



Neutral Citation Number: [2019] EWCOP 24

Case No: 13436488

**COURT OF PROTECTION**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 04/07/2019

**Before :**

**MR JUSTICE FRANCIS**

**Between :**

**United Lincolnshire Hospitals NHS Trust**  
**- and -**  
**CD**

**Applicant**

**Respondent**

**Sophia Roper** (instructed by **Browne Jacobson LLP**) for the **Claimant**  
**Parishil Patel QC** and **Katie Scott** (instructed by **The Official Solicitor**) for the **Defendant**

Hearing dates: 4<sup>th</sup> June 2019

**Approved Judgment**

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....  
**MR JUSTICE FRANCIS**

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the incapacitated person and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

**Mr Justice Francis :**

1. This case concerns the medical treatment of CD, a 27-year-old woman who is currently detained pursuant to section 3 of the Mental Health Act 1983. CD is 35 weeks pregnant with a full-term delivery date of 21 June 2019. CD has a diagnosis of paranoid schizophrenia and emotionally unstable personality disorder. It is not in issue that she lacks capacity to conduct these proceedings; she has been represented by her litigation friend, the Official Solicitor who has instructed Parishil Patel QC and Katie Scott. The Applicant hospital NHS Trust has been represented by Sophia Roper of counsel. The case was due to be heard on Friday 7 June but came before me on Tuesday 4 June as an emergency application. I am indebted to counsel and their instructing solicitors for the clear and efficient way that they have presented this case in response to an obvious emergency.
2. I have already made an order pursuant to COPR r4.3 and Practice Direction 4C prohibiting the publication of any information that might lead to the identification of CD, her family or her geographical location, including identification of the hospitals where she is cared for and of her treating clinicians. Subject to that order, the matter was heard in open court.
3. The difficult and, I am told, novel issue that arises in this case is that it is common ground among the treating clinicians that CD does not presently lack capacity to make decisions in respect of the birth and the treatment and necessary procedures in connection therewith. However, based on her history, her clinicians are agreed that there is a substantial risk that she may become incapacitous in relation to such decisions at a critical moment in her labour. CD also suffers from polyhydramnios (excess of amniotic fluid in the amniotic sac). At that point, defined as once either CD's membranes have ruptured or CD's waters have broken, the clinicians agree that there would almost certainly be insufficient time to make a renewed application to the court, even though I have agreed to make myself available by telephone throughout the day and night for this case so far as consistent with other professional obligations. Accordingly, Ms Roper on behalf of the NHS trust asks me to make what she has referred to as an anticipatory and contingent declaration in the following terms:

“1. CD has capacity to make decisions regarding her obstetric care and the delivery of her baby.

2. Once CD's membranes have ruptured (either spontaneously or artificially) and in the event that CD is assessed as lacking capacity to make decisions about her obstetric care and labour and the delivery of her baby it is lawful for the applicant to deliver care and treatment to her in accordance with the care plan annexed to the order.

3. To the extent that the arrangements set out at paragraph 3 and the care plan amount to a deprivation of CD's liberty, this is authorised, providing always that any measures used to facilitate or provide the arrangements shall be the minimum necessary to protect the safety of CD and those involved in her transfer and treatment, and that all reasonable and proportionate steps are taken to minimise distress to CD and to maintain her dignity.”

4. It is, of course, common ground that every possible step should be taken to act in the best interests of CD and to promote her welfare and, as part of that process, to protect her unborn child. Whilst it is of course the case that the unborn child's best interests cannot be taken into account *per se*, it is obvious both from the evidence received and as a matter of common sense that the loss of the baby would have a profound negative impact on CD.
5. At the time that these proceedings were instituted, namely 17 May 2019, it was the view of both CD's mental health treating team and her obstetric treating team that she lacked capacity to make decisions about her obstetric care, labour and the delivery of her baby. All those who have treated CD recently acknowledge that her presentation is variable and that at times she may be choosing to disengage rather than being unable to engage. Her mental health has, happily, been improving with the administration of Olanzapine and her capacity was therefore kept under regular review. On 24 May 2019, a LPFT nurse and her IMCA/IMHA found that she was "able to discuss her views on all the stages and interventions possible during labour and delivery.... Her priority was the health of her baby and she was able to express that even where interventions she dislikes such as cannulation were required she would engage in intervention for the sake of her baby."
6. On 29 May 2019, Dr S, consultant psychiatrist employed by Lincolnshire partnership NHS Foundation Trust, found that CD was improved, and on balance he considered that she had capacity to make decisions about the delivery of her baby. He acknowledged that CD's presentation is "variable" and considers that it is possible that during labour her delusional beliefs may affect her judgement and she may again lose capacity to make decisions about the delivery for herself.
7. CD has consistently expressed the wish to have a vaginal delivery. If this cannot be achieved then she has been clear that she does not want an epidural, but instead wants a general anaesthetic and a Caesarean section. The applicant has produced a comprehensive care plan which is faithful to CD's expressed wishes, so far as is consistent with best medical practice.
8. On 29 May 2019, CD underwent an ultrasound which confirmed that the polyhydramnios had increased. The view of the obstetric team was that the level of polyhydramnios is severe and significantly increases the risk of an obstetric emergency. These include the risks of cord prolapse and malpresentation. Cord prolapse is where the cord comes out of the uterus ahead of the baby. The baby has to be delivered within 15 minutes if its life is to be saved. Malpresentation is where the baby presents with some part of its body other than the head coming first. Again, this is likely to be an obstetric emergency risking the loss of the baby, bleeding and rupture of the uterus. It is obvious that the consequences for CD would be catastrophic in the event of such an outcome. It is equally obvious, I suggest, that I must take all possible steps to protect the welfare of CD and to give the best possible chance for a safe delivery in the event that she lacks capacity to make these decisions for herself.
9. On 3 June 2019, CD's treating consultant obstetrician and gynaecologist reported as follows: "in both cases [i.e. cord prolapse and malpresentation] the risk to CD is mostly about the psychological impact of the emergency and the risk that her baby

will be damaged/die. For malpresentation you also have bleeding, uterus rupture and pain. The very real risk for baby in both scenarios is death.”

10. The Official Solicitor on behalf of CD has, in my judgement, correctly identified the range of orders which could be made by the court in this case:

- i) an order bringing these proceedings to an end on the basis that CD has capacity to make decisions about the birth;
- ii) an interim order adjourning the proceedings for a short period to enable the applicant to come back for an urgent order should CD’s capacity deteriorate;
- iii) an interim order which would enable the applicant to implement the care plan pursuant to section 4B of the MCA;
- iv) a final order declaring, pursuant to section 15 (1)(c) that, in the event CD is assessed at some later date as lacking the capacity to make decisions about the birth, the implementation of the care plan would be lawful;
- v) an order pursuant to the inherent jurisdiction.

11. Although the inherent jurisdiction of the High Court is a convenient tool in many cases for finding an appropriate remedy, I am in no doubt that I should work within the statutory provisions of the MCA as far as is possible. I am reinforced in this view by the note to s 15 of the Mental Capacity Act 2005 in the Court of Protection Practice 2019 which provides:

“this section confers on the court the discretionary power to make declarations of the nature stated this includes the initial decision as to whether there is a lack of capacity which would trigger the remaining jurisdiction of the court. This new statutory jurisdiction largely replaces the former inherent jurisdiction previously assumed by the Family Division of the High Court to make declarations in respect of mentally incapacitated adults in regard to medical treatment and personal welfare.”

12. I now address each of the five options set out above.

13. **Bringing these proceedings to an end**

The jurisdiction of this court is founded on a lack of capacity on the part of CD to make decisions for herself. It is, accordingly, arguable that the court has no jurisdiction in this case. The applicant Trust accepts that it cannot, on the evidence currently available, ask for a declaration that CD lacks capacity to make decisions about her obstetric care and the delivery of her baby. The practical position, however, is that if (as those treating CD consider very likely) CD subsequently loses capacity to make decisions about her delivery, this is likely to be in an urgent situation where a renewed application would cause unacceptable delay with potentially catastrophic consequences as discussed above. In my judgement it would be dangerous and plainly wrong to do nothing. This court cannot and will not take what is regarded by all as an unacceptable risk. If, as has been summarised above, a medical emergency were to

arise and if it were to be determined that CD has again lost capacity to make decisions about herself, the treating clinicians would find themselves in the invidious position of possibly carrying out invasive surgery and administering anaesthetic or other drugs without lawful authority.

**14. Adjourning these proceedings**

For the reasons discussed above, adjourning the proceedings would possibly, if not probably, have the effect of leaving things too late and insufficient time for an emergency order to be obtained.

**15. Interim order pursuant to section 4B**

Section 4B authorises the deprivation of liberty “while a decision as respect any relevant issue is sought from the court” and is not, in my judgement, the appropriate route to take here. Whilst I agree with Mr Patel that all three conditions of subsection 4B could be said to be met in the circumstances of this case, the court is fully seized of the issues and I am in a position to make a decision now. I agree with the submission made by Mr Patel on behalf of the Official Solicitor that using section 4B to make an interim order would be a device to fit CD’s circumstances within section 4A/B. It would involve adjourning the s16 order until after the birth, which is entirely artificial since it is in relation to treatment during labour that the issue arises.

**16. Final order**

- i) Section 15 of the Mental Capacity Act 2005 provides that the court may make declarations as to “..... *the lawfulness or otherwise of any act done, or yet to be done, in relation to that person*”. Section 16 commences with the words, “*this section applies if a person (“P”) lacks capacity in relation to a matter or matters concerning (a) P’s personal welfare, or (b) P’s property and affairs*”.
- ii) Subsection 3 of section 16 makes it clear that the powers of the court under this section are subject to the provisions of this act and, in particular, to sections 1 (the principles) and four (best interests).
- iii) I acknowledge that I am not currently empowered to make an order pursuant to section 16(2) because the principle enunciated in section 16(1), namely incapacity, is not yet made out. However, as I have already said, there is a substantial risk that if I fail to address the matter now I could put the welfare, and even the life, of CD at risk and would also put the life of her as yet undelivered baby at risk. As I have said, I am not prepared to take that risk. I am prepared to find that, in exceptional circumstances, the court has the power to make an anticipatory declaration of lawfulness, contingent on CD losing capacity, pursuant to section 15(1)(c).
- iv) Accordingly, I am willing to make the declarations which are sought by the applicant and the Official Solicitor. All are agreed that, for so long as CD retains capacity to make decisions about her obstetric care and the delivery of a baby, she will of course be allowed to do so, even if those decisions are considered to be unwise. If, however, her mental health deteriorates and she loses capacity I consider that it would be in the best interests to try for a normal vaginal delivery if possible and this is consistent with *either* CD’s expressed wish *or* best interests. The care plan drawn up by the applicant

records the expectation that CD will comply with what is proposed but also includes fall back options, including for appropriate minimal restraint, should this not be the case. Restraint would potentially be used to transfer her to the maternity suite, insert a cannula (although only if medically required) or provide general anaesthetic in order to proceed to a caesarean section. A caesarean section would be very much a last resort.

- v) As I set out at the beginning of this Judgment, this case appears to give rise to an issue which has not appeared in other reported decisions. In many ways this surprises me. I was, however, referred to an unreported decision in 2009 in which McFarlane J (as he then was) made contingent declarations as to the circumstances in which P would lack capacity and her best interests in that event. The only reference that I have been able to find to this decision appears in note 7 to #1.483 of the Court of Protection Practice 2019. The text of the Practice refers to the possibility of making a declaration that as at the point of the hearing the person has capacity to take the relevant decisions but indicate the circumstances under which they might lose or lack that capacity. There is then the reference to the 2009 case as follows:

*“the circumstances of this case were very unusual, it being held by the court that the individual in question suffered from a particularly acute form of PTSD which would be triggered by certain clearly identifiable events linked to the prospect of hospital admission and would render her incapable of taking decisions as to whether she required such admission in the event of medical emergency. It is therefore a limited, but it is suggested sound, foundation upon which to build a general statement of principles; although query whether the indications should be in the declaration itself, or in the accompanying judgment (cross-referenced to in the recital to the order).”*

- vi) In my judgement, if making such an anticipatory or preemptory order, it is necessary to make it in the declaration itself. It is the declarations and orders of the court which authorise the applicant to take the particular course of action, not the wording of the Judgment. Moreover, these cases are by definition going to be urgent and a hospital trust, or other person with the benefit of such an order, will not want to be trawling through what could be a long Judgment. I am not in any doubt that, if making such a declaration, it needs to be on the face of the court order.

17. **Inherent jurisdiction**

I have already explained above, as I suggest is obvious, that I must work within the Mental Capacity Act 2005 if at all possible. However, were it necessary for me to say that the unusual circumstances of this case are not covered by that Act, I would have no hesitation in making an order pursuant to the inherent jurisdiction if faced with a situation where the choice is to make such an order or to risk life itself.

18. Accordingly, and with the support of the Official Solicitor, I accede to the Trust’s application.