Neutral Citation Number: [2020] EWCOP 4

Case No: 13490075

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/01/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

(1) Guys and St Thomas' NHS Foundation Trust (GSTT) **(2) South London and Maudsley NHS Foundation Trust (SLAM)**	**Applicant**
- and -	
R	**Respondent**

- -
- -

Ms Sophia Roper and Ms Bridget Dolan QC (instructed by **Hill Dickinson LLP & Bevan Brittan**) for the **Applicant**
Mr Parishil Patel QC (instructed by **Official Solicitor)** as Advocate to the Court. The Respondent did not appear and was not represented

Hearing date: 25th October 2019

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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.

THE HONOURABLE MR JUSTICE HAYDEN

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 children 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 Hayden :

1. On the 30th August 2019, I heard an application, in the Urgent Applications List, brought jointly by Guys and St Thomas's NHS Foundation Trust (GSTT) and the South London and Maudsley NHS Foundation Trust (SLAM). The case concerned the obstetric treatment of R who, on 30th August 2019, was 39 weeks and six days in to her pregnancy. R has a diagnosis of Bipolar Affective Disorder which is characterised by psychotic episodes. R was detained in a psychiatric ward which fell within the jurisdiction of the second applicant (SLAM). The first applicant (GSTT) is the Trust responsible for R's obstetric care.

2. Given that R might have entered labour at any moment, I gave my decision in an extempore judgment. Some key facts of the case require to be stated plainly. All the treating clinicians agreed: R had capacity to make decisions as to her ante-natal and obstetric care; there was a substantial risk of a deterioration in R's mental health, such that she would likely lose capacity during labour; there was a risk to her physical health, in that she could require an urgent Caesarean section ('C-section') for the safe delivery of her baby but might resist.

3. For completeness, I should record that the relevant evidence as to capacity incorporated the following: short capacity assessments on 19th June 2019 and 3rd July 2019 in the SLAM medical records, both stating that R had capacity to consent to or decline antenatal care; a statement by Dr Walker-Tilley, a Consultant Psychiatrist from SLAM, stating his view that R remained capacitous as of 22nd August 2019, and setting out the evidence in support of the Trusts' case that there was a high risk of R losing capacity in labour; a statement by Dr Clarke, Consultant Obstetrician at GSTT, confirming her agreement with Dr Walker-Tilley. This factual situation i.e. a capacitous woman who is likely to become incapacitous, during the course of labour is relatively unusual but it is not unprecedented.

4. The evaluation of the obstetric risk was analysed in the report of Dr Clarke. R was suffering from polyhydramnios (excess amniotic fluid round the baby); her baby was large, and it was uncertain whether the baby would present head down or be in a transverse, breech, or unstable presentation. These factors all increased the obstetric risks: continuous monitoring was recommended, and there was a real risk that C-section would be necessary to ensure the safe delivery of the baby. There was also a manifest risk of non-cooperation or resistance by R if the baby required delivery urgently. It is unnecessary for me to identify the particulars of that evidence here, other than to say it was well established by R's earlier behaviours. If a C-section were then to be recommended, it might be required in minutes. Dr Clarke's statement included the proposed plan for delivery of the baby, exhibiting an obstetric plan and a plan to manage any physical restraint.

5. Self-evidently, the Court was in the entirely invidious position of having to determine applications which have an obviously draconian complexion to them, in circumstances which were far from ideal. Moreover, R was unrepresented. Mr Patel QC and his instructing solicitor had stepped in, to seek to protect R's interests. I appointed Mr Patel to act as 'Advocate to the Court'. Neither he nor his solicitor was representing R. The role of Advocate to the Court involves very different obligations and is not to be conflated with the role of the Official Solicitor as litigation friend.

6. There had not been time to appoint the Official Solicitor nor, for obvious reasons, was there any opportunity to do so. However, self-evidently, a decision had to be made. I was satisfied that the application was well founded and that the declarations contended for met R's

best interests. I do however deprecate the delay in bringing the application. The delay was avoidable but perhaps not so starkly so as first appeared. It became clear to the applicants, only ten days before the August hearing, that R had stopped taking her anti-psychotic medication. This manifestly required a re-evaluation of the risk and the need to reassess the birth plan.

7. On 30th August 2019, I made the following declarations:

> ***"IT IS DECLARED PURSUANT TO S.15 MCA AND PURSUANT TO THE INHERENT JURISDICTION OF THE HIGH COURT THAT:***
> *(1) The Respondent has, at the present time, mental capacity to make decisions regarding her obstetric care and the delivery of her baby;*
>
> ***and it is declared pursuant to S.15 MCA in the event that the respondent should come to lack the capacity to make decisions about her obstetric care, and, in any event pursuant to the inherent jurisdiction of the High Court that:***
> *(2) It is lawful for the Applicants to deliver care and treatment to her in accordance with the obstetric care plan annexed to this Order;*
>
> *(3) To the extent that the arrangements set out in the care plan amount to a deprivation of the Respondent'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 the Respondent and those involved in her transfer and treatment; and that all reasonable and proportionate steps are taken to minimise distress to the Respondent and to maintain her dignity."*

8. Whilst I was persuaded, as I have said above, of the need to make such declarations, I was uncertain as to whether fell properly within the structure of the Mental Capacity Act 2005 (MCA) and/or which required the inherent jurisdiction of the High Court to be invoked. Francis J, confronted with a not dissimilar situation in **United Lincolnshire Hospitals NHS Trust v CD [2019] EWCOP 24,** looked at the Court's power to make anticipatory declarations pursuant to section 15(1)(c) MCA. At para 16 (iii), he observed:

> *"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 power to make an anticipatory declaration of lawfulness, contingent on CD losing capacity, pursuant to section 15(1)(c)"*

9. Recognising that this assertion might not establish the jurisdiction of the MCA beyond peradventure, Francis J made the following observations as to the likely reach of the Court's inherent jurisdictional powers:

> *"I have already explained above, as I suggest is obvious, that I must work within the [MCA] if at all possible. However, were it necessary for me to say that the unusual circumstances of this case are not covered by the 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"

10. **In Wakefield MDC and Wakefield CCG v DN and MN [2019] EWHC 2306 (Fam)** Cobb J followed the approach of Francis J. He did so in circumstances where all the parties agreed that he 'could or should' make anticipatory declarations about *'residence and/or care (and if appropriate his best interests) pursuant to sections 15 and 16 of the MCA 2005, to cover occasions when [P] has 'meltdowns' and is at that point (it is agreed) unable to make capacitous decisions'. Cobb J also observed: 'It seems to me that the outcome of an anticipatory declaration would provide a proper legal framework for the care team, ensuring that any temporary periods of deprivation of liberty are duly authorised and thereby protecting them from civil liability'.* The scope and ambit of the applicable law appears to have been agreed between the parties, who were understandably driven by the powerful welfare imperatives in the case. Cobb J did not, however, have the advantage of the focused legal argument that has been provided to me by Mr Patel, who continues to act as Advocate to the Court and Ms Dolan QC and Ms Roper who appear on behalf of the applicants.

11. Following my ex tempore judgment of 30th August 2019 and for reasons that are clear from the above passages, I directed further written submissions to be filed in order that I could properly identify the framework of the applicable law with greater clarity. It is axiomatic that if anticipatory declarations are to be made relating to the capacitous and which have the effect of authorising intervention and/or deprivation of liberty at some future point where there is unlikely to be recourse to a court (following a subsequent loss of capacity) that should be rooted very securely in law. I have received submissions of the highest quality from both legal teams.

12. R, as it transpired, did not give birth until 8th September 2019. She was cooperative throughout the labour and her healthy child was born by spontaneous vertex vaginal birth. There was, as it transpired and as R had always asserted would be the case, despite the cogent medical concerns, no need for a caesarean. This was her sixth child and such records as were available indicated that C section had not been necessary in the past. I have been told that the police attended and a Police Protection Order (PPO) was issued followed by Local Authority applications for an Emergency Protection Order (EPO) and an Interim Care Order (ICO).

13. Of course, these developments render my earlier concerns somewhat academic. Nonetheless, I granted these draconian orders and they require, properly to be justified in law. Moreover, they should, in my judgement, be clarified properly for future cases.

14. Before I turn to consider the jurisdictional issues, it is, I think, helpful to preface that exercise by identifying some of the important practical realities. These find clear expression in the guidance of Keehan J in **NHS Trust & Ors v FG (Rev 1) [2014] EWCOP 30**. There the crucial importance of clear and timely planning, particularly in cases involving obstetric care and caesarean section, is identified in unambiguous terms:

> *"19. Save in a case of genuine medical emergency, any application should be made no later than 4 weeks before the expected date of delivery. This time frame is required for the following reasons:*
> *i. where P is assessed as lacking capacity to litigate, it will enable the Official Solicitor to undertake any necessary investigations;*
> *ii. to ensure the final hearing is listed and heard at least a few days before the proposed interventions; and*

iii. to enable a directions hearing to be held around 2 weeks before the final hearing. The court and the parties will then have the opportunity to ensure the court has all the relevant and necessary evidence at the final hearing."

15. Central to this guidance is its focus on ensuring that in both the medical context and in the legal proceedings, there is careful and informed planning:

"20. In compliance with the timetable set out above, the Trusts should in a timely manner, take the following steps:
i. issue the application
ii. notify the Official Solicitor of the application;
iii. disclose any evidence to the Official Solicitor which they consider appropriate;
iv. seek an urgent directions hearing, preferably around two weeks before the final hearing, at which disclosure and the scope of the evidence can be determined;
v. liaise with the Clerk of the Rules to list the substantive hearing at an early stage.
21. It is important that the Trusts should seek early advice and input from their legal advisers.
22. Late applications are to be avoided save in a case of genuine medical emergency. They have four very undesirable consequences:
i. the application is more likely to be dealt with by the out of hours judge and without a full hearing in public;
ii. the available written evidence is more likely to be incomplete and necessitate substantial oral evidence;
iii. it seriously undermines the role that the Official Solicitor can and should properly play in the proceedings; and
iv. it deprives the court of the opportunity to direct that further evidence, including independent expert evidence, if necessary, is obtained in relation to the issue of capacity or best interests.
This approach is dictated by P's Article 5, 6 and 8 rights and best interests."

16. Careful planning and the avoidance of delay, where that is not purposeful, is intrinsic to every case in the Court of Protection, without exception. The focus however is, as Keehan J has emphasised, particularly acute in cases such as this. The need for an informed birth plan, identifying the appropriate support required, reviewed by the Court in a way which permits it properly to be scrutinised and facilitative of representation for P is essential. So too, is the need for a fully transparent process, given the fundamental rights and freedoms that are engaged here. As Keehan J highlights, these rudimentary requirements are a facet of the Article 6 rights of all involved. Moreover, failure to plan in a careful and properly informed manner may jeopardise the health, even the lives of the mother and the unborn baby. Thus, it follows, to my mind, inexorably, the court will need to be involved in a way which anticipates rather than being merely reactive to crisis or emergency.

17. None of this can be permitted to occlude the reality that the court is being invited to make orders of a profoundly intrusive nature which also contemplate a deprivation of liberty. In this case the application arises in the face of opposition by a woman who, all agree, was capacitous at the time of the application and unrepresented. It is a profound understatement to say that such a situation should give any court real concern for the autonomy of the individual at the centre of the process.

The Statutory Framework.

The MCA.

18. Ms Dolan and Mr Patel have, properly, identified the provisions which require to be considered.

19. Section 2(1) provides:

> *"For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain. [my emphasis]"*

20. The MCA Code of Practice makes it clear that a person's capacity must be **assessed at the time when the decision needs to be made** (see paragraphs 4.4, 4.26 and 4.27). Section 3, MCA sets out the matters which must be satisfied if P is unable to make the decision. Section 4, MCA sets out the matters to be considered in determining P's best interests.

21. Section 4A provides:

> *"(1) This Act does not authorise any person ("D") to deprive any other person ("P") of his liberty [my emphasis].*
>
> *(2) But that is subject to:*
> *...*
> *(3) D may deprive P of his liberty if, by doing so, D is giving effect to a relevant decision of the court.*
> *(4) A relevant decision of the court is a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare."*

22. Section 5, MCA *"gives a general authority, to act in relation to the care or treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done"* (per Lady Hale in **N v. ACCG & ors. [2017] AC 549** at [38]). Lady Hale continued:

> *"This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court. But if there is a dispute (or if what is to be done amounts to a deprivation of liberty for which there is no authorisation under the "deprivation of liberty safeguards" in Schedule A1 to the 2005 Act) then it may be necessary to bring the case to court, as the authorities did in this case".*

23. It is clear that the reach of section 5, MCA extends to permitting "restraint", where it is identified as necessary to prevent harm and is a proportionate response both to the likelihood of P suffering harm and the anticipated seriousness of it (see section 6 MCA). Section 15 MCA provides:

"Power to make declarations

(1)The court may make declarations as to—

(a)whether a person has or lacks capacity to make a decision specified in the declaration;
(b)whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;
(c)the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.
(2)"Act" includes an omission and a course of conduct."

24. Section 16 MCA also requires to be stated in full:

"Powers to make decisions and appoint deputies: general

(1)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.

(2)The court may—

(a)by making an order, make the decision or decisions on P's behalf in relation to the matter or matters, or

(b)appoint a person (a "deputy") to make decisions on P's behalf in relation to the matter or matters.

(3)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 4 (best interests).

(4)When deciding whether it is in P's best interests to appoint a deputy, the court must have regard (in addition to the matters mentioned in section 4) to the principles that—

(a)a decision by the court is to be preferred to the appointment of a deputy to make a decision, and

(b)the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances.

(5)The court may make such further orders or give such directions, and confer on a deputy such powers or impose on him such duties, as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order or appointment made by it under subsection (2).

(6)Without prejudice to section 4, the court may make the order, give the directions or make the appointment on such terms as it considers are in P's best interests, even though no application is before the court for an order, directions or an appointment on those terms.

(7)An order of the court may be varied or discharged by a subsequent order.

(8)The court may, in particular, revoke the appointment of a deputy or vary the powers conferred on him if it is satisfied that the deputy—

(a)has behaved, or is behaving, in a way that contravenes the authority conferred on him by the court or is not in P's best interests, or

(b)proposes to behave in a way that would contravene that authority or would not be in P's"

25. Ms Dolan and Ms Roper submitted their skeleton argument on the 4th October 2019. This gave the respondents proper opportunity to analyse and reflect upon it. Mr Patel has, broadly, accepted the thrust of the applicants' submissions.

26. Section 16 (set out at para 24 above) strikes me as the starting point for consideration of the available jurisdiction. There are, at least arguably, alternative constructions to be placed on this section. The most striking is that the section has no application at all here and is entirely confined to decision making where *"a person (P) lacks capacity…"* Alternatively, it is suggested that Section 16 could, whilst precluding the making of an immediate order, nonetheless facilitate the making of a contingency or anticipatory order, which will be triggered only in circumstances where P loses capacity. This latter construction, self-evidently, requires reading the word *"if"* in Section 16 (1) as *"when"*. Moreover, it strikes me as essentially corrosive of the logic of the provision. Such an interpretation strikes me as beyond *'purposive'*, it requires a complete distortion of what is, to my mind, the pellucidly clear wording of the statute.

27. In so far as Cobb J, in **Wakefield MDC and Wakefield CCG v DN and MN** (supra) may be taken to have assumed the existence of a power under Section 16 (2), it is the latter construction (above) that Ms Dolan contends must have prevailed. I agree with the logic of her submission. However, as I have already alluded to, the judge did not have the benefit of the detailed argument that I have received. As I read his judgment, I do not think Cobb J heard any argument on the point. All the advocates before him had agreed that a jurisdiction existed, generally, under the aegis of Section 16, 15 or pursuant to the inherent jurisdiction. In **United Lincolnshire Hospitals NHS Trust v CD** (supra) Francis J found himself in a strikingly similar position to the one I faced in August. In those circumstances he, like me, did not have time to consider extensive legal arguments. The decision was required quickly. Francis J's welfare and legal instincts, led him to the conclusion that either Section 15 or the inherent jurisdictional powers of the High Court provided a sound jurisdictional basis for the intervention sought.

28. I am clear that the explicit wording of Section 16 (1) specifically and unambiguously curtails the ambit of the section, limiting its reach to those who lack capacity. This also resonates with a further and central principle of the MCA, namely that the test for capacity is to be regarded not only as *'issue'* but as *'time'* specific:

*"…if **at the material time** (my emphasis) he is unable to make a decision for himself (section 2 (1) MCA 2005)"*

Ms Dolan makes the additional and attractive point, that for a court to identify jurisdiction, pursuant to Section 16, in respect of a person who does not lack capacity but, who may lose on some future contingency, it would be infringing the cardinal principle of Section 1 MCA i.e.

that a person is not to be treated as unable to make a decision, unless all practical steps have been taken to help him to do so without success. Logically, such steps could not have been taken with an individual who remained capacitous at the time of the application.

29. In contrast to Section 16 (2), the power to make declarations of lawfulness, pursuant to Section 15 MCA, is not expressly curtailed by any requirement of incapacity. Section 15 (1) (see paragraph 23 above) enables the Court both to determine whether an individual has or lacks capacity and the lawfulness of any act done or 'yet to be done'. The wording here contrasts markedly with Section 16 and cannot be said to be explicitly confined to those lacking capacity. On the contrary, this section contemplates consideration and determination of the issue of capacity. Furthermore, there is nothing in Section 15 (1) (c) which inhibits or restricts the Court's declaratory powers to those individuals assessed as lacking in capacity (i.e. on any particular issue). In their skeleton argument Ms Dolan and Ms Roper submit:
"The absence of any pre-condition of incapacity similar to that within s16 and s48 might be taken as an indication that Parliament eschewed limiting the s15(1)(c) declaratory powers to the currently incapacitous. The wording permits the court to make declarations as to the lawfulness or unlawfulness of current and future acts in respect of both the capacitous and incapacitous alike."

30. I should record that the Applicants argument here properly incorporates the qualification in Section 48, which permits interim orders and directions to be made in the context of a different test i.e. where there is 'reason to believe' that P lacks capacity.

31. All this leads Ms Dolan and Ms Roper, in their written submissions, to analyses the scope of Section 15 (1) (c) in these terms:

> *"Section 15(1)(c) therefore empowers a range of different types declarations, for example:*
>
> *i) that X lacks capacity and that the doing of an act in relation to X is or will be lawful, (being predicated on the court finding the act to be in X's best interests); or*
>
> *ii) that X lacks capacity and that the doing of an act in relation to X is or would be unlawful (being predicated on the court finding the act not to be in X's best interests); or*
>
> *iii) that X has capacity, and that the doing of the act would be lawful, (e.g. because X has consent to it);*
>
> *iv) that X has capacity, and that the doing of the act is or would be unlawful, (e.g. because X does not consent to it, or X has made a valid and applicable advanced decision refusing treatment (s24-s26)).*"

32. I broadly agree. There is nothing here, in my judgement, which requires a construction of Section 15 which restricts its declaratory relief to those whom the Court has found to lack capacity. Of course, the section must be construed in the schematic context of the MCA generally. The legislation is intended to protect and guard the autonomy of those who lack decision making capacity in whatever sphere.

33. It is important here to restate that which is obvious in order to identify the clear parameters of this application. I am not being asked to authorise medical intervention in relation to a capacitous adult. I am being invited to determine whether, if the adult in question loses capacity, a medical intervention can be authorised which is contrary to her expressed wishes, whilst capacitous. In virtually every application that comes before this Court, relating to medical treatment, the answer to the question posed here would be a resounding 'no'. There is now a raft of case law, including many of my own judgments, which illustrate the efforts the Court of Protection will go to in order to identify what the likely wishes of P would be, in circumstances where P has lost the capacity for the relevant decision making (see e.g: **Cumbria NHS Clinical Commissioning Group v Ms S & Ors [2016] EWCOP 32; Briggs v Briggs [2016] EWCOP 53; Salford Royal NHS Foundation Trust v Mrs P [2017] EWCOP 23; PL v Sutton Commissioning Group [2017] EWCOP 22**). Whilst the identified wishes of P will not in and of themselves be determinative, they will always be given substantial weight and are highly likely to be reflected in the order or declaration the Court makes. This careful approach, forged by the case law of the last few years, is adopted by the Royal College of Physicians and the British Medical Association in their guidance **'Clinically – assisted nutrition and hydration (CANH and Adults who lack the capacity to consent'**.

34. Just as it would be wrong to distort and import language into Section 16, artificially to extend the scope and ambit of that provision, so too would it be logically inconsistent to import implicit restriction in to the equally plain wording of Section 15. All this is simply to apply the basic rules of statutory construction and, in particular, the 'literal rule' i.e. that the Court should, where possible, construe a statute by giving its words the plain and literal meaning. The classic iteration of this was that of Lord Diplock: **Duport Steels Ltd v Sirs [1980] 1 WLR 142; [1980] 1 All ER 529**. The House of Lords emphasised that where the words of the statute are plain and unambiguous, the Court ought to give effect to that plain meaning:

> *"My Lords, at a time where more and more cases involve the application of legislation which gives effect to policies that are the subject of bitter public and Parliamentary controversy it cannot be too strongly emphasised that the British constitution, though largely unwritten, is firmly based upon the separation of powers; Parliament makes the laws, the judiciary interpret them. When Parliament legislates to remedy what the majority of its members, at the time, perceive to be a defect or a lacuna in the existing law (whether it be the written law enacted by existing statutes or the unwritten common law as it has been expounded by the Judge's in decided cases), the role of the judiciary is confined to ascertaining from the words that Parliament has approved as expressing its intention what that intention was and to giving effect to it. Where the meaning of the statutory words is plain and unambiguous it is not for the judges to invent fancy ambiguities as an excuse for failing to give effect to its plain meaning because they themselves consider that the consequences of doing so would be in expedient, or even unjust or immoral…"*

35. Those responsible for the drafting of the MCA drew heavily on the established jurisprudence relating to cases that had hitherto been litigated under the aegis of the inherent jurisdiction in the Family Division. Many of the cardinal principles that I have referred to above find expression in the earlier case law. A convenient example of this is the recognition within the Act that capacity might be 'fluctuating' and, further, that various strategies may be deployed to enable an incapacitous individual to achieve capacity in a particular sphere of decision taking, where properly and appropriately assisted. This may require the salient issues to be distilled into a format which resonate more comfortably with P's own experiences in life

and his personal characteristics. It may, in different circumstances, involve a change, perhaps even temporarily, to P's medical regimen. In another context it may involve the appointment of an intermediary e.g. to assist in achieving capacity to litigate. All this recognises that 'capacity' is not a static concept. It follows that, inevitably, this Court will find itself involved in situations in which an individual may have capacity to take decisions on some issues but not on others and facing circumstances where P may be able to take decisions on one day that he is unable to on another. Manifestly, it is neither practical nor desirable for the Court to resolve questions of fluctuating capacity on a day to day basis. It may, depending on the individual facts, have to make orders which anticipate a likely loss of capacity if it is going to be able to protect P efficiently.

36. Any declaration relating to an act **'yet to be done'** must, it seems to me, contemplate a factual scenario occurring at some future point. It does not strain the wording of this provision, in any way, to extrapolate that it is apt to apply to circumstances which are foreseeable as well as to those which are current. There is no need at all to diverge from the plain language of the section. In making a declaration that is contingent upon a person losing capacity in the future, the Court is doing no more than emphasising that the anticipated relief will be lawful when and only when P becomes incapacitous. It is at that stage that the full protective regime of the MCA is activated, not before.

37. Before I turn, generally, to the circumstances in which these declarations might be considered, it is important that I confront the complex situation that arises in the context of a prospective authorisation of deprivation of liberty. Mr Patel reminded me that at the August hearing, my declarations provided for R's *"transfer and treatment"*. This involved, potentially, taking R against her will from the psychiatric unit for obstetric care. Thus, a deprivation of liberty was contemplated. Ms Roper also considered that the administering of anaesthetic in such circumstances, properly considered, amounts to a deprivation of liberty. I see the force in that submission but it is unnecessary for me to resolve it here.

38. Mr Patel submits that the Court of Protection does not have power, pursuant to Section 15 (1) (c) MCA, to declare lawful any deprivation of liberty. That, he contends, would be inconsistent with what he submits are the clear terms of Section 4A MCA, which provide that authorisation of deprivation of liberty cannot be made "except" in accordance with the terms of that section and those of Section 4B MCA. Both require to be set out:

> *"4 A Restriction on deprivation of liberty*
>
> *(1) This Act does not authorise any person ("D") to deprive any other person ("P") of his liberty.*
>
> *(2) But that is subject to—*
>
> *(a)the following provisions of this section, and*
>
> *(b)section 4B.*
>
> *(3) D may deprive P of his liberty if, by doing so, D is giving effect to a relevant decision of the court.*

(4) A relevant decision of the court is a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare.

(5) D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty). D may deprive P of liberty if, by doing so, D is carrying out arrangements authorised under Schedule AA1 (arrangements enabling the care and treatment of persons who lack capacity)."

4B Deprivation of liberty necessary for life-sustaining treatment etc][F1Deprivation of liberty necessary for life-sustaining treatment or vital act]

(1) If the following conditions are met, D is authorised to deprive P of his liberty while a decision as respects any relevant issue is sought from the court.

(2) The first condition is that there is a question about whether D is authorised to deprive P of his liberty under section 4A.

(3) The second condition is that the deprivation of liberty—

(a)is wholly or partly for the purpose of—(i)giving P life-sustaining treatment, or (ii)doing any vital act, or

(b)consists wholly or partly of—

(i)giving P life-sustaining treatment, or

(ii)doing any vital act.

(4) The third condition is that the deprivation of liberty is necessary in order to—

(a)give the life-sustaining treatment, or (b)do the vital act.

(5) A vital act is any act which the person doing it reasonably believes to be necessary to prevent a serious deterioration in P's condition.

(1) If Conditions 1 to 4 are met, D is authorised to take steps which deprive P of liberty.

(2) Condition 1 is that the steps—(a)are wholly or partly for the purpose of giving P life-sustaining treatment or doing any vital act, or (b)consist wholly or partly of giving P life-sustaining treatment or doing any vital act.

(3) A vital act is any act which the person doing it reasonably believes to be necessary to prevent a serious deterioration in P's condition.

(4) Condition 2 is that the steps are necessary in order to give the life-sustaining treatment or do the vital act.

(5) Condition 3 is that D reasonably believes that P lacks capacity to consent to D taking the steps.

(6) Condition 4 is that—(a)subsection (7) applies, or (b)there is an emergency.

(7) This subsection applies if—(a)a decision relevant to whether D is authorised to deprive P of liberty is being sought from the court, or (b)a responsible body is carrying out functions under Schedule AA1 with a view to determining whether to authorise arrangements that give rise to a deprivation of P's liberty.

(8) In subsection (7) it does not matter—(a)whether the decision mentioned in paragraph (a) relates to the steps mentioned in subsection (1); (b)whether the arrangements mentioned in paragraph (b) include those steps.

(9) There is an emergency if D reasonably believes that—

(a)there is an urgent need to take the steps mentioned in subsection (1) in order to give the life-sustaining treatment or do the vital act, and

(b)it is not reasonably practicable before taking those steps—

(i)to make an application for P to be detained under Part 2 of the Mental Health Act,

(ii)to make an application within subsection (7)(a), or(iii)to secure that action within subsection (7)(b) is taken."

39. Ms Dolan and Ms Roper also agree that deprivation of liberty can only be authorised in a limited number of circumstances, i.e. by the Court pursuant to Section 16 (2) (a): s4 A (3) and (4); by standard urgent authorisation under Sch A 1: s 4 A (5); by operation of s4 B; while a decision is sought from the Court, if the deprivation of liberty is necessary to provide P with life sustaining treatment or to do any vital act.

40. I agree with the Official Solicitor's approach here. A deprivation of the liberty of any human being will always and self-evidently require scrutiny and vigilance. I agree that these orders may only be made via the above provisions. Parliament plainly intended, for reasons that are obvious, that the granting of such orders would be confined within strict criteria. It strikes me as a distortion not only of the provisions themselves but of the entire framework of the act to contemplate facilitating such draconian restrictions through other and far less obvious channels.

41. Section 4B will also not be available on a contingency basis. It is manifestly intended to be applicable in an unforeseen emergency pending an application to the Court. That was plainly not the case here. Equally, it would be artificial and, arguably an abuse of process, for professionals treating P to seek to trigger the protective regime of Section 4B, by the making of a second application, when P loses capacity. Francis J rejected this **in United Lincolnshire Hospitals NHS Trust v CD**, describing it as *"artificial"* and *"a device"*. I agree.

42. It may be possible, in some cases, to envisage an application for urgent authorisation under DOLS set out in Sch A1. However, for the reasons I have discussed, at para 16 above, I consider that in these difficult obstetric cases, that is not only unviable but also potentially dangerous. It is not an overstatement to say that the inevitable potential for delay, including for a very short period, may lead to compromise of the health or risk to the life of the mother and unborn child. It is, also, necessary to say that risk to the health or life of the unborn child is, in

these circumstances, rarely likely to be in the mother's best interests. I say 'rarely' rather than never because it is possible to contemplate an obstetric crisis which requires a binary choice to be made between the survival of the mother or the unborn child. This is the prism through which this particular aspect of risk must be evaluated.

43. There is clear authority that the inherent jurisdiction may properly be utilised to authorise a deprivation of liberty in appropriate circumstances, where that is identifiably in P's best interests: see Re: **PS (Incapacitated or vulnerable adult) [2007] EWHC 623 Fam; An NHS Trust v Dr A [2013] EWHC 2422**. This must be compatible with Article 5 ECHR. The observations of Baker LJ in **A Local Authority v BF [2018] EWCA Civ 2962** are relevant:

> *"(1) The inherent jurisdiction of the High Court for the protection of vulnerable and incapacity adults remains available notwithstanding the implementation of the Mental Capacity Act 2005: Re DL per McFarlane LJ (as he then was) at [52] et seq and Davis LJ at [70] et seq. In the memorable phrase first deployed by Lord Donaldson in Re F (Mental Patient: Sterilisation) [1990] 2 AC 1, it is "the great safety net".(2) The jurisdiction extends to protecting vulnerable persons who do not fall within the categories of those covered by the Mental Capacity Act 2005: see, for example, Re DL itself and London Borough of Wandsworth v M & Ors [2018] 1 FLR 919; [2017] EWHC 2435 Fam, and further to providing additional protection to adults lacking capacity within the meaning of the Mental Capacity Act 2005 when the remedy sought does not fall within those provided in the Act: see, for example, City of Westminster v IC [2008] EWCA Civ 198 and NHS Trust v Dr A [2013] EWHC 2442 COP.(3) As to the definition of vulnerability in these cases, the picture is comprehensively outlined in the judgment of Munby J in Re SA [Citing paragraphs 77, 78 and 80].(4) Insofar as such actions infringe with rights under Article 8 of the Human Rights Convention,* ***the interference may be justified to protect the health of the individual but only if they are necessary and proportionate****: see Re DL, McFarlane LJ at [86] and Davis LJ at [76].(5) In an appropriate case, orders can be made depriving someone of their liberty under the inherent jurisdiction provided the exercise of the jurisdiction is compatible with Article 5 of ECHR: see Re PS (Incapacitated or vulnerable adult) [2007] EWHC 623 Fam per Munby J.(6) In cases involving incapacitated or vulnerable adults, Article 5(1) of the Convention provides, so far as relevant to this case:"Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:...(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants..."Article 5(4) provides:"Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."(7) "...[E]xcept in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the component national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends on the persistence of such a disorder..." Winterwerp v Netherlands [1979] 2 EHRR 387 at [39].(8)* ***Under Article 5(4), the lawfulness of the detention has to be reviewed under the principles set out in the Convention****. It must therefore be wide enough to bear on those conditions that are essential for the lawful detention. In particular, with a view to ascertaining whether*

there still persists unsoundness of mind of a kind or degree warranting compulsory confinement: see Winterwerp at [55] and Re PS at [20]. (9) As explained by Munby J in Re SA, the inherent jurisdiction in this context is exercisable not merely where a vulnerable adult is but also where he is reasonably believed to be incapacitated. [Citing paragraph 80 above]. See also Re SK [2004] EWHC 3202 Fam; [2005] 2 FLR 230 and London Borough of Wandsworth (Supra) at [84]-[86]. But, as McFarlane LJ pointed out in Re DL at [68]:"Whilst such interim provision may be of benefit in any given case, it does not represent the totality of the High Court's inherent powers."(10) In exercising its powers as set out above, the court must attach due weight to the individual's personal autonomy. The court must, furthermore, be careful to avoid the so-called protective imperative to which I first referred in the case of CC v KK [2012] EWHC 2136 (COP) at [25]."

Whilst that judgment concerns an application for permission to appeal and thus not ordinarily citable, the above passages are a characteristically helpful distillation of the central principles emerging from the case law.

44. In other cases, I have emphasised that the scope of the inherent jurisdiction is not 'ubiquitous', in the sense that its reach is all pervasive or unlimited. Though I have deprecated any tendency to regard the inherent jurisdiction as 'a lawless void permitting Judges to do whatever we consider to be right for children or the vulnerable…' (see **London Borough Redbridge Council v SNA [2015] EWHC 2140 Fam**.), I do not doubt that the jurisdiction remains available to fill lacunae when they occur within the applicable statutory framework. Having concluded that Section 15 (1) (c) is apt to authorise contingent declarations, it would be rendered nugatory if there were no mechanism to authorise the contemplated intervention as being lawful. This is, to my mind, a paradigmatic situation for recourse to the inherent jurisdiction.

45. Baker J (as he then was) analysed the reach of the inherent jurisdiction in the context of deprivation of liberty in **An NHS Trust v Dr A [2013]** (supra). He made the following observations:

"94. Under its inherent jurisdiction, the High Court can make an order authorising a deprivation of liberty but such an order must comply with the provisions of Article 5: per Munby J in Re PS (Incapacitated or Vulnerable Adult) [2007] EWHC 623 (Fam)). In particular, any order authorising detention must contain provision for an adequate review at reasonable intervals (see paragraph 23). The reason for this requirement was explained by Munby J in Re BJ (Incapacitated Adult) [2009] EWHC 3310 (Fam) at paragraph 10:
"...regular reviews by the court are not merely desirable, not merely a matter of good practice; they go, as both the Strasbourg jurisprudence and the domestic case-law make clear, to the very legality of what is being done."
95. Finally, as stated above, the court, as a public authority, cannot lawfully act in a way that is incompatible with a right under ECHR. I accept the submission that I am under an operational duty under Article 2 to protect Dr. A., a man who, as I have found, lacks capacity to decide whether to accept nutrition and hydration against the risk of death from starvation. By making the orders sought by the Trust under the inherent jurisdiction, I will be complying with that operational duty.
96. In all the circumstances, I hold that this court has the power under its inherent jurisdiction to make a declaration and order authorising the treatment of an

incapacitated adult that includes the provision for the deprivation of his liberty provided that the order complies with Article 5. Unless and until this court or another court clarifies the interpretation of section 16A of the MCA, it will therefore be necessary, in any case in which a hospital wishes to give treatment to a patient who is ineligible under section 16A, for the hospital to apply for an order under the inherent jurisdiction where the treatment (a) is outside the meaning of medical treatment of the MHA 1983 and (b) involves the deprivation of a patient's liberty."

46. In explicit terms and, in so far as the circumstances of that case amounted to a deprivation of liberty, Baker J identified the jurisdictional foundation for intervention. I agree with the reasoning in those passages and the conclusions:

"97. Under that jurisdiction, I am satisfied, for the reasons set out above, that an order for forcible feeding of Dr. A. is in his best interests. I therefore make the orders sought by the applicant Trust, that is to say declaring that it shall be lawful for the Trust clinicians to provide Dr. A. with artificial nutrition and hydration and to use reasonable force and restraint for that purpose, and further declaring that, insofar as those measures amount to a deprivation of liberty, they shall be lawful."

47. I am satisfied that the inherent jurisdiction is an available route to authorise deprivation of liberty in the circumstances arising in this case. It is a classic application of the powers to supplement and give effect to the objectives of the statute.

48. Having analysed the jurisdictional basis for the Trust's applications, I consider that Ms Dolan and Ms Roper are correct, in their written argument, to confront the circumstances in which such contingent declarations should be made. All agree that they should be made sparingly. The case law, to which I have referred, emphasises the 'exceptional' circumstances of the particular cases. However, in the context of the applications that come before Tier 3 (i.e. High Court) judges of the Court of Protection, many cases may properly be described as exceptional. Certainly, the families of those involved would consider them to be so. The cases frequently present issues of medical, moral, legal complexity. The MCA emphasises the importance of identifying P's capacity to take individual decisions. The jurisdiction is highly case or fact specific. Against this backdrop it is easy to see that the concept of 'exceptional' is vulnerable to being corroded i.e. interpreted as having wider application than that which the Court might intend. The right of all individuals to respect for their bodily integrity is a fundamental one. It is every bit the right of the incapacitous as well as the capacitous.

49. In **Re: S (Adult: refusal of medical treatment [1992] 4 All ER 671**) Sir Stephen Brown (P) granted a declaration that a caesarean could be performed on a capacitous women to save her life and the life of her unborn child. This order was granted notwithstanding her clearly articulated objections which were rooted in profound religious beliefs. This was the first occasion this issue was considered by the High Court. It was a life and death situation both for the mother and for the unborn child and a decision, once again, was required in minutes rather than hours. It was heard by Sir Stephen Brown, P. as a matter of the utmost urgency. The hearing was, of necessity, short and it was not possible for the mother to be represented. So many of these applications, of which this one is typical, have required to be dealt with in circumstances which have not provided proper opportunity for these very complex ethical issues to be analysed with the care that they require. In Re: S, the health authority applied for a declaration that it was lawful for the hospital to carry out an emergency caesarean section. The Official Solicitor acted as Amicus Curiae. The patient`s objection to the operation was, as

I have stated, on religious grounds. The judge heard brief evidence and made the following observations in his judgment at **page 27**:

> *"Although this application only came to the notice of the court officials at 1.30pm, it has come on for hearing just before 2.0pm and now at 2.18pm I propose to make the declaration which is sought. I do so in the knowledge that the fundamental question appears to have been left open by the Master of the Rolls in the case of Re T (supra) heard earlier this year in the Court of Appeal, and in the knowledge that there is no English authority which is directly in point. There is, however, some American authority which suggests that if this case were being heard in the American courts the answer would be likely to be in favour of granting a declaration in these circumstances: see Re AC (1990) 573 A 2d 1235 at pp 1240,1246-1248, 1252.*
>
> *I do not propose to say any more at this stage, except that I wholly accept the evidence of Mr P as to the desperate nature of this situation, and that I grant the declaration as sought."*

50. That decision attracted immediate and wide spread criticism, not only from academics but also from all those properly concerned with women's rights to control their own bodies. In Re: **MB (An Adult: Medical Treatment) [1997] EWCA Civ 3093**, Lady Justice Butler-Sloss identified the following principles:

"(1). Subject to (3) below, in general it is a criminal and tortious assault to perform physically invasive medical treatment, however minimal the invasion might be, without the patient`s consent, see **Collins v Wilcox [1984] 1 WLR 1172 per Goff LJ at page 1177**, cited with approval in **Re F (Mental Patient: Sterilisation) [1990] 2 AC 1**.

(2). A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death, see **Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871 per Lord Templeman at pages 904-905**; see also **Re T (An Adult)(Consent to Medical Treatment) [1993] Fam 95 per Lord Donaldson MR at page 102**.

(3). Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent had been competently given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient: **Re F (supra)**."

51. Lady Justice Butler-Sloss undertook a review of the relevant case law. At risk of overburdening this judgment, I think it important to incorporate that review, not least because it illuminates both the anxious thought and consideration that judges give to these profoundly troubling cases and also the evolution in the Court's understanding and protection of personal autonomy. Thus:

> *"21. We turn now to consider some of the caesarian section decisions. In **Tameside and Glossop Acute Services Trust v CH [1996] 1 FLR 762** the patient was suffering from paranoid schizophrenia and was admitted under **section 3** of the **Mental Health Act 1983**. She was found to be pregnant and that the foetus was in danger if the pregnancy continued. There was overwhelming evidence that she lacked the capacity to consent to or refuse the treatment proposed. **Wall J**, in making the declaration sought under **section 63** of the **Mental Health Act**, set out the general principles which govern*

*non-consensual treatment and applied the three part test, (**the C Test**), set out by **Thorpe J** in **Re C, (supra)**.*

*22. In **Norfolk and Norwich HealthCare (NHS) Trust v W [1996] 2 FLR 613** the patient arrived at the hospital in labour denying that she was pregnant. She had a history of psychiatric treatment. She was in a state of arrested labour. The obstetrician considered a forceps delivery or a caesarian section had to be performed. A psychiatrist examined her and found she was not suffering from a mental disorder. He was not certain whether she was capable of comprehending and retaining information about the proposed treatment but she continued to deny she was pregnant. He was not sure if she was capable of believing the information about the treatment. He was however of the opinion that she was not able to balance the information given to her. **Johnson J** at **page 616** held that:-*

"although she was not suffering from a mental disorder within the meaning of the statute, she lacked the mental competence to make a decision about the treatment that was proposed because she was incapable of weighing up the considerations that were involved. She was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour made even more difficult for her because of her own particular mental history."

23. The judge was satisfied that the operation was in her best interests and that in the circumstances the court had power at common law to authorise the use of reasonable force.

*24. During the hearing of the **Norfolk and Norwich case Johnson J** was asked to make declarations **in Rochdale Healthcare (NHS) Trust v C [3 July 1996] (unreported)**. It was extremely urgent in that the consultant obstetrician considered that the caesarian section had to be carried out within the hour if the foetus was to survive and risk of damage to the patient`s health was to be avoided. The mother had previously had a caesarian section and said she would rather die than have it again. It was not possible to obtain psychiatric evidence in the time available. The obstetrician considered that the patient was fully competent. The judge had very little time and only `the scantiest information` upon which to assess the patient and make a decision. He applied **the C Test** and found that the patient was not capable of weighing up the information that she was given, the third element of **the C test**. He held:-*

"The patient was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh-up the considerations that arose so as to make any valid decision, about anything of even the most trivial kind, still one which involved her own life."

25. One may question whether there was evidence before the court which enabled the judge to come to a conclusion contrary to the opinion of the obstetrician that she was competent. Nonetheless he made the declarations sought. In fact the patient changed her mind and consented to the operation.

*26. In **Re L [5th December 1996] (unreported) Kirkwood J** was faced with an application on facts similar to the present appeal. This was the decision relied upon by Hollis J. It was an urgent application in respect of a patient `L`in her twenties who had been in labour for some hours and the labour had become obstructed. In the absence of intervention the foetus was at risk and deterioration was inevitable and death would follow. The carrying of a dead foetus would be injurious to the patient`s health and the removal of the foetus by surgical procedure would become necessary. An emergency caesarian section was strongly indicated. `L` wanted her baby to be born alive but she*

suffered from a needle phobia and was unable to consent to the use of a needle and therefore to the proposed course of treatment. The judge applied ***the C test*** *and said:-*
"that her extreme needle phobia amounted to an involuntary compulsion that disabled `L` from weighing treatment information in the balance to make a choice. Indeed it was an affliction of a psychological nature that compelled `L` against medical advice with such force that her own life would be in serious peril."
27. He held that she was incapable of weighing the relevant treatment information in the balance and thus lacked the relevant mental competence to make the treatment decision. He further held that it was in her best interest to have the operation and he granted the declaration sought by the hospital.
28. In each of the decisions to which we have referred the question of the competence of the woman concerned was in issue and in each case she was found to lack the capacity to consent to or refuse treatment. The only reported decision, to our knowledge, in which the capacity of the patient to decide does not appear to have been specifically raised was ***Re S (Adult: Surgical Treatment) [1993] 1 FLR 26****. It was the first occasion upon which this problem was considered by the High Court. It was a life and death situation both for the mother and for the unborn child and a decision was required in minutes rather than hours. It was heard by Sir* ***Stephen Brown, P.*** *as a matter of the utmost urgency…"*

52. However, Lady Butler-Sloss was clear that the decision as to whether a competent woman should have a caesarean was the woman's decision and hers alone. Her reasoning was not to be subjected to scrutiny, the right engaged was one of personal autonomy, control over her own body and her own foetus:

"A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise.

3. Irrationality is here used to connote a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided it could have arrived at it."

53. Later in the judgment Butler-Sloss LJ observes:

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

54. These passages permit of no ambiguity. The Court of Appeal revisited the point the following year in **St Georges Health Care NHS Trust v S [1998] 3 All ER 673**, reiterating that a woman was not required to submit to 'an invasion of her body' against her will whether her own life or that of her unborn child depended on it. 'Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant'. This growth towards emphasising individual autonomy was reflected in both the American and Canadian case law (see **Re: AC (1990) cite 573 A 2d 1235 (DC App 1990); Winipeg and Child Family Services (North West Area) v G (1997) 152 DLR (4th) 193**). In that latter case, the Canadian Supreme Court held that it would be unlawful to detain a young woman addicted to solvent inhalation for the purposes of protecting her unborn child. Again, in forthright language McCloughlin J stated:

> *"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."*

55. The approach of the Courts in the Republic of Ireland is particularly illuminating, given that the Irish constitution expressly acknowledges the right to life of the unborn child and weighs it, in equal terms, alongside the mother's. Nonetheless, in **Health Service Executive v B [2016] EHC 605** the Irish High Court held that a woman could not be compelled to undergo a caesarean even though the evaluated risk of injury to both her and her unborn child was considered to be high.

56. The mother in the case before me was reported as having told medical staff that a caesarean section would be 'the last thing she would want'. People use this phrase loosely, frequently it means it is something they would never want. It can also be interpreted very literally as being an option only to be contemplated 'last' of all. I do not consider that it would be morally or intellectually honest of me to give it the latter construction. I think that would be to distort the essence of the evidence and the impression of the mother's wishes that the medical staff were interpreting and which generated this application. It is, I think, important to acknowledge, as others have done, that judges in the past may have strained to conclude that women, in these difficult circumstances, lacked decision making capacity in order, for the highest of motives, to protect the life or health of both the mother and her unborn child. To give the mother's articulated position this very limited interpretation would, on careful reflection, be sophistry, designed to enable me to protect the mother and her unborn child without confronting what I consider to be the true evidential picture.

57. The particular challenge presented by the facts of this case and those before Cobb and Francis JJ's is that unlike her capacitous coeval, the mother, upon losing capacity, would lose the opportunity to express a changed decision. The birth process is, self-evidently, highly dynamic. It will frequently require obstetric re-evaluation. With considerable diffidence, I suspect that many birth plans are changed, when confronted with the painful realities of a complicated labour. Many expectant mothers who may have vociferously disavowed epidurals re-evaluate this choice in labour. This is true of the whole gamut of obstetric options, including both induction and caesarean section. Accordingly, the strength and consistency of previously expressed views must be considered with intense subtlety and sensitivity in this highly uncertain and emotionally charged obstetric context. Thus, it seems to me, that I must balance my instinctive inclination to protect the autonomy of a woman's control over the invasion of her own body, with my obligation to try to ensure that her options on losing capacity are not

diminished. It may be that this is not capable of resolution in principle. As always in this sphere, much will depend on the circumstances of the individual case. What, I speculate, would the medical staff be expected to do if, the Court having granted a declaration as to the unlawfulness of intervention, they found themselves confronted with a desperate but incapcitous woman screaming for unspecified medical assistance during the birth process? Certainly, there would not be time to contact a judge. Moreover, in those circumstances, I find it hard to see how the judge's evaluation would be likely to add anything to the assessments of the nursing and medical team. In Re: **DM [2014] EWHC 3119 (Fam)** I emphasised the important and powerful observations of Judge LJ in **St George's Healthcare NHS Trust v S and R v Collins & Ors, ex parte S [1998] 2 FLR 728**:

> *"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." [page 742]*
>
> *It needs to be emphasised that Judge LJ was there considering a "competent adult" who remained capacitous throughout.*

58. As I have stated, in this case, as in some of the others I have looked at above, it was not possible for the Official Solicitor to speak with R to achieve greater clarity as to her wishes and feelings in order, if nothing more, to help craft a declaration which kept options open for her and her unborn child.

59. It is necessary to consider the status of the unborn child. As Sir George Baker (P) stated in **Paton v British Pregnancy Advisory Service Trustees [1979] QB 276**:

> *"The foetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country"*

60. The correctness of this approach was confirmed in **Paton v United Kingdom (1981) 3 E.H.R.R. 408** where it was held that an unborn child did not have a right to life within the scope of Article 2 of the ECHR.

61. It is important to recognise that whilst English law may not confer rights on the foetus, there are many instances where it is protected by the law. The **Congenital Disabilities (Civil Liabilities) Act**, for example, enables a child to bring an action in relation to a tort occurring when still in utero. Similarly, a baby injured in utero, but born alive, may properly be regarded as a victim of manslaughter when death occurs as a result of the inflicted injuries. By the

Abortion Act 1967 section 1, (as amended by the Human Fertilisation and Embryology Act 1990) pregnancies up to 24 weeks may, in certain defined circumstances, be terminated. Pregnancies after 24 weeks may only be terminated where it is necessary to prevent grave injury to the mental or physical health of the pregnant woman. The Act gives precedence to the health of the mother over the unborn child. Butler-Sloss LJ identifies an apparent paradox in Re: MB (Supra):

> *"50. Although it might seem illogical that a child capable of being born alive is protected by the criminal law from intentional destruction, and by the **Abortion Act** from termination otherwise than as permitted by the Act, but is not protected from the (irrational) decision of a competent mother not to allow medical intervention to avert the risk of death, this appears to be the present state of the law. Moreover, if the competent mother by refusing medical intervention is delivered of a handicapped child, she cannot be sued by that child for her decision not to take steps to protect it at the moment of birth. The **Law Commission** rejected the proposal that a child should be able to have a claim against his mother for injury sustained before birth, (**Law Commission Report No 60**)."*

62. When an individual loses capacity, Section 4 MCA 2005 imposes on the Court of Protection an independent obligation to evaluate P's 'best interests'. In making a contingent declaration i.e. in the event of a loss of capacity, this obligation is also engaged. The Court must assume the onerous responsibility of deciding, for itself, where the best interests of P will lie, recognising that the delivery of her healthy unborn baby will be an intrinsic factor. P's expressed wishes, as I have stated above, are not regarded, within the statutory framework, as synonymous with P's best interests. In particular, the provisions introduce the concept of 'reasonableness'. The ambit of the relevant factors is extensive:

> *"Best interests*
>
> *(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—*
>
> *(a)the person's age or appearance, or*
> *(b)a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.*
>
> *(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*
>
> *(3) He must consider—*
>
> *(a)whether it is likely that the person will at some time have capacity in relation to the matter in question, and*
> *(b)if it appears likely that he will, when that is likely to be.*
>
> *(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.*

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

(a)the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
(b)the beliefs and values that would be likely to influence his decision if he had capacity, and
(c)the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a)anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b)anyone engaged in caring for the person or interested in his welfare,
(c)any donee of a lasting power of attorney granted by the person, and
(d)any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—

(a)are exercisable under a lasting power of attorney, or
(b)are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) "Relevant circumstances" are those—

(a)of which the person making the determination is aware, and
(b)which it would be reasonable to regard as relevant."

63. The caselaw has emphasised the right of a capacitous woman, in these circumstances, to behave in a way which many might regard as unreasonable or "morally repugnant", to use Butler-Sloss LJ's phrase. This includes the right to jeopardise the life and welfare of her foetus. When the Court has the responsibility for taking the decision, I do not consider it has the same latitude. It should not sanction that which it objectively considers to be contrary to P's best interests. The statute prohibits this by its specific insistence on 'reasonable belief' as to where P's best interests truly lie. It is important that respect for P's autonomy remains in focus but it

will rarely be the case, in my judgement, that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus. In this case it may be that R's instincts and intuitive understanding of her own body (which it must be emphasised were entirely correct) led to her strenuous insistence on a natural birth. Notwithstanding the paucity of information available, I note that there is nothing at all to suggest that R was motivated by anything other than an honest belief that this was best for both her and her baby. It is to be distinguished, for example, from those circumstances where intervention is resisted on religious or ethical grounds. In the circumstances therefore, it seems reasonable to conclude that R would wish for a safe birth and a healthy baby.

64. Sections 24 – 26 MCA 2005 give statutory recognition to, and regulate the applicability and effect of, Advanced Decisions to refuse specified treatments made by an adult when they have capacity to consent to or refuse medical treatment, which are to have effect in the event of loss of capacity. Again, the provisions largely embody the common law position, modified by additional safeguards. Thus:

> *"24 Advance decisions to refuse treatment: general*
> *(1) "Advance decision" means a decision made by a person ("P"), after he has reached 18 and when he has capacity to do so, that if—*
> *(a)at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and*
> *(b)at that time he lacks capacity to consent to the carrying out or continuation of the treatment,*
> *the specified treatment is not to be carried out or continued.*
> *(2) For the purposes of subsection (1)(a), a decision may be regarded as specifying a treatment or circumstances even though expressed in layman's terms.*
> *(3) P may withdraw or alter an advance decision at any time when he has capacity to do so.*
> *(4) A withdrawal (including a partial withdrawal) need not be in writing.*
> *(5) An alteration of an advance decision need not be in writing (unless section 25(5) applies in relation to the decision resulting from the alteration).*
> *25 Validity and applicability of advance decisions*
> *(1) An advance decision does not affect the liability which a person may incur for carrying out or continuing a treatment in relation to P unless the decision is at the material time—*
> *(a)valid, and*
> *(b)applicable to the treatment.*
> *(2) An advance decision is not valid if P—*
> *(a)has withdrawn the decision at a time when he had capacity to do so,*
> *(b)has, under a lasting power of attorney created after the advance decision was made, conferred authority on the donee (or, if more than one, any of them) to give or refuse consent to the treatment to which the advance decision relates, or*
> *(c)has done anything else clearly inconsistent with the advance decision remaining his fixed decision.*
> *(3) An advance decision is not applicable to the treatment in question if at the material time P has capacity to give or refuse consent to it.*
> *(4) An advance decision is not applicable to the treatment in question if—*
> *(a)that treatment is not the treatment specified in the advance decision,*
> *(b)any circumstances specified in the advance decision are absent, or*

(c)there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.
(5) An advance decision is not applicable to life-sustaining treatment unless—
(a)the decision is verified by a statement by P to the effect that it is to apply to that treatment even if life is at risk, and
(b)the decision and statement comply with subsection (6).
(6) A decision or statement complies with this subsection only if—
(a)it is in writing,
(b)it is signed by P or by another person in P's presence and by P's direction,
(c)the signature is made or acknowledged by P in the presence of a witness, and
(d)the witness signs it, or acknowledges his signature, in P's presence.
(7) The existence of any lasting power of attorney other than one of a description mentioned in subsection (2)(b) does not prevent the advance decision from being regarded as valid and applicable."

65. It is important, in testing the reasoning above, to consider whether R, by parity of analysis, should be regarded as being in essentially the same position as an individual who had prepared an Advance Decision in the correct manner. Had R done so, could this application have been sustained? I say, at once, that I consider that an Advance Decision, properly constructed, with the appropriate safeguards in place would, in my judgement, be binding on the Court. I do not however, consider that R is in an analogous position. In preparing and drafting a carefully worded Advanced Decision, which is compliant with the statutory safeguards, P will, of necessity, have been required to identify the clear circumstances in which the refusal to comply is made. Neither, in my view, is the requirement for a signature in the presence of a witness to be regarded as a mere legal formality. It is part of a process in which a competent and capacitous adult can safely be regarded as having made prospective instructions on issues of the utmost gravity. Self-evidently, a statement, as made here, that a caesarean section is 'the last thing I would want' would not be compliant with the provisions. This is not because it is expressed in lay terms, it is because it is not sufficiently choate. A woman might choose, for example, not to have a caesarean even though her own life is at risk but elect to do so if the life or health of her baby is compromised. Also, and unequivocally, the capacitous adult who has prepared a statutory compliant Advanced Decision, has consciously waived the right to change her mind upon loss of capacity. R cannot be regarded, on the available evidence, as being in that position.

66. I do not think that I have previously delivered a judgment relating to serious medical intervention, in which I have decided the issue contrary to the identifiable wishes and feelings of P. These views are often articulated with clarity, colour and, with remarkable frequency, humour by P's family and close friends, at a time when P has lost the capacity for reasoned expression. The Court of Protection has, for example, recognised P's right to refuse lifesaving dialysis. It has declined applications to authorise amputations which would have, at least, significantly extended life. In extreme cases the Court has respected the refusal of nutrition by those with chronic eating disorders. The case law emphasises the importance of individual autonomy.

67. Caesarean sections however, present particular challenges even weighed against all these parlous circumstances. The inviolability of a woman's body is a facet of her fundamental freedom but so too is her right to take decisions relating to her unborn child based on access, at all stages, to the complete range of options available to her. Loss of capacity in the process

of labour may crucially inhibit a woman's entitlement to make choices. At this stage the Court is required to step in to protect her, recognising that this will always require a complex, delicate and sensitive evaluation of a range of her competing rights and interests. The outcome will always depend on the particular circumstances of the individual case.