Neutral Citation Number: [2023] EWCOP 20

Case No: COP 13960658

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/05/2023

Before :

MRS JUSTICE LIEVEN

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Between :

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Applicant

and

(1) T (BY HER PROPOSED LITIGATION FRIEND, THE OFFICIAL SOLICITOR)
(2) MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST

Respondents

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Ms Stephanie David (instructed by **The Shrewsbury and Telford NHS Trust**) for the **Applicant**
Ms Claire Watson KC (instructed by **the Official Solicitor**) for the **First Respondent**
Ms Nageena Khalique KC (instructed by **Capsticks Solicitors LLP**) for the **Second Respondent**

Hearing dates: **1 August 2022**

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Approved Judgment

This judgment was handed down remotely at 10.30am on 23 May 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives

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MRS JUSTICE LIEVEN

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 anonymity 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.

Mrs Justice Lieven DBE :

1. This is a very belated judgment in a case concerning an anticipatory declaration which came before me as an urgent application on 1 August 2022. I declined to make the declaration sought and said that I would give reasons later. Given the subject matter there was no urgency about the reasons. Unfortunately, various other matters intervened, and I sincerely apologise to the parties for the great delay in producing this reasoned judgment.

2. The NHS Trust applied in the Court of Protection for an anticipatory declaration in respect of obstetric care for T. At the date of the application T was 39 weeks gestation and her estimated delivery date by scan was 6 August 2022. The Trust was represented before me by Ms Stephanie David of Counsel, T, through the Official Solicitor, by Ms Claire Watson QC (as she then was), and Midlands Partnership NHS Foundation Trust by Ms Nageena Khalique QC (as she then was).

3. T had a diagnosis of Persistent Delusion Disorder and had been detained under s.2 of the Mental Health Act 1983 ("MHA") between 18 May and 9 June 2022. She had been prescribed Quetiapine for the condition but was recorded as not taking the medication.

4. T had something of a chaotic lifestyle, having at various points been homeless and having lived in a refuge. In the records since she had become pregnant there is reference to the police having found her intoxicated and acting very strangely, to her being preoccupied with delusional thoughts and not being able to hold a conversation, and to her becoming highly distressed at times.

5. However, on 14 July her treating Consultant Obstetrician and Gynaecologist assessed T as having capacity about her obstetric care. She noted that:

> *"I was concerned about how T would react during labour due to the fact that she had been assessed by a psychiatrist as having delusions of a sexual nature, which raised concerns about how she would act in labour when she was tired, possibly with opioid analgesia onboard and required pelvic examinations which could trigger flashbacks."*

6. In late July, T called her midwife and sounded very distressed, angry and delusional.

7. T's Consultant Obstetrician and Gynaecologist put in her report:

> *"38. Although I have assessed T as retaining capacity to make decisions in respect of her obstetric care and treatment during labour, I am concerned that she has fluctuating capacity and may lose capacity due to the stress and pain of labour and the effects of drugs, which may cause her to have delusional thoughts which mean she cannot discuss her delivery options and obstetric care at the time. T has been known to focus on her delusional thoughts to the extent that it is not possible to discuss her pregnancy, and if this were to occur during labour it could place her and her baby at significant risk of harm.*

> *39. I believe that there is a small risk that T's Persistent Delusion Disorder will be present during labour such that she is so focussed on her delusional thoughts that she either cannot listen to or understand the information she is being told about the delivery of her baby, cannot retain that information, cannot use and weigh up that information to come to her own decision, or cannot communicate her decision to her treating team.*
>
> *40. Although the risk of T losing capacity to make decisions about her obstetric care and treatment is small, the potential consequences are life-threatening, because in an emergency situation, decisions will need to be taken to ensure the health and life of T and her baby."*

8. The Trust was concerned that although T had capacity in terms of her obstetric care, she might lose capacity when going through the stress of labour. T's midwife said in her statement:

> *"34. It appears to me that her delusional thinking becomes more apparent during times of stress and changes very quickly based on the situation.*
>
> *35. Labour is a stressful and painful event. In my experience of observing T and interacting with her during her pregnancy, stress appears to trigger her Persistent Delusion Disorder, which makes communication with T exceptionally challenging, and sometimes impossible.*
>
> *36. My concerns for T in labour are that she will not be able to make decisions in relation to her obstetric care that are necessary during labour because, if her Persistent Delusion Disorder has taken over at that particular time, she will not be able to listen to the information provided by the midwifery or obstetric team as to her options, she will not be able to retain and weigh up that information, and she will not be able to communicate her decision because she will be entirely focussed on discussing her history of alleged sexual assaults."*

9. In the light of those concerns the Trust made the application to the Court of Protection for an anticipatory declaration.

10. However, it is of some note that the first time that the Official Solicitor was notified of the intention to make an application was Tuesday 26 July and she was sent the Application bundle on Friday 29 July. At that stage the plan was to induce labour on Tuesday 2 August, i.e. 2 working days after the bundle was sent. This was in circumstances where the Trust had been aware of T's mental health condition since at least 19 May. As Ms Watson pointed out, the need for the application should have been apparent since at least 24 June when T's midwife was unable to complete a full antenatal check.

11. The representative of the Official Solicitor, Mr Cullen, spoke to T on the telephone on the afternoon of 29 July and found that she was very lucid:

> *"12. Following his discussion with T Mr Cullen emailed the Applicant's solicitors at 5.26pm to ask whether the application had been issued and whether the court had listed the matter for a hearing on Monday 1 August 2022. Mr Cullen has also asked the Trust's solicitors to discuss the possibility of drafting an advance statement with T and to clarify why she had been booked in for an induction of labour on 2 August 2022, as this is not addressed in the evidence filed with the application.*
>
> *13. The Trust solicitor provided a response by email at 8.37am on Saturday 30 July 2022, however this was not read by Mr Cullen until Sunday evening. In that response it was confirmed that the application had been issued on 29 July and an induction of labour is indicated because (i) T is a heavy smoker and the rate of stillbirth goes up after 39 weeks, and (ii) T has decided that she would like to have her baby by the estimated delivery date and she wishes for the induction to take place on 2 August 2022 if spontaneous labour has not occurred by that date. This does not appear to be entirely consistent with T's understanding as expressed to Mr Cullen.*
>
> *14. There has been no response to the Official Solicitor's suggestion that an advance statement should be discussed with T. Despite having a "care plan discussion" with T yesterday (see 31 July 2022 Note) an advance statement does not appear to have been mentioned to T at all. In the circumstances the Official Solicitor has arranged for an agent, Ms Kauser-Hussain, to visit T at 10.30am and facilitate her attendance at the hearing this morning."*

12. By the time the matter came before me, the Midlands Partnership Trust, which was responsible for T's mental health care, had declined to carry out a capacity assessment. T's Consultant Psychiatrist has indicated that she is *"not able to make any predictive statement regarding her capacity in any situation"*. She also states that if T were to lose capacity during labour, *"then I would assume that the clinicians involved would manage the situation under The Mental Capacity Act and act in her best interest…"*. The Consultant Psychiatrist does not address the question of T's current capacity to make decisions about her obstetric treatment nor does she address T's litigation capacity.

13. There had been some discussion of T entering into an advance statement of her wishes and feelings. The Trust met with T on 31 July 2022 to prepare an advance statement. This was then read out to T for her approval and lodged at court shortly before the hearing.

14. There is no doubt that the Court has the power to make anticipatory declarations where P has fluctuating capacity, and there is a real risk that they will lose capacity in respect of an important decision, pursuant to s.15(1)(c) Mental Capacity Act 2005 ("MCA"); see *University Lincolnshire Hospitals NHS Trust v CD* [2019] EWCOP 24. Whilst the court's decision to exercise that power depends upon the facts, in CD Francis J made such an anticipatory declaration in a case concerning a 27 year old woman who was 35 weeks pregnant and had a diagnosis of paranoid schizophrenia and emotionally unstable personality disorder. It was common ground in that case that CD, at the time of the hearing, had capacity to make decisions in respect of the birth

of her child, but the clinicians were concerned that there was a risk that she would lose capacity to make decisions at critical moments during the course of her labour. In the course of his judgment, Francis J stated inter alia as follows:

> *"16.*
>
> *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".*
>
> *...*
>
> *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.*
>
> *...*
>
> *vii) In my judgement, if making such an anticipatory or peremptory 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."*

15. Francis J did not consider that it was appropriate to end the proceedings because that *"would be dangerous"* and it was *"plainly wrong to do nothing"* [13]. He noted that:

> *"… 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."*

16. However, there is very clear guidance from the court about the timing of applications concerning obstetric care where capacity is an issue. In *NHS Trust 1 and NHS Trust 2 v FG* [2014] EWCOP 30 Keehan J set out clear guidance on the steps to be taken in obstetric cases concerning pregnant women with mental health problems, who also potentially lack capacity to litigate and to make decisions about their welfare or medical treatment. The guidance states that an application should be made *"at the earliest opportunity"* [18] and no later than four weeks before the expected delivery date [19].

17. As set out in [22] of the judgment, the rationale for making an early application is to prevent the undesirable consequences of late and incomplete evidence. It was recognised that a late application *"…seriously undermines the role that the Official Solicitor can and should properly play in the proceedings"* and prevents the court from giving directions for further evidence, if necessary.

18. In *A University Hospital NHS Trust v CA* [2016] EWCOP51 at [5] Baker J stated that *"all NHS Trusts must ensure that their clinicians, administrators and lawyers are fully aware of, and comply with, the important guidance given by Keehan J in respect of applications of this sort."*

19. In *Guys and St Thomas' NHS Foundation Trust v R* [2020] 4 WLR 96 (*"GSTT"*), the court was asked to make anticipatory declarations concerning the obstetric treatment of a woman with bipolar affective disorder who was considered to be at substantial risk of a deterioration in her mental health, such that she was likely to lose capacity during labour. Hayden J stated at [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."*

20. In that case and in *NHS Trust v G* [2015] 1 WLR 1984 the Courts set out guidance on when an NHS Trust should make an application for anticipatory declarations about obstetric care. At [103-5] the Court said:

> *"103. There are, however, a number of circumstances in which the Official Solicitor submits that an application should be made by the Trusts treating P to obtain permissive orders relating to P's obstetric care. They are as follows:*
>
> *1. the interventions proposed by the Trust(s) probably amount to serious medical treatment within the meaning of COP Practice Direction 9E, irrespective of whether it is contemplated that the obstetric treatment would otherwise be provided under the MCA or MHA ; or*
>
> *2. there is a real risk that P will be subject to more than transient forcible restraint; or*
>
> *3. there is a serious dispute as to what obstetric care is in P's best interests whether as between the clinicians caring for P, or between the clinicians and P and/or those whose views must be taken into account under s 4(7) of the MCA; or*
>
> *4. there is a real risk that P will suffer a deprivation of her liberty which, absent a Court order which has the effect of authorising it, would otherwise be unlawful (i.e. not authorised under s 4B of or Schedule A1 to the MCA).*
>
> *104. I agree.*
>
> *105. Further in relation to category 1, it is recommended that the following categories of case should be the subject of an application to the court, namely:*
>
> *i) delivery by caesarean section is proposed in circumstances where the merits of that proposal are finely balanced; or*
>
> *ii) delivery by caesarean section is proposed and is likely to involve more than transient forcible restraint of P."*

21. In *GSTT* Hayden J said at [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."*

22. The Applicant's submission is that this case falls within categories 1,2 and 4 as set out above and therefore an application to the Court was needed. I am not convinced on the facts of this case that that is correct, but in any event any such application should have been made much earlier, so that the Court and the Official Solicitor could properly consider the matter.

23. T had indicated quite clearly, at a point when no one disputed her capacity, that she would enter into an advanced declaration about medical treatment. In my view that was a far more appropriate way to deal with a potential loss of capacity, rather than engaging the Court in making an invasive and draconian order. Such an approach protects the woman's autonomy, in a way that an anticipatory declaration does not do.

24. Further, the Courts need to be careful about granting anticipatory declarations, particularly concerning sensitive decisions about obstetric care, unless the evidence clearly supports it. In the present case the Court did not have evidence that T did not have capacity at the time of the hearing and was in reality doing no more than speculating as to whether she might lose it. The evidence was that there was nothing more than a "small risk" that she might lose capacity, and in my judgment that is insufficient to justify an anticipatory declaration in a case such as this. There is a serious risk in a case such as this that a woman's autonomy will be overridden at such an important time, because of an assumption that she has lost capacity.

25. In this case there are other ways of managing the situation, apart from taking the draconian and properly exceptional step, of making an anticipatory declaration in respect of a woman who at the present time has capacity. Firstly, she could be invited to enter into an advance statement of her wishes and feelings in respect of her obstetric care during birth. It was clear that T was prepared to enter into such an advanced declaration. Secondly, if there was a true emergency, then the clinicians can use the doctrine of necessity to protect the mother. There needs to be some caution about turning what are in truth medical decisions into legal ones.

26. Therefore, on the facts of this case these were more appropriate and proportionate approaches than making an anticipatory declaration. In any event, any such application should have been made much more timeously.