IN THE SUPREME COURT OF JUDICATURE
IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
CROWN OFFICE LIST

FC3 97/5649/D
CO/4306/96

Royal Courts of Justice
Strand, London WC2
Thursday, 7 May 1998

B e f o r e:
LADY JUSTICE BUTLER-SLOSS
LORD JUSTICE JUDGE
LORD JUSTICE ROBERT WALKER

- - - - - -

IN THE MATTER OF AN APPLICATION FOR JUDICIAL REVIEW

THE QUEEN

- v -

(1) LOUIZE COLLINS
(2) PATHFINDER MENTAL HEALTH SERVICES NHS TRUST
(3) ST GEORGES HEALTHCARE NHS TRUST

Respondents

EX PARTE "S"

Applicant

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MR RICHARD GORDON QC, MISS BARBARA HEWSON & MR R O'DONOGHUE (Instructed by Messrs Leigh Day & Co., London, EC1M 4LB) appeared on behalf of the Applicant
LORD LESTER OF HERNE HILL QC & MISS BEVERLEY LANG (Instructed by London Borough of Merton, Morden, Surrey, SM4 5DX) appeared on behalf of the First Respondent
MR PHILIP HAVERS QC & MISS MONICA CARSS-FRISK (Instructed by Bevan Ashford, Bristol, BS1 4TT) appeared on behalf of the Second and Third Respondents

J U D G M E N T
(As approved by the Court)

LORD JUSTICE JUDGE:

This is the judgment of the Court.

Introduction

On 25th April 1996 MS, 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 ante natal 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 ("the Act"), and two doctors, Dr Caroline Chill and Dr Siobhan Jeffreys, a duly qualified practitioner registered under section 12(2). They repeated the advice she had already been given. She adamantly refused to accept it. An application was made under section 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 (25th April) MS 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 MS's consent to treatment. Later that evening appropriate medical procedures were carried out and at 22.00 MS 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 30th April she was returned to Springfield Hospital. On 2nd May her detention under section 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 MS between 25th April and 2nd 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 MS should be admitted to and detained at Springfield Hospital under section 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.

MS attended Dr Chill's surgery on 25th 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. MS 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 MS 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 MS's mental state was affecting her decision making about her own and her baby's health". In the meantime MS waited there for them. MS 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. MS 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 was 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 MS's physical condition and that her "mental state may be compromising her ability to make decisions". Dr Jeffreys' advice was that MS 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 MS needed some form of intervention and that she should not be left to her own devices as she, MS, 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 section 2 of the Act. She concluded her assessment:

> "I had attempted to persuade MS 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 MS 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 MS refused was intended to reduce the physical risks to her and her unborn child.

Dr Jeffreys and Dr Chill completed the form prescribed by regulation 4 of the Mental Health (Hospital, Guardianship & Consent to Treatment) Regulations 1983. Both expressed the opinion that MS "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 and "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 MS.

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

On her arrival at Springfield Hospital in the evening of 25th April, when her rights under s132 of the Act were explained to her, MS fully comprehended her position. Another very detailed examination was carried out by a different specialist, Dr Maginn, who diagnosed pre-eclampsia and depression. MS remained adamant, refusing any intervention with her pregnancy. At 10.30 pm it was concluded that MS needed "to be on obstetrics ward". There was a risk to her and the baby. MS was saying that she "would not be bothered if she dies and it would be better for the baby to be dead".

MS 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". In the same articulate letter she explained her intention to seek legal advice at the earliest possible opportunity 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 25th/26th April, after a stay of no more than a few hours at Springfield Hospital, her transfer to St George's was completed. Those responsible failed to act in accordance with the provisions of the Act and Mental Health (Guardianship & Consent to Treatment) Regulations 1983. 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 MS was not provided with the information prescribed by section 132. MS was transferred (not granted leave of absence under section 17 nor discharged under section 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 section 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 have been a lawful transfer.

On admission to St George's the reference letter recorded that MS had been sectioned due to "depressive illness". She was immediately seen by Dr Green, a registrar in obstetrics. Her 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 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 continued to refuse any examination of the

foetal heart. When Mr Sultan saw her at about 8.45am MS 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 psychiatrist has mapped out that treatment cannot be given to (MS) due to the fact that the section 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 Bevan Ashford, the solicitors to the Trust. Among the subjects raised in her discussion with Simon Lindsay of that firm were MS'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, MS 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 MS appeared "at times to be sad and distressed" but denied feeling depressed or having suffered any biological symptoms of depression recently. She noted that MS 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 MS provided an inconsistent explanation for her attitude. For example she had said on the 25th 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 MS'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".

MS 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 MS 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 MS's own understanding. It is clear from the hospital records that by 13.00 on 26th April it was appreciated by those responsible for the care and treatment of MS 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 25th 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 section 2 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 lunchtime adjournment. Before making it he had spoken to Joanna Lloyd of Bevan Ashford. He understood from her that MS 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 MS's "capacity" for consent "was intact", adding that "it could be affected by a mental/psychiatric state". He was also told that MS 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 MS would die", and that "every minute counted".

Labour had not started. Quite how Mr Pitt came to be given the information that MS 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 MS 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 MS had been in labour for about 24 hours, thus inadvertently misleading the judge. He said that MS 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. Her attention was drawn to the fact that MS had been admitted under section 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 MS 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 MS had been admitted for assessment as a Mental Health Act patient.

Mr Pitt drew the attention of the judge to the second edition of Powers & Harris on Medical Negligence together with the decision of the President of the Family Division, Sir Stephen Brown, in Re S (adult: refusal of treatment) [1993] Fam 123 and to the passage in Powers & Harris quoting the observations of Balcombe LJ in Re F (in utero) [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 Re F [1990] 2 AC 1.

The hearing concluded without the judge being informed that MS 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 MS 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 (NH Trust) was in the following terms

> "And notwithstanding the purported refusal to consent of M.... 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 MS'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 MS) appreciated the risks." She considered the decision in Re C 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 MS by Dr Jeffreys. MS reiterated her objection to any form of medical intervention.

Just after 17.00 the copy order made by Hogg J was shown to her by Andrea Sutcliffe, who expressed sympathy with her. MS 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. MS 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 MS spoke to her solicitor. After the end of the telephone call MS 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 MS's solicitor interpreted as merely meaning that the anaesthetic had to be agreed with his client. That is consistent with what MS 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, MS 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, MS 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, MS 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 MS'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. MS 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 26th 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 MS 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 27th 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.

MS remained at St George's Hospital receiving post natal care throughout 28th and 29th April. Her attitude was unchanged. On 29th April Dr Jeffreys saw her again and reviewed the psychiatric situation. She noted that MS 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 30th April it was no longer necessary for MS 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 MS 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 MS did not represent any significant continuing risk to anyone. By the next day he decided that the section 2 order should be discharged. Although MS 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 [1993] AC 789.

> "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: In Re F (Mental Patient: Sterilisation) [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." (per Lord Keith at p.857)

> "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." (per Lord Goff of Chieveley at p.864).

> "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". (per Lord Browne-Wilkinson at p.882.)

> "..... 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." (per Lord Mustill at p.891.)

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 McC: W v W [1972] AC 25 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:

> "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'etat 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 [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 Treatment) [1993] Fam 123 where Sir Stephen Brown, President, 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 Attorney-General's Reference (No. 3 of 1994) [1997] 3 WLR 421 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 (at p.428) 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 of the physical linkage between them of the nutrients, 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;

> "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 S 2d 457) or "the potentiality of human life" (in Re Madyyun [1986] 573 A 2d 1259). In Winnipeg Child & Family Services Limited v G [1997] Lexis 92, a decision which will need further examination, in his dissenting judgment Major J commented, "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 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 ....." (His 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. 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

> "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 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 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 law 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 (Paton v British Pregnancy Advisory Service Trustees [1979] QB 276 and C v S [1988] QB 135, and with Re F (in utero) [1988] Fam 122 where, refusing an application that the foetus of an unstable pregnant woman should be made a ward of court Balcombe LJ observed at page 143

> "..... 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

> "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 upon 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 control for the benefit of her unborn child, then doubtless it would 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 (probably because they were not strictly relevant) or in Re S (Adult: Refusal of Treatment) referred to earlier and, although obiter, the principle encapsulated in the language used by Butler-Sloss LJ in Re MB 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 31st October 1997 in Winnipeg Child & Family Services v G [1997] Lexis 92.

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

> "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 foetus' complete physical existence is dependent on the body of the woman. As a result, any intervention to further the foetus' interests would 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 foetus and potentially attract tort liability. ..... The common law does not clothe the courts with power to order the detention of a pregnant woman for the purpose of preventing her from harming 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 Attorney-General's Reference (No 3 of 1994). In the later part of his speech Lord Mustill said

> "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 [1993] QB 204) that the child en ventre sa mere 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

> "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 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

> "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 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

> "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 effect 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

> "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 & Family Services, 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 9 of Magna Carta 1297 (25 Edw 1c1) 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 involuntary 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."
> (per Sir Thomas Bingham MR in Re S - C (mental patient: Habeas Corpus) [1996] QB 599)

In R v Hallstrom ex parte W (No 2), R v Gardner, ex parte L [1986] 2 All ER 306 at 314, 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. That is as true for a mentally disordered person as that of anyone else."

So even assuming lawful admission and detention in accordance with the 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] Fam 133) provided the treatment is given by or under the direction of the responsible medical officer. The treatment administered to MS 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. (Re JT (Adult: Refusal of Medical Treatment) [1998] 1 FLR 48)

In Re T (Adult: Refusal of Medical Treatment) [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 Treatment) [1994] 1 WLR 290, for present purposes it is sufficient to notice his observation at page 115 that:

> "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."

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 Section 2

It is clear that everyone involved in the process which led to MS'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 MS herself and for her baby. It is equally clear that MS 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 section 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 MS and the unborn child rather than for the purpose of assessing MS's mental condition, and that she failed to take into account that the detention of MS 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 section 13(1) of the Act it is the duty not of the doctors but of an approved social worker to make an application under section 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". (section 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 (section 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 section 2(2) are satisfied. An application made for an improper or collateral purpose (R v Wilson, Ex parte Williamson [1996] COD

42) or flawed in the Wednesbury sense (R v South Western Hospital Managers, Ex parte M 161 at 176) would be susceptible to judicial review: so would similarly tainted recommendations by the medical practitioners.

A patient is an individual "suffering or appearing to suffer from mental disorder" (section 145) and mental disorder extends to "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of the mind" (section 1(2)). Applied to the present case the necessary care and treatment for MS's pregnancy would not fall within section 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 MS's pregnancy would not have been sufficient on its own to bring the provisions of section 13 into play. Nevertheless the pregnancy was not irrelevant. In deciding whether it is "necessary or proper" to make an application under section 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. MS 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 Attorney-General Reference (No 3) of 1994 referred to earlier in this judgment about the profound physical and emotional bond between the unborn child and its mother. Therefore the fact that MS was heavily pregnant and adamantly refusing treatment were, at least potentially, of compelling importance to any informed judgment.

The application for MS's admission was made not under section 3 but under section 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 section 3 is admission for treatment whereas under section 2 the application is made for "admission for assessment", and that whereas the basis for admission under section 2 is mental disorder, under section 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 section 2(2) must be established. They are cumulative. There was considerable discussion whether section

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 MBC, Ex parte C [1993] 2 FLR 187 Lloyd LJ commented

> ".....There is in my view, power to admit a patient for assessment under s2, 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 s2 and confine assessment to choice of treatments."

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 MS'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 MS'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 MS's mental state might be "compromising her ability to make decisions". In the general context of applications under section 2 an omission to deal more directly with the issue of MS'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 section 2(2). The first requirement of section 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 section 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 section 2(2)(b), and assuming that the requirements of section 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 MS. 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 MS was dangerously ill. Although the risks were caused by her pregnancy, the potential damage could have fallen within section 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 MS 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 MS, and their own lengthy examination and discussion with her. Each completed the prescribed form because she believed that MS "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 MS 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 MS'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 MS (a judgment confirmed by the very brief period MS remained in Springfield Hospital before being transferred to St George's). She believed, rightly, that

MS'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 MS's mental condition or treating her depression. Put another way, if MS 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 section 2(2)(b) might well have been fulfilled, the cumulative grounds prescribed in section 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 MS 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) referred to earlier in this judgment, the Court of Appeal considered the impact of section 6(3) where an application had been made for admission under section 3 of the Act in contravention of section 11(4). It was held that even when the application appeared to have been "duly made" unless the relevant pre conditions to admission had been complied with, the application itself would not have been "duly completed" as required by section 6(1). Accordingly the application itself remained defective and the detention in hospital was unlawful.

Sir Thomas Bingham MR pointed out that section 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 s145(1), or if the recommendations which ought 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."

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 s6(3) is not intended to prevent, nor can it have the effect of preventing, a court, satisfied that the original application was not made in accordance with s3 of the Act, from issuing a writ of habeas corpus or making some other appropriate order."

Plainly the same reasoning applies to an application under section 2. After detailed analysis by counsel we have concluded that the application was not "duly completed". However on 25th 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 MS was unlawful, without exonerating the first defendant, the provisions of section 6(3) operate to enable the hospital to escape liability for accepting MS as a patient.

Appropriate declaratory relief will be ordered.

St George's Hospital

It is admitted that the transfer to and period while MS 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 MS 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 [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 the case of Patten v Burke Publishing [1991] AER 821, 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 at page 823e,

> "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."
>
> (emphasis supplied)

and at page 823h,

> "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."

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 [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 Re F (Mental Patient: Sterilisation) [1990] 2 AC 1, especially at pages 20-1 (Lord Donaldson MR) and 42 (Butler Sloss LJ). In the House of Lords Lord Brandon (at page 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 (at pages 81-2) did not share the misgivings that had been expressed in this court. An application for declaratory relief has since Re F 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 Treatment) [1994] 1 WLR 290 and B v Croydon Health Authority [1995] 1 AER 683).

The possible drawbacks of declaratory relief were again considered by the House of Lords in Airedale NHS v Bland [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 (at pages 862-3) reiterated his opinion that declaratory relief was justified, while recognising

> "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 that grants it': see Imperial Tobacco v Attorney-General [1981] AC 718, 741, per Viscount Dilhorne and see also at page 752, per Lord Lane."

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

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 v C & E Commissioners [1962] Ch 784, 790) a contradiction in terms. That was recognised by this court, in the context of authority for medical intervention, in Riverside Mental Health Trust v Fox [1994] 1 FLR 614.

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 objections, it will simply be ineffective to achieve its purpose, that is (in Lord Brandon's words in Re F at page 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 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 LBC [1983] QB 698. Apart from that rare exception it operates solely by creating an estoppel *per rem judicatam* between the parties and their privies (Re F [1990] 2 AC 1, 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 Railway v British & French Trust Corporation [1939] AC 1) that an estoppel *per rem judicatam* may arise on a default judgment, but in that 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 v Elcombe [1988] 1 WLR 1350, 1356-7) as to the importance of the duty of 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 R v Foreign Compensation Tribunal ex parte Anisminic [1968] 2 QB 862, 889: reversed [1969] 2 AC 147) "an

expression which is used in a variety of senses and takes its colour from its context". In Oscroft v Benabo [1967] 1 WLR 1087, 1100 Diplock LJ observed that

> "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 Isaacs v Robertson [1985] AC 97, 102-3

> "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 the appeals Marsh v Marsh [1945] AC 271, 284 and MacFoy v United Africa Co Ltd [1962] AC 152, 160; 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 MS'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 section 2 application. As already indicated this was itself unlawful. In addition MS 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 MS 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.

Guidelines

This case has highlighted some major problems which can suddenly confront hospital authorities and medical practitioners when a pregnant woman presents at hospital and the possible need for a Caesarean section is diagnosed. After consultations with the President of the Family Division and the Official Solicitor, and to avoid any recurrence of the unsatisfactory events recorded in this judgment, and subject to any submissions which counsel may make in writing when they have had an opportunity to consider them, we shall repeat and expand the advice given in Re MB. This advice also applies when any other surgical or invasive treatment may be needed by a female or male patient.

i Those in charge, both medical and administrative, should identify as soon as possible whether there is any problem about mental capacity to consent to treatment.

ii If there is a problem the capacity of the patient to accept or refuse treatment must be assessed as a priority. The issues should be addressed if possible by a consultant psychiatrist approved under section 12(2) of the Act, who should also assess whether the patient is incapable of managing her property and affairs by reason of mental disorder as defined in the Act. If so the patient will not be able to instruct a solicitor and will require a guardian ad litem. Potential medical witnesses should be made aware of the criteria laid down in Re C and Re MB and the Department of Health guidelines provided to the hospital.

iii If the patient already has instructed a solicitor the solicitors should be informed immediately, and if possible they should be allowed time to apply for legal aid where necessary, and to take instructions.

iv In problematic cases and if there is a real doubt as to capacity the issue should be resolved by the court and the hospital should seek legal advice as soon as possible. It will be desirable in such cases for a declaration to be sought from the High Court, as soon as possible so as to avoid the necessity for an emergency hearing. Oral evidence will generally be preferable to affidavit evidence and should reduce delay and the possibility of further adjournments.

v If the patient is competent to accept or refuse treatment (which she may be, even if detained in hospital under the Act), the hospital is obliged to accept her decision.

vi If the patient is incapable of giving or refusing consent, either in the long term or temporarily, eg due to unconsciousness, she must be cared for according to her best interests.

vii Problematic cases include those where the patient though presently lacking capacity has already indicated a clear refusal before lapsing into incapacity (the advance directive situation).

viii If the patient does not have solicitors, or if she is considered incapable of instructing solicitors, the hospital or its legal advisors must notify the Official Solicitor as soon as a question of refusal of treatment arises. Wherever possible, the Official Solicitor, if he acts as guardian ad litem, will wish to arrange for the patient to be interviewed to ascertain her wishes and feelings and to explore the reasons for the refusal of treatment. At the very least the Official Solicitor, who now has great experience in medical emergencies, is in a position to assist even if he does not seek to intervene. By notification he will be able to continue to build up a body of experience and expertise which will be helpful to the

High Court.

ix The hearing before the judge should be inter partes. As the order will not be binding on the patient unless the patient is represented either by a guardian ad litem, or, if capable of giving instructions by counsel or a solicitor, a declaration granted ex parte is of no assistance to the hospital trust or health authority. The Official Solicitor cannot act for the patient if she is capable of instructing a solicitor, but the court may call on the Official Solicitor to assist as amicus curiae.

x It is axiomatic that the judge must be provided with accurate and all the relevant available information. This should include the reason for the proposed treatment and why, if ascertainable, the patient is refusing it. The judge will need sufficient information to reach an informed conclusion about the patient's capacity and (where it arises) best interests.

xi The precise terms of any order should be recorded and approved by the judge before its terms are transmitted to the hospital.

xii The Official Solicitor can be contacted through the Urgent Court Business Officer out of office hours on 0171 936 6000.

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

xiv If the patient is and remains competent to make up her mind whether to undergo the treatment proposed by the hospital, so that (as in this case) an application for a declaration would be pointless, for their own protection hospital authorities will no doubt seek unequivocal assurances in writing that the refusal represents an informed and settled decision, that is to say 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 not prepared to provide such an assurance then the decision should be carefully noted and the refusal to sign any written indication of the refusal should itself also be noted in writing.