles on which his decision should be based. If the law is to be extended in this manner, so as to impose control over the mother of an unborn child, where such control may be necessary for the benefit of that child, then under our system of parliamentary democracy it is for Parliament to decide whether such controls can be imposed and, if so, subject to what limitations or conditions … If Parliament were to think it appropriate that a pregnant woman should be subject to controls for the benefit of her unborn child, then doubtless it will

stipulate the circumstances in which such controls may be applied and the safeguards appropriate for the mother's protection. In such a sensitive field, affecting as it does the liberty of the individual, it is not for the judiciary to extend the law.'

None of these authorities appears to have been cited either in *Re T* (*adult: refusal of medical treatment*) [1992] 4 All ER 649, [1993] Fam 95 (probably because they were not strictly relevant) or in *Re S* (*adult: refusal of medical treatment*) [1992] 4 All ER 671, [1993] Fam 123, referred to earlier and, although obiter, the principle encapsulated in the language used by Butler-Sloss LJ in *Re MB* (*an adult: medical treatment*) [1997] 2 FCR 541, 38 BMLR 175 reflected the existing state of the law.

A number of authorities from outside this jurisdiction were cited in the present case which were not before the court in *Re MB*. However it is unnecessary to go beyond the decision of the Supreme Court of Canada given on 31 October 1997 in *Winnipeg Child and Family Services* (*Northwest Area*) *v G* (1997) 3 BHRC 611.

The mother was five months pregnant and addicted to glue sniffing. In consequence two of her previous children had been born with permanent disability. On the basis of parens patriae jurisdiction (not available in England, nor in view of the judgment of the Supreme Court, in Canada) it was ordered that the mother should be detained for treatment prescribed by the director of Child & Family Services. The objective was the protection of the unborn child. The Court of Appeal in Manitoba set aside the order. The Supreme Court (by a seven-two majority) confirmed the decision of the Court of Appeal.

In a detailed judgment, McLachlin J giving the judgment of the majority observed (at 620, 622, 628):

> 'To permit an unborn child to sue its pregnant mother-to-be would introduce a radically new conception into the law; the unborn child and its mother as separate juristic persons in a mutually separable and antagonistic relation. Such a legal conception, moreover, is belied by the reality of the physical situation; for practical purposes, the unborn child and its mother-to-be are bonded in a union separable only by birth … "… Judicial intervention … ignores the basic components of women's fundamental human rights—the right to bodily integrity, and the right to equality, privacy, and dignity … The fetus' complete physical existence is dependent on the body of the woman. As a result, any intervention to further the fetus' interests will necessarily implicate, and possibly conflict with the mother's interests. Similarly, each choice made by the woman in relation to her body will affect the fetus and potentially attract tort liability." [See Royal Commission Report on New Reproductive Technologies *Proceed with Care* (1993) vol 2, pp 957–958.] … the common law does not clothe the courts with power to order the detention of a pregnant woman for the purpose of preventing harm to her unborn child. Nor, given the magnitude of the changes and their potential ramifications, would it be appropriate for the courts to extend their power to make such an order.'

Mr Havers invited us to follow the reasoning in the dissenting judgment delivered by Major J. We decline to do so. Quite apart from the problem that the parens patriae jurisdiction on which the dissenting judgment depended has no more validity in this jurisdiction than it does in Canada, the reasoning of the majority coincides with the approach of this court in *Re MB*, reinforced by the observations of Lord Mustill and Lord Hope in *A-G's Reference* (*No 3 of 1994*) [1997] 3 All ER 936,

[1998] AC 245. In the later part of his speech Lord Mustill said ([1997] 3 All ER 936 at 948, [1998] AC 245 at 261):

> 'It is sufficient to say that it is established beyond doubt for the criminal law, as for the civil law (*Burton v Islington Health Authority, de Martell v Merton and Sutton Health Authority* [1992] 3 All ER 833, [1993] QB 204) that the child en ventre sa mère does not have a distinct human personality, whose extinguishment gives rise to any penalties or liabilities at common law.'

In a final observation relevant to the issues in the present case he added ([1997] 3 All ER 936 at 949, [1998] AC 245 at 262):

> 'The defendant intended to commit and did commit an immediate crime of violence to the mother. He committed no relevant violence to the foetus, which was not a person, either at the time or in the future, and intended no harm to the foetus or to the human person which it would become.'

The reasoning which led Lord Hope of Craighead to conclude that the crime of manslaughter could be committed reinforced this observation. After examining the submission based on the proposition that manslaughter could not be established where the victim of an unlawful violent act was already dead, he continued ([1997] 3 All ER 936 at 957, [1998] AC 245 at 271):

> 'If the person is already dead, his life is over and no further harm can be done. No act which is done to him now or in the future can be dangerous. The mens rea which a person has when doing an unlawful act to a person who is dead is not that which is required for manslaughter. So also a person who is already dead cannot be within the scope of the mens rea which the defendant has when he does an unlawful and dangerous act to someone who is alive.'

He then went on to examine the 'different problem' of the foetus. He said ([1997] 3 All ER 936 at 957, [1998] AC 245 at 271):

> 'For the foetus, life lies in the future, not the past. It is not sensible to say that it cannot ever be harmed, or that nothing can be done to it which can ever be dangerous. Once it is born it is exposed, like all other living persons, to the risk of injury. It may also carry with it the effects of things done to it before birth which, after birth, may prove to be harmful. It would seem not to be unreasonable therefore, on public policy grounds, to regard the child in this case, when she became a living person, as within the scope of the mens rea which B had when he stabbed her mother before she was born.'

At the conclusion of his speech he said ([1997] 3 All ER 936 at 960, [1998] AC 245 at 274):

> 'The fact that the child whom the mother was carrying at the time was born alive and then died as a result of the stabbing is all that was needed for the offence of manslaughter when actus reus for that crime was completed by the child's death.'

In essence if the child had not been born alive she could not have been the victim of manslaughter. The language of Lord Hope demonstrates that the concept of being 'born alive', rejected in his dissenting judgment by Major J in *Winnipeg Child and Family Services (Northwest Area) v G,* remains undiminished.

In our judgment while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways set out in the judgment in *Re MB*, an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant. The declaration in this case involved the removal of the baby from within the body of her mother under physical compulsion. Unless lawfully justified, this constituted an infringement of the mother's autonomy. Of themselves, the perceived needs of the foetus did not provide the necessary justification.

The Mental Health Act 1983

The Act cannot be deployed to achieve the detention of an individual against her will merely because her thinking process is unusual, even apparently bizarre and irrational, and contrary to the views of the overwhelming majority of the community at large. The prohibited reasoning is readily identified and easily understood. Here is an intelligent woman. She knows perfectly well that if she persists with this course against medical advice she is likely to cause serious harm, and possibly death, to her baby and to herself. No normal mother-to-be could possibly think like that. Although this mother would not dream of taking any positive steps to cause injury to herself or her baby, her refusal is likely to lead to such a result. Her bizarre thinking represents a danger to their safety and health. It therefore follows that she *must* be mentally disordered and detained in hospital in her own interests and those of her baby. The short answer is that she may be perfectly rational and quite outside the ambit of the Act, and will remain so notwithstanding her eccentric thought process.

Even when used by well-intentioned individuals for what they believe to be genuine and powerful reasons, perhaps shared by a large section of the community, unless the individual case falls within the prescribed conditions, the Act cannot be used to justify detention for mental disorder:

> '… no adult citizen of the United Kingdom is liable to be confined in any institution against his will, save by the authority of the law. That is a fundamental constitutional principle, traceable back to Ch 29 of Magna Carta 1297 (25 Edw 1 c 1) and before that to Ch 39 of Magna Carta (1215) … Powers therefore exist to ensure that those who suffer from mental illness may, in appropriate circumstances, be involuntarily admitted to mental hospitals and detained. But, and it is a very important but, the circumstances in which the mentally ill may be detained are very carefully prescribed by statute.' (See *Re S-C (mental patient: habeas corpus)* [1996] 1 All ER 532 at 534–535, [1996] QB 599 at 603 per Bingham MR.)

In *R v Hallstrom, ex p W (No 2), R v Gardner, ex p L* [1986] 2 All ER 306 at 314, [1986] QB 1090 at 1104 McCullough J used language which encapsulated an axiomatic principle:

> 'There is … no canon of construction which presumes that Parliament intended that people should, against their will, be subjected to treatment which others, however professionally competent, perceive, however sincerely and however correctly, to be in their best interests … Parliament is

> presumed not to enact legislation which interferes with the liberty of the subject without making it clear that this was its intention. It goes without saying that, unless clear statutory authority to the contrary exists, no one is to be detained in hospital or to undergo medical treatment or even to submit himself to a medical examination without his consent. This is as true of a mentally disordered person as of anyone else.'

So even assuming lawful admission and detention in accordance with the 1983 Act, the patient is not deprived of all autonomy. Part IV of the Act provides a carefully structured scheme setting out the circumstances in which the patient's consent to treatment may be dispensed with. Section 63 of the Act may apply to the treatment of any condition which is integral to the mental disorder (*B v Croydon Health Authority* [1995] 1 All ER 683, [1995] Fam 133) provided the treatment is given by, or under the direction of, the responsible medical officer. The treatment administered to S was not so ordered; she was neither offered nor did she refuse treatment for mental disorder. Her detention under the Act did not undermine or restrict her right to self-determination unless she was deprived, 'either by long term mental capacity or retarded development or by temporary factors such as unconsciousness or confusion or the effects of fatigue, shock, pain or drugs', of her capacity to decide for herself. (See *Re JT (an adult: refusal of medical treatment)* [1998] 1 FLR 48.)

In *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649, [1993] Fam 95 Lord Donaldson MR set out a number of principles of general application for patients detained under the Act. Although these principles have been considered and extended in a number of subsequent cases, including *Re C (adult: refusal of medical treatment)* [1994] 1 All ER 819, [1994] 1 WLR 290, for present purposes it is sufficient to notice his observation:

> 'What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health. Others may not.' (See [1992] 4 All ER 649 at 664, [1993] Fam 95 at 116.)

In the final analysis, a woman detained under the Act for mental disorder cannot be forced into medical procedures unconnected with her mental condition unless her capacity to consent to such treatment is diminished. When she retains her capacity her consent remains an essential prerequisite and whether she does, or not, must be decided on the basis of the evidence in each individual case, care being taken by those responsible for the detention of the patient, and indeed any court considering the problem, to ensure that the prohibited reasoning identified earlier in this judgment is avoided in relation to consent as it is with admission and detention under the Act.

Application for admission under s 2

It is clear that everyone involved in the process which led to S's admission, Louize Collins and both Dr Chill and Dr Jeffreys, was equally motivated by a genuine desire to achieve what, in their professional judgment, was best for S herself and for her baby. It is equally clear that S utterly rejected their well intentioned efforts to help her. She knew the risks. She was quite prepared to accept them. She was not willing to change her mind. She said that she saw birth as an entirely natural occurrence in which there was no place for medical or surgical intervention.

Faced with the serious consequent risk to the health of their babies very many mothers would be prepared to compromise with their beliefs. Many doctors would believe that for them to do nothing in the face of such intransigence, at least for the sake of the unborn child, was not consistent with the ethics which underpin their profession.

We have been asked to consider the impact of an adverse judgment on Louize Collins—a 'stigma' on her career. We should be astonished if it were to have any such effect. At the very worst it would mean that she had made a mistake that had taken volumes of papers, days of legal argument and the measured reflection of this court to identify. Whatever our conclusion we admire her courage in reaching any decision at all in such difficult circumstances when faced with a life and death situation and an unusual, unreasonable mother to be. Indeed at the end of the hearing, notwithstanding the somewhat extravagant allegations contained in the Form 86A, Mr Richard Gordon QC summarised the case against her in language which cannot amount to a stigma: 'For humane reasons she has erred in law.' Any errors for which Dr Chill and Dr Jeffreys were responsible should attract a similar compliment. We are not at all concerned with possible stigma; either the application for admission under s 2 should be judicially reviewed, or it should not.

Section 2(2) provides:

> 'An application for admission for assessment may be made in respect of a patient on the grounds that—(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.'

Mr Gordon submitted that there were a number of grounds for concluding that this application was unlawful. He suggested that Louize Collins acted for a collateral motive, that is to save S and the unborn child, rather than for the purpose of assessing S's mental condition and that she failed to take into account that the detention of S could not be justified unless she lacked capacity to make an informed decision for herself. He also suggested that she acted on the basis of defective medical recommendations and that Dr Chill and Dr Jeffreys, like her, focused on the same collateral consideration and equally failed to address the issue of capacity. Moreover he suggested that their diagnosis of mental disorder was provisional rather than conclusive and accordingly fell outside the statutory provisions.

Under s 13(1) of the Act it is the duty not of the doctors, but of an approved social worker, to make an application under s 2, where satisfied 'that such an application ought to be made and … of the opinion … that it is necessary or proper for the application to be made'. Moreover the social worker must be satisfied that 'detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need' (see s 13(2)).

These provisions make clear that the social worker must exercise her own independent judgment on the basis of all the available material, including her interview and assessment of the 'patient', and personally make the appropriate decision. When doing so she is required to take account of the recommendations made by the medical practitioners. Indeed the application must be 'founded' on their written recommendations (s 2(3)). The doctors too are required to make their recommendations on the basis of their best judgment of the relevant facts

and, while eschewing the prohibited reasoning, decide whether the conditions provided in s 2(2) are satisfied. An application made for an improper or collateral purpose (*R v Wilson, ex p Williamson* [1996] COD 42), or flawed in the *Wednesbury* sense (see *Associated Provincial Picture Houses Ltd v Wednesbury Corp* [1947] 2 All ER 680, [1948] 1 KB 223) (*R v South Western Hospital Managers, ex p M* [1994] 1 All ER 161 at 176, [1993] QB 683 at 700) would be susceptible to judicial review; so would similarly tainted recommendations by the medical practitioners.

A patient is an individual 'suffering or appearing to be suffering from mental disorder' (s 145) and mental disorder extends to 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind' (s 1(2)). Applied to the present case, the necessary care and treatment for S's pregnancy would not fall within s 13.

There was considerable argument about the proper approach to the pregnancy. Mr Gordon suggested that the existence of the unborn child was a wholly irrelevant consideration. As far as the prohibited reasoning is concerned, we agree. We repeat that S's pregnancy would not have been sufficient on its own to bring the provisions of s 13 into play. Nevertheless the pregnancy was not irrelevant. In deciding whether it is 'necessary or proper' to make an application under s 2, the approved social worker has to approach the individual 'patient' as she is, or at any rate as on the best analysis she can make at the time, the patient appears to be. S was heavily pregnant; that was an indisputable fact. She was also adamantly refusing treatment for complications arising from her pregnancy, another certain fact. The possible consequences if she continued to refuse treatment and her attitude to the consequences all formed part of the material on which Louize Collins had to make her judgment. To require her to do so by ignoring reality would be absurd, making a sometimes desperately delicate assessment virtually impossible. Our conclusion is supported by the observations of Lord Mustill in *A-G's Reference (No 3 of 1994)* [1997] 3 All ER 936, [1998] AC 245, referred to earlier in this judgment, about the profound physical and emotional bond between the unborn child and its mother. Therefore the facts that S was heavily pregnant and adamantly refusing treatment were, at least potentially, of compelling importance to any informed judgment.

The application for S's admission was made, not under s 3, but under s 2 of the Act. These are distinct provisions with significant differences between them. For present purposes it is sufficient to notice that the application under s 3 is admission for treatment whereas under s 2 the application is made for 'admission for assessment', and that whereas the basis for admission under s 2 is mental disorder, under s 3 treatment involves a more closely detailed diagnosis of the precise form of mental disorder from which the patient is suffering.

Before an application for assessment may be made, each of the specified grounds provided in s 2(2) must be established. They are cumulative. There was considerable discussion whether s 2(2)(a) required a final or provisional diagnosis of mental disorder. Section 2 is directed to admission for 'assessment' and not a final diagnosis. In *R v Kirklees Metropolitan BC, ex p C* [1993] 2 FCR 381 at 383, [1993] 2 FLR 187 at 190 Lloyd LJ commented:

> '… there is, in my view, power to admit a patient for assessment under s 2, if he appears to be suffering from mental disorder, on the ground that he or she is so suffering, even though it turns out on assessment that she is not. Any other construction would unnecessarily emasculate the beneficial power under s 2 and confine assessment to choice of treatment.'

In our judgment at the time when the application for admission for assessment is made, the social worker should believe that the patient is suffering from mental disorder which warrants detention for such assessment. It cannot be a final concluded diagnosis. She is entitled to be wrong; so are the medical practitioners on whose recommendations her application is based. The final diagnosis may or may not confirm what can only be a provisional view formed, in the case of the social worker, by an individual who is not medically qualified. None of these considerations would vitiate an application made by a social worker who reasonably believed that the statutory conditions were fulfilled. The same principles apply to the medical practitioners.

Mr Gordon further argued that Louize Collins and the doctors failed to attend to the question of S's capacity to consent or refuse consent to treatment. None of the contemporary documents suggests that this factor was given express attention during the decision-making process. Accordingly Mr Gordon suggests that a material consideration was ignored. In the sense that all the circumstances should be taken into account, S's capacity to consent, or its absence, would be one relevant consideration. However an argument based on the omission of any express reference to a feature identified in the course of his submissions by counsel should be approached with some care. The question to be addressed is whether the application falls within the statutory criteria; if it does then the social worker has to form her judgment whether it is necessary or proper to make the application. She is not required to go through a checklist of all the possible criteria. In this case Louize Collins was advised that S's mental state might be 'compromising her ability to make decisions'. In the general context of applications under s 2, an omission to deal more directly with the issue of S's capacity to consent would not of itself provide any sufficient basis for interfering with the decision to make the application. That said, in this particular case we cannot avoid reflecting whether the omission underlines that the urgent concern of the social worker and doctors was the need somehow to save the mother and her unborn child.

We can now return to s 2(2). The first requirement of s 2(2)(a) is that the patient should be suffering from mental disorder. Mental disorder includes any 'disorder or disability of mind'. Conditions such as promiscuity or alcohol or drug dependency are excluded. We do not doubt that reactive depression (not merely a transient sense of being 'a little down' or 'fed up with everything') is capable of amounting to mental disorder. The second requirement is that even if the patient suffers from mental disorder it must be of 'such a nature or degree' that the patient's *detention* for assessment or assessment followed by treatment is warranted. For the purposes of s 2(2)(a), such detention must be related to or linked with mental disorder. Treatment for the effects of pregnancy does not provide the necessary warrant. Turning to s 2(2)(b), and assuming that the requirements of s 2(2)(a) were otherwise fulfilled, for the reasons already given the unborn child is not a 'person' in need of protection. The only 'person' whose health and safety arose for consideration was S. Again, for the reasons already given, her health and safety could not be assessed on the basis that she was not 36 weeks pregnant and not suffering from pre-eclampsia. Those responsible have to deal in realities, and S was dangerously ill. Although the risks were caused by her pregnancy, the potential damage could have fallen within s 2(2)(b).

We can now consider the submissions made by Mr Gordon in the light of the summary of the facts outlined earlier in this judgment. On the basis of the material available to them, Louize Collins and the doctors were entitled to conclude that S

was suffering from mental disorder. Her refusal of treatment which would assist both her and her baby was unusual and unreasonable. Unassisted by human hands, nature's course involved the risk of death or disability for herself and her baby. She was profoundly indifferent to these consequences; an abnormal state of mind. Each doctor diagnosed depression. It was a view based on a report of earlier depression from another doctor who knew S and their own lengthy examination and discussion with her. Each completed the prescribed form because she believed that S 'was suffering from mental disorder' which warranted her admission for assessment and set out her reasons.

The contemporaneous documents themselves demonstrate that those involved in the decision to make an application for admission failed to maintain the distinction between the urgent need of S for treatment arising from her pregnancy, and the separate question whether her mental disorder (in the form of depression) warranted her detention in hospital. From the reasoning to be found in them, the conclusion that the detention was believed to be warranted in order that adequate provision could be made to deal with S's pregnancy and the safety of her unborn child is unavoidable. The reasoning process emerges most strongly from Louize Collins' assessment. She expressly acknowledged that a psychiatric ward was not 'the best place' for S (a judgment confirmed by the very brief period S remained in Springfield Hospital before being transferred to St George's). She believed, rightly, that S's condition was threatened by her very severe pre-eclampsia. At the time when she reached her conclusion she did not suggest that detention was required for the purpose of assessing S's mental condition or treating her depression. Put another way, if S had not been suffering from severe pre-eclampsia there is nothing in the contemporaneous documents to suggest that an application for her detention would have been considered, let alone justified.

We are satisfied that, notwithstanding our view that the requirements of s 2(2)(b) might well have been fulfilled, the cumulative grounds prescribed in s 2(2)(a) were not established. Therefore the application for admission was unlawful. Appropriate declaratory relief will be ordered.

Admission to Springfield Hospital

Section 6(1) provides:

> 'An application for the admission of a patient to a hospital … duly completed in accordance with the provisions of this Part of this Act, shall be sufficient authority … to take the patient and convey him to the hospital …'

Section 6(3) provides:

> 'Any application for the admission of a patient under this Part of this Act which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendation is made or given or of any matter of fact or opinion stated in it.'

It was argued that even if this application for admission were found to have been unlawful the admission itself and the subsequent detention at Springfield Hospital were not unlawful. Section 6(3) operated to protect the hospital from any liability. Mr Havers suggested that the form signed by Louize Collins and the doctors stated unequivocally that S fell within the statutory ground justifying the application for admission and that, notwithstanding any conclusion based on a prolonged analysis

of the explanatory sections of the forms, they appeared to be 'duly made'. No further proof was required.

In *Re S-C (mental patient: habeas corpus)* [1996] 1 All ER 532, [1996] QB 599 referred to earlier in this judgment, the Court of Appeal considered the impact of s 6(3) where an application had been made for admission under s 3 of the Act in contravention of s 11(4). It was held that even when the application appeared to have been 'duly made' unless the relevant preconditions to admission had been complied with, the application itself would not have been 'duly completed' as required by s 6(1). Accordingly the application itself remained defective and the detention in hospital was unlawful.

Bingham MR pointed out that s 6 provided—

> 'protection for a hospital to which a patient is admitted or in which a patient is detained. Such a hospital is not at risk of liability for false imprisonment if it turns out that the approved social worker does not meet the definition in s 145(1), or if the recommendations which purport to be signed by registered medical practitioners are in truth not signed by such, although appearing to be so. That is obviously good sense. A mental hospital is not obliged to act like a private detective; it can take documents at face value. Provided they appear to conform with the requirements of the statute, the hospital is entitled to act on them.' (See [1996] 1 All ER 532 at 537, [1996] QB 599 at 605–606.)

Neill LJ reached the same conclusion, observing:

> 'The hospital must check the application, but if on careful checking the application appears to be duly made, the hospital can act on it. However, s 6(3) is not intended to prevent, nor can it have the effect of preventing, a court, if satisfied that the original application was not made in accordance with s 3 of the Act, from issuing a writ of habeas corpus or making some other appropriate order.' (See [1996] 1 All ER 532 at 544, [1996] QB 599 at 613.)

Plainly the same reasoning applies to an application under s 2. After detailed analysis by counsel we have concluded that the application was not 'duly completed'. However on 25 April 1996 careful examination of the documents would readily have left the authorities at Springfield Hospital with the impression that the application had been duly made. Therefore although the detention of S was unlawful, without exonerating the first defendant, the provisions of s 6(3) operate to enable the hospital to escape liability for accepting S as a patient.

Appropriate declaratory relief will be ordered.

St George's Hospital

It is admitted that the transfer to, and period while S was detained at, St George's hospital were both unlawful. Although this was due to an administrative oversight, the temptation to dismiss it as technical, and therefore insignificant, must be resisted. The stark reality is that S would have been entitled to make an application for habeas corpus which would have led to her immediate release. She was therefore wrongly detained throughout the period when she was in St George's Hospital and throughout the operative procedures which were carried out on her in accordance with the declaration made by Hogg J.

Appropriate declaratory relief will be ordered.

The declaration by Hogg J

The proceedings before Hogg J were so extraordinary and unfortunate that we feel it appropriate to restate some fairly elementary points about declaratory relief.

The court is cautious about granting declaratory relief and it is an almost universal rule that a declaration will not be granted by consent, or against a party in default of appearance, or otherwise than after a full investigation of the merits: see *Wallersteiner v Moir, Moir v Wallersteiner* [1974] 3 All ER 217, [1974] 1 WLR 991. A casual observer might suppose that the court's caution arose from the binding effect of a declaratory order on third parties; but the true explanation is that a declaratory order may appear to bind third parties. That is illustrated by *Patten v Burke Publishing Co Ltd* [1991] 2 All ER 821, [1991] 1 WLR 541, in which Millett J took the exceptional course of making a declaration, on a motion for judgment in default, in order to clarify the plaintiff's copyright title. Millett J said ([1991] 2 All ER 821 at 823):

> '… the rule of practice is also justified by the fact that declarations in this division are usually declarations of legal right which *may appear* to affect third parties who are not bound by the declaration … Although the declaration sought is a declaration of legal right, it cannot affect the rights of anyone other than the defendants or persons claiming through them. This much weakens the force of the objection to the making of the declaration.' (Our emphasis.)

That a declaratory order does not take effect in rem, but only as between the parties to the proceedings (and any other persons bound by a representation order) is illustrated by the practice of the Chancery Division in making declaratory orders as to the true construction of wills, settlements and similar instruments. In the absence of a representation order, the meaning of a trust instrument may have been conclusively determined as between father and son, but not as between father and grandson. *Blathwayt v Lord Cawley* [1975] 3 All ER 625, [1976] AC 397 is a particularly striking illustration.

The limited effect of a declaratory order was one of the matters which troubled this court in *F v West Berkshire Health Authority* (*Mental Health Act Commission intervening*) [1990] 2 AC 1 esp at 20–21 and 42 per Lord Donaldson MR and Butler-Sloss LJ. In the House of Lords, Lord Brandon ([1989] 2 All ER 545 at 557, [1990] 2 AC 1 at 64) expressed the provisional view—

> 'that, whatever procedure were to be used, only the parties to the proceedings and their privies would be bound by, or could rely on, the decision made. In practice, however, I think that would be enough.'

Similarly Lord Goff ([1989] 2 All ER 545 at 569–570, [1990] 2 AC 1 at 81–82) did not share the misgivings that had been expressed in this court. An application for declaratory relief has, since *F v West Berkshire Health Authority*, been the usual procedure when a health authority has taken the initiative in seeking the court's ruling on lawfulness of treatment. An application for an injunction has been the usual procedure when it is the patient who is taking the initiative (as in *Re C* (*adult: refusal of medical treatment*) [1994] 1 All ER 819, [1994] 1 WLR and *B v Croydon Health Authority* [1995] 1 All ER 683, [1995] Fam 133).

The possible drawbacks of declaratory relief were again considered by the House of Lords in *Airedale NHS Trust v Bland* [1993] 1 All ER 821, [1993] AC 789, the case of the Hillsborough victim in a persistent vegetative state. In that case the emphasis was on the efficacy of a declaration as a protection against criminal liability, since the coroner had declined to rule out that possibility. Lord Goff

([1993] 1 All ER 821 at 864–865, [1993] AC 789 at 862–863) reiterated his opinion that declaratory relief was justified, while recognising— *a*

> 'that strong warnings have been given against the civil courts usurping the function of the criminal courts, and it has been authoritatively stated that a declaration as to the lawfulness or otherwise of future conduct is "no bar to criminal prosecution, no matter the authority of the court which grants it": *b* see *Imperial Tobacco Ltd v A-G* [1980] 1 All ER 866 at 875, 884, [1981] AC 718 at 741, 752 per Viscount Dilhorne, and see also per Lord Lane.'

Nevertheless Lord Goff was satisfied that the court should give authoritative guidance, and that it would in practice inhibit prosecution.

c

Because a declaratory order does have effect, between the parties to the proceedings in which it was made, as a conclusive definition of their legal rights, it should only be made as a final order. The notion of an interim declaration is (as Diplock LJ said in *International General Electric Co of New York Ltd v Customs and Excise Comrs* [1962] 2 All ER 398 at 401, [1962] Ch 784 at 790) a contradiction in terms. That was recognised by this court, in the context of authority for medical *d* intervention, in *Riverside Mental Health NHS Trust v Fox* [1994] 2 FCR 577.

Since a declaration ought not to be made on an interim basis, or without adequate investigation of the evidence put forward by either side, it follows that a declaration (especially one affecting an individual's personal autonomy) ought not to be made on an ex parte basis. Apart from injustice and other more obvious *e* objections, it will simply be ineffective to achieve its purpose, that is (in Lord Brandon's words in *F v West Berkshire Health Authority* (*Mental Health Act Commission intervening*) [1989] 2 All ER 545 at 552, [1990] 2 AC 1 at 56) 'to protect the doctor or doctors who perform the operation, and any others who may be concerned in it, from subsequent adverse criticisms and claims'. Non-compliance *f* with a declaration cannot be punished as a contempt of court, nor can a declaration be enforced by any normal form of execution, although exceptionally a writ of sequestration might be appropriate: see *Webster v Southwark London BC* [1983] QB 698. Apart from that rare exception, it operates solely by creating an estoppel per rem judicatam between the parties and their privies (see *F v West Berkshire Health Authority* (*Mental Health Act Commission intervening*) [1989] 2 All ER *g* 545 at 557, [1990] 2 AC 1 at 56 at 64). No estoppel can be created by a judgment pronounced in a party's absence without that party having been given notice of the proceedings or any opportunity to be heard. There is authority (*New Brunswick Rly Co v British and French Trust Corp Ltd* [1938] 4 All ER 747, [1939] AC 1) that an estoppel per rem judicatam may arise on a default judgment, but in that *h* case the default judgment was regularly obtained. No estoppel can arise from an order which the defendant could not oppose, and which was made in proceedings (or proposed proceedings) of which he or she knew nothing.

Mr Gordon cited some well-known authorities (conveniently summarised in the judgment of Ralph Gibson LJ in *Brink's-MAT Ltd v Elcombe* [1988] 3 All ER 188 at 192–193, [1988] 1 WLR 1350 at 1356–1357) as to the importance of the duty of *j* full and frank disclosure on ex parte applications and the likely consequences of a plaintiff's failure to perform that duty. On St George's ex parte application, Hogg J was, as we have already noted, told of some things which were not true (notably that S had been in labour for 24 hours) and was not told some other things which would have been highly material (that S was thought to have capacity to refuse treatment, that she had been in touch with a solicitor and that she had not been

told of the application). Those lapses, although not involving any bad faith, are highly regrettable.

Mr Havers (while not wishing to minimise the seriousness of the lapses) submitted that the authorities on full and frank disclosure are not really in point, since they were all concerned with ex parte applications for interlocutory injunctions, where the party enjoined has the right (and is now clearly informed by the standard form of order of his right) to apply to vary or discharge the order at short notice. The distinction which Mr Havers makes is obviously correct, but it can hardly assist him in defending the conduct of the application to Hogg J. An interim injunction is granted ex parte only in exceptional circumstances, and then only subject to the triple safeguards of (i) the duty of full and frank disclosure; (ii) the cross-undertaking in damages which is required as a matter of course; and (iii) the right of the party enjoined to apply to vary or discharge the ex parte order. If an interim declaration were a remedy known to English law it could hardly be obtainable without the same safeguards being put it place.

There was some rather inconclusive discussion in the course of argument, as to whether Hogg J had jurisdiction to make the order which she made. Jurisdiction is, as Diplock LJ said in *Anisminic Ltd v Foreign Compensation Commission* [1967] 2 All ER 986 at 994, [1968] 2 QB 862 at 889: '… an expression which is used in a variety of senses and takes its colour from its context.' In *Oscroft v Benabo* [1967] 2 All ER 548 at 557, [1967] 1 WLR 1087 at 1100 Diplock LJ observed:

> 'Courts (even inferior courts) have "jurisdiction" to be wrong in law; that is why we hear appeals on questions of law and not merely applications for certiorari.'

Diplock LJ then gave examples of when either a superior or an inferior court might lack jurisdiction. In relation to the High Court it is worth setting out at length what Lord Diplock said in delivering the Privy Council's advice in *Issacs v Robertson* [1984] 3 All ER 140 at 143, [1985] AC at 102–103:

> '… in relation to orders of a court of unlimited jurisdiction it is misleading to seek to draw distinctions between orders that are "void" in the sense that they can be ignored with impunity by those persons to whom they are addressed, and orders that are "voidable" and may be enforced unless and until they are set aside. Dicta that refer to the possibility of there being such a distinction between orders to which the descriptions "void" and "voidable" respectively have been applied can be found in the opinions given by the Judicial Committee of the Privy Council in *Marsh v Marsh* [1945] AC 271 at 284 and *MacFoy v United Africa Co Ltd* [1961] 3 All ER 1169, [1962] AC 152; but in neither of those appeals nor in any other case to which counsel had been able to refer their Lordships has any order of a court of unlimited jurisdiction been held to fall into a category of court orders that can simply be ignored because they are void ipso facto without there being any need for proceedings to have them set aside. The cases that are referred to in these dicta do not support the proposition that there is any category of orders of a court of unlimited jurisdiction of this kind: what they do support is the quite different proposition that there is a category of orders of such a court which a person affected by the order is entitled to apply to have set aside ex debito justitiae in the exercise of the inherent jurisdiction of the court without his needing to have recourse to the rules that deal expressly with proceedings to set aside orders for irregularity and give to the judge a discretion as to the order he will make.'

In this case the judge made a declaratory order (i) on an ex parte application in proceedings which had not then been (and at the start of the hearing of this appeal still had not been) instituted by the issue of a summons; (ii) without S's knowledge, or even any attempt to inform her or her solicitor of the application; (iii) without any evidence, oral or by affidavit; and (iv) without any provision for S to apply to vary or discharge the order. The order declared that St George's could subject S to invasive surgery. It is inappropriate (for the reasons given by Lord Diplock) to describe such an order as void, or made without jurisdiction. But it is an order which S is entitled to have set aside ex debito justitiae. That may involve some unfairness to the doctors and nurses at St George's who were all conscientiously, and in very anxious circumstances, seeking to do the right thing. But the unfairness (indeed, injustice) to S would be much greater if the order were not set aside.

It is unnecessary to re-emphasise our conclusions about S's autonomy. The Caesarean section performed on her (together with the accompanying medical procedures) amounted to trespass. The appeal against Hogg J's order will be allowed. While it may be available to defeat any claim based on aggravated or exemplary damages, in the extraordinary circumstances of this case, the declaration provides no defence to the claim for damages for trespass against St George's Hospital. Additional relief by way of judicial review is inappropriate.

The transfer back to Springfield Hospital

The transfer back to Springfield Hospital and subsequent period before the final discharge was based on the original s 2 application. As already indicated, this was itself unlawful. In addition, S was not absent from Springfield without leave nor liable to be arrested and taken into custody in order to return her to the hospital. While detained at St George's she would have been entitled to discharge herself (and she would have done if she had known the facts) and to an order for habeas corpus.

The detention of S until she eventually discharged herself was unlawful. Again, appropriate declaratory relief will be ordered.

We shall invite counsel to agree the precise terms of the declarations which should be made to give effect to each of our conclusions that declaratory relief should be ordered.

As indicated during argument, all issues relating to damages will be adjourned for hearing before Judge LJ. A directions hearing will be arranged as soon as the parties have had time to consider the judgment in detail. [On 30 July 1998 the court handed down the following guidelines in open court. These guidelines replace those originally set out in the judgment.]

Guidelines

We have now received written submissions from Mr Havers and Mr Gordon. We understand that the applicant's solicitor has taken soundings from the Royal College of Midwives, The Royal College of Nurses, The United Kingdom Central Council for Nursing Midwifery and Health Visiting, The Law Society's Mental Health and Disability subcommittee, MIND, the Association for Improvements in the Maternity Services, The National Childbirth Trust, The Maternity Alliance and The Association of Community Health Councils for England and Wales. We further understand that Mr Havers received comment from the British Medical Association, who in the available time has not any practical opportunity to carry out a formal consultation process, and the Department of Health. We have also received a letter from the head of legal services for the first respondent confirming

that no submissions in relation to the proposed guidelines would be made 'as they do not appear to impact upon the role of an approved social worker'.

The case highlighted some major problems which could arise for hospital authorities when a pregnant woman presented at hospital, the possible need for Caesarean surgery was diagnosed, and there was serious doubt about the patient's capacity to accept or decline treatment. To avoid any recurrence of the unsatisfactory events recorded in this judgment, and after consultations with the President of the Family Division and the Official Solicitor, and in the light of the written submissions from Mr Havers and Mr Gordon, we shall attempt to repeat and expand the advice given in *Re MB* [1997] 2 FCR 541, 38 BMLR 175. This advice also applies to any cases involving capacity when surgical or invasive treatment may be needed by a patient, whether female or male. References to 'she' and 'her' should be read accordingly. It also extends, where relevant, to medical practitioners and health professionals generally as well as to hospital authorities.

The guidelines depend on basic legal principles, which we summarise.

(i) They have no application where the patient is competent to accept or refuse treatment. In principle a patient may remain competent notwithstanding detention under the Mental Health Act.

(ii) If the patient is competent and refuses consent to the treatment, an application to the High Court for a declaration would be pointless. In this situation the advice given to the patient should be recorded. For their own protection hospital authorities should seek unequivocal assurances from the patient (to be recorded in writing) that the refusal represents an informed decision: that is that she understands the nature of and reasons for the proposed treatment, and the risks and likely prognosis involved in the decision to refuse or accept it. If the patient is unwilling to sign a written indication of this refusal, this too should be noted in writing. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

(iii) If the patient is incapable of giving or refusing consent, either in the long term or temporarily (e g due to unconsciousness), the patient must be cared for according to the authority's judgment of the patient's best interests. Where the patient has given an advance directive, before becoming incapable, treatment and care should normally be subject to the advance directive. However if there is reason to doubt the reliability of the advance directive (e g it may sensibly be thought not to apply to the circumstances which have arisen), then an application for a declaration may be made.

Concern over capacity

(iv) The authority should identify as soon as possible whether there is concern about a patient's competence to consent to or refuse treatment.

(v) If the capacity of the patient is seriously in doubt it should be assessed as a matter of priority. In many such cases the patient's general practitioner or other responsible doctor may be sufficiently qualified to make the necessary assessment, but in serious or complex cases involving difficult issues about the future health and well-being or even the life of the patient, the issue of capacity should be examined by an independent psychiatrist, ideally one approved under s 12(2) of the Mental Health Act. If following this assessment there remains a serious doubt about the patient's competence, and the seriousness or complexity of the issues in the particular case may require the involvement of the court, the psychiatrist should further consider whether the patient is incapable by reason of mental disorder of managing her property or affairs. If so the patient may be unable to instruct a solicitor and will require a guardian ad litem in any court proceedings.

The authority should seek legal advice as quickly as possible. If a declaration is to be sought, the patient's solicitors should be informed immediately and if practicable they should have a proper opportunity to take instructions and apply for legal aid where necessary. Potential witnesses for the authority should be made aware of the criteria laid down in *Re MB* and this case, together with any guidance issued by the Department of Health, and the British Medical Association.

(vi) If the patient is unable to instruct solicitors, or is believed to be incapable of doing so, the authority or its legal advisers must notify the Official Solicitor and invite him to act as guardian ad litem. If the Official Solicitor agrees he will no doubt wish, if possible, to arrange for the patient to be interviewed to ascertain her wishes and to explore the reasons for any refusal of treatment. The Official Solicitor can be contacted through the Urgent Court Business Officer out of office hours on 0171 936 6000.

The hearing

(vii) The hearing before the judge should be inter partes. As the order made in her absence will not be binding on the patient unless she is represented either by a guardian ad litem (if incapable of giving instructions) or (if capable) by counsel or solicitor, a declaration granted ex parte is of no assistance to the authority. Although the Official Solicitor will not act for a patient if she is capable of instructing a solicitor, the court may in any event call on the Official Solicitor (who has considerable expertise in these matters) to assist as an amicus curiae.

(viii) It is axiomatic that the judge must be provided with accurate and all the relevant information. This should include the reasons for the proposed treatment, the risks involved in the proposed treatment, and in not proceeding with it, whether any alternative treatment exists, and the reason, if ascertainable, why the patient is refusing the proposed treatment. The judge will need sufficient information to reach an informed conclusion about the patient's capacity, and, where it arises, the issue of best interest.

(ix) The precise terms of any order should be recorded and approved by the judge before its terms are transmitted to the authority. The patient should be accurately informed of the precise terms.

(x) Applicants for emergency orders from the High Court made without first issuing and serving the relevant applications and evidence in support have a duty to comply with the procedural requirements (and pay the court fees) as soon as possible after the urgency hearing.

Conclusion

There may be occasions when, assuming a serious question arises about the competence of the patient, the situation facing the authority may be so urgent and the consequences so desperate that it is impracticable to attempt to comply with these guidelines. The guidelines should be approached for what they are, that is guidelines. Where delay may itself cause serious damage to the patient's health or put her life at risk then formulaic compliance with these guidelines would be inappropriate.

Appeal allowed. Application for judicial review granted.

Dilys Tausz Barrister.