Are we still "policing pregnancy"?

Sara Fovargue and José Miola

Introduction

During the 1990s seven cases were heard concerning the ability of women in the later stages of pregnancy to choose their method of delivery.[1] In every case, for various reasons, it was declared lawful to perform a caesarean section against the woman's wishes. These cases caused some commentators, including Margaret Brazier and ourselves, to consider the moral and legal responsibilities of pregnant women for foetal health when the decision to continue the pregnancy to term had been made.[2] While some questioned whether the decision of the Court of Appeal in *St George's Healthcare NHS Trust v S*[3] was the end of the story,[4] Brazier presciently cautioned that 'the conclusion, or news of a conclusion, to the story is premature (…) in terms of legal analysis because other issues where liberty and procreative responsibility conflict remain to be resolved'.[5] Only one case involving a court ordered caesarean was reported between 1998 and 2003,[6] but since 2013 at least five have been heard,[7] all involving women under the protection of the Mental Health Act 1983 (MHA). When these cases are read alongside the decisions relating to *CP (A Child) v First-tier Tribunal (Criminal Injuries Compensation)*,[8] discussed by Catherine Stanton and Emma

---

1 *Re S (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 671; *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FCR 274; *Norfolk and Norwich (NHS) Trust v W* [1996] 2 FLR 613; *Re L (An Adult: Non Consensual Treatment)* [1997] 1 FLR 837; *Tameside and Glossop Acute Services Trust v CS* [1996] 1 FCR 753; *Re MB (Caesarean Section)* [1997] 2 FLR 426, CA; *St George's Healthcare NHS Trust v S, R v Collins, ex parte S* [1998] 3 WLR 936, CA.

2 For e.g., Margaret Brazier, 'Liberty, responsibility, maternity' (1999) 52 *Current Legal Problems* 359; Sara Fovargue and José Miola, 'Policing Pregnancy: Implications of the *Attorney-General's Reference (No 3 of 1994)* [1998] 6 *Medical Law Review* 265; Margaret Brazier, 'Parental responsibilities, foetal welfare and children's health' in Caroline Bridge (ed.), *Family Law Towards the Millennium: Essays for PM Bromley* (Butterworths 1997); Heather Draper, 'Women, forced caesareans and antenatal responsibilities' (1996) 22 *Journal of Medical Ethics* 327.

3 *St George's* (n 1).

4 See, for e.g., Sabine Michalowski, 'Court ordered caesareans – the end of a trend?' (1999) 62(1) *Modern Law Review* 1157.

5 Brazier (1999) (n 2) 359-360.

6 *Bolton NHS Trust* v *O* [2003] 1 FLR 824.

7 *Re AA* [2012] EWHC 4378 (COP); *In the matter of P* [2013] EWHC 4581 (COP); *Great Western Hospitals NHS Foundation Trust v AA* [2014] EWHC 132 (Fam); *NHS Trust 1, NHS Trust 2 v FG* [2014] EWCOP 30. The fifth case involved the Royal Free London NHS Trust and is unreported, but it is discussed in, for e.g., Press Association, 'Judge gives permission for a caesarean section on mentally ill woman' *The Guardian* (London, 31 January 2014) <http://www.theguardian.com/society/2014/jan/31/judge-caesarean-section-mentally-ill>; Patrick Sawer, 'Judge orders mentally ill woman to have forced caesarean' *Daily Telegraph* (London, 1 February 2014) <http://www.telegraph.co.uk/health/healthnews/10611575/Judge-orders-mentally-ill-woman-to-have-forced-caesarean.html>; BBC News, 'Judge approves forced Caesarean for mentally-ill woman <http://www.bbc.co.uk/news/uk-england-london-25996231> all accessed 16 January 2015.

8 [2014] EWCA Civ 1554. See previously *CICA v First-Tier Tribunal and CP (CIC)* [2013] UKUT 638 (AAC).

Cave in this collection,[9] we see that the issue of maternal responsibility during pregnancy is again in the spotlight.

In this chapter we consider the role of the law in determining maternal responsibility for foetal welfare in relation to decisions regarding delivery, note identifiable trends in the older cases, and examine the four recent reported decisions. We suggest that, as Brazier said, such cases will continue to be brought to court until 'other issues where liberty and procreative responsibility conflict' are resolved.

Moral and/or legal maternal responsibility for foetal health in the 1990s

When considering the legal and ethical issues raised by maternal and parental responsibility for foetal health, Brazier argued that:

> mothers-to-be have especial responsibility to their children *in utero*. The absolute dependency of the future child on its mother increases, not diminishes her *moral* responsibility for its welfare. She can no more morally justify causing injury to that child than to any of her born children, or any other woman's children.[10]

Nevertheless, moral responsibility should not result in *legal* responsibility, which '[w]omen rightly fear (…) not out of a lack of concern for their future child but because of the potential impact on their liberty and privacy during and prior to a pregnancy'.[11] The lack of tortious liability for maternal behaviour affecting foetal welfare, and the family courts' refusal to extend wardship to a foetus, or to authorise the non-consensual treatment of pregnant women with capacity, was not due to women owing no moral duty to have regard to the welfare of the child-to-be, but because the price of legally enforcing that duty was too high.[12] Law's limited involvement in foetal welfare was thus a pragmatic recognition of three realities. First, legal intervention was unlikely to be effective unless it entailed 'intrusive policing of (…) pregnancies', setting women apart from all others in society and 'subject to medically dictated codes of pregnancy practice'.[13] Secondly, because even pre-conception acts can affect a child, if the law were to enforce any responsibility for foetal

---

9 'Maternal responsibility to the child not yet born', Ch. xx.
10 Brazier (1997) (n 2) 272, emphasis in original.
11 *ibid* 273.
12 *ibid* 281.
13 *ibid* 293.

welfare this would mean that fertile women *and* men must 'prioritise the health of their future children over all other competing interests'.[14] Finally:

> [f]oetal welfare is most likely to be maximised if society concentrates, not on using the law to pursue the occasional "bad" mother-to-be, but on ensuring that all those who may become parents grow up themselves and reproduce in a society which ensures that parental health maximises foetal health.[15]

Thus, '[w]e need to rediscover means of support and encouraging responsible choice without inevitably allowing the heavy boots of the law to trample over private choice'.[16] We suggest that the recent caesarean cases highlight the continuing deficiencies in this regard, but that they were somewhat unexpected for three reasons. First, the decisions in *Re MB* and *St George's* made it clear that cases involving refusals of consent from women with capacity should be rejected because such women *are* able to make decisions concerning their medical treatment.[17] Indeed, Andrew Grubb cautiously welcomed the decision in *St George's* as being a potential watershed, with its influence to be determined in later judgments.[18] Although the Court heard that case *after* the caesarean had been performed, it provided guidelines to ensure that labouring, or near-to-labouring, women were not automatically deemed to lack capacity if they refused to consent to a proposed form of delivery.[19] These include the need to identify concerns about capacity as early as possible, that the hearing should be inter partes, the woman represented, and relevant and accurate information provided to the court.

Secondly, the law on capacity, formalised in the Mental Capacity Act 2005 (MCA), now presumes that those aged 16 and over have the capacity to make decisions for themselves.[20] A lack of capacity must be proved by those alleging otherwise on the balance of probabilities,[21] by applying the tests set out in sections 2 (1) and 3 (1). A least restrictive

---

14 *ibid*.
15 *ibid*.
16 *ibid* 391.
17 *St George's* (n 1); *Re MB* (n 1).
18 Andrew Grubb, 'Competent adult (pregnant woman): forced treatment and Mental Health Act' (1998) 6(3) *Medical Law Review* 356.
19 *St George's* (n 1) 968-970.
20 s 1 (2).
21 s 2 (4).

alternative approach is endorsed,[22] and anything done in or on behalf of the person must be in their best interests.[23] Factors to be considered when determining a patient's best interests are set out, building on and drawing from common law developments prior to the Act, which emphasised a less medically focused definition.[24] Thus, under section 4, there is a duty to consult the patient and certain other people, including those caring for her, so that their views can be taken into account in a best interests assessment.[25] This assessment includes a consideration of what the patient would have wanted (their 'past and present wishes and feelings' and their 'beliefs and values' likely to influence any decision if they had capacity),[26] and the person determining whether a patient has capacity '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'.[27] The (easy) assumption, identifiable in the 1990s cases, that a woman's best interests were her best *medical* interests should now thus be rare,[28] and serious regard should be given to what the pregnant woman wants and/or wanted.

Finally, the landscape of medical law has changed dramatically since the 1990s. When the first caesarean case, *Re S*, was decided in 1992, medical law was dominated by *Bolam*[29] The answer to most medical law questions, including what was in a patient's best interests, was determined by whether there was a body of medical opinion that would do as the doctors proposed to do. Medical interests and expertise dominated. Times have changed, and the courts have acknowledged their ability to examine health professionals' decisions, albeit that it will be rare to go against them.[30] The prime consideration is now *balancing* the patient's autonomy with her welfare and best interests, rather than purely welfare considerations dominating.[31] This exercise should result in the woman's voice being heard in decisions about delivery, minimising the possibility that decisions are made *about* her but

---

22 s 1 (6).
23 s 1 (5).
24 See, e.g., *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 FCR 193, CA; *Re A (Male Sterilisation)*; *Re S (Adult Patient: Sterilisation)* [2001] Fam 15, CA.
25 ss 4 (6) and s 4 (7), respectively.
26 s 4 (6) (a) and (b).
27 s 4 (4).
28 *Tameside* (n 1).
29 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
30 See *Bolitho v City and Hackney Health Authority* [1998] AC 232.
31 See *Chester v Afshar* [2004] UKHL 41.

without her, as occurred in some of the 1990s cases.[32] Rather, the broader definition of best interests should introduce balance where previously there was none.

It might therefore be imagined that the law has accepted that while women have a *moral* responsibility to their foetuses, this does not extend to a *legal* duty. Brazier's view thus seems to accord with the law's development since the 1990s caesarean cases. However, we suggest that the newer cases indicate a continued scope for and desire to create the sort of legal framework that she warned against, at least with regards to a specific category of pregnant woman.

The backdrop to the recent cases: Criminal responsibility for (maternal) conduct during pregnancy?

Just as the 1990s cases were heard while the criminal responsibility of a third party for harm caused to a foetus *in utero* was being considered by the House of Lords,[33] during 2013 and 2014 the courts were asked to consider whether maternal conduct (drinking alcohol) which harmed the foetus *in utero* could be viewed as a crime (for the purposes of awarding the child compensation under the Criminal Injuries Compensation Scheme) if it results in a child being born injured.[34] In 1998 the House of Lords held that a man who stabbed his pregnant girlfriend in the abdomen, causing the baby to be born alive but subsequently dying from the injuries sustained in the attack, could be charged with unlawful act manslaughter.[35] At the time we argued, as did Brazier, that this decision was dangerous for pregnant women because if one sort of manslaughter was appropriate, then why not another, such as gross negligence manslaughter? And if a third party might be liable for foetal injuries, what was to stop maternal liability?[36] We all concluded that when the philosophies of the caesarean cases and the *Attorney-General's Reference* were considered together, there was a danger that the desire to protect the foetus might develop into maternal liability for foetal health. Our concerns have, in some ways, been vindicated by the arguments presented in the recent

32 *Norfolk* and *Rochdale* (n 1).
33 *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245, HL.
34 *CP (A Child)* (n 8); *CICA* (n 8).
35 *Attorney-General's Reference* (n 33).
36 Fovargue and Miola (n 2); Brazier (1999) (n 2).

criminal injuries case, and media reports of it,[37] but our focus here is on the themes evident in the recent caesarean cases and what they tell us about law's policing of pregnancy today.

The newer caesarean cases: *Re AA* [2012][38]

AA was 39 weeks pregnant, and compulsorily detained under the section 3 of the MHA with 'a schizophrenic disorder, which [was] psychotic in nature'.[39] It was determined that she lacked the capacity to make decisions for herself. She had already had two caesarean sections. An NHS Trust made an urgent application for a declaration that it would be in AA's 'medical best interests' to deliver by caesarean section.[40] This was supported by a consultant obstetrician, and the consultant psychiatrist treating her. Because of her previous caesareans there was a 'significant risk' of a ruptured womb if AA delivered vaginally, and this would endanger both her and the foetus' health.[41] Mostyn J held that AA's 'mental health best interests' would be best served by the birth of a healthy baby,[42] and authorised a planned elective caesarean delivery the following day.[43]

Prima facie the case was straightforward, but an examination of the detail highlights the complexities and our concerns. For example, as the 'significant risk' of uterine rupture was actually only 1%, 'it was 99 per cent likely that the patient's uterus would not rupture'.[44] Given the size of this risk, we suggest that had this been a risk disclosure case the risk would not have been deemed 'material', and so not require disclosure.[45] As well as relying on this risk, Mostyn J appears to have equated best interests with *medical* best interests in the form of AA's '*mental health* best interests'.[46] This is not necessarily problematic, as mental health well-being is so fundamental to our well-being as individuals and when we are mentally well we are able to function properly, and express our genuine wishes. Thus, mental health best

---

37 See, for e.g., Owen Bowcott, 'Foetal damage caused by alcohol "equivalent to manslaughter"' *The Guardian* (London, 5 November 2014); Loulla-Mae Elefthriou-Smith, 'Drinking while pregnant is a "crime of violence" court hears' *The Independent* (London, 6 November 2014).

38 *Re AA* (n 7).

39 *ibid* Proceedings.

40 *ibid* Note by Mostyn J.

41 *ibid* [4].

42 *ibid* [5].

43 *ibid* Proposed Proceedings.

44 Emma Walmsley, '*Mama Mia!* Serious shortcomings with another "(en)forced" caesarean case *Re AA* [2012] EWHC 4378 (COP)' (2015) 23 *Medical Law Review* 135.

45 *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR 53, CA.

46 *Re AA* (n 7) [5], emphasis added.

interests may weigh more heavily than other *purely medical* best interests.[47] Nevertheless, wider best interests considerations, required by the MCA, were only minimally attended to.

The health of the foetus was, however, noted, and the Trust argued that a planned caesarean was required because if AA were 'dissembling' because of her mental state 'or otherwise being uncooperative, [the Trust] would not be able to monitor the baby's heartbeat to see whether there were potential uterine rupture complications emerging'.[48] Given this, the least restrictive option, which under the MCA and it's *Code of Practice* is required for the treatment to be in the patient's best interests,[49] may have been to authorise foetal heart monitoring using reasonable restraint, and if signs of uterine rupture presented, then the caesarean could be authorised.[50] Instead, the move to caesarean was swift and medically supported.

Speed was also evident in the urgent nature of the application, which resulted in AA only being represented by the Official Solicitor. It is unclear whether AA was aware of the Trust's application, and/or contributed to the proceedings at all. Was she lacking capacity at all times, or were there lucid periods when she was able to express an opinion? It is also unclear from the case report and transcript whether any attempts were made to treat AA's mental health condition and explore the delivery plans with her. AA was detained under section 3 of the MHA on 13 June 2012, and the Trust's application was made on 23 August when she was 39 weeks pregnant and, presumably, known to midwives and obstetricians. So why was the management of her labour seemingly not considered until so late? Furthermore, it was surely known that AA had already had two caesareans, and that this might influence the delivery method for subsequent pregnancies.

These are precisely the sorts of issues that the *Collins* guidelines were supposed to address, along with the provisions of the MCA.[51] Yet the factors to be considered in the MCA's best interests assessment are conspicuous by their absence. Rather, the medical evidence was seemingly determinative, with the best outcome for AA deemed to be the delivery of a healthy baby. While this may have been true, the decision appears to have been

---

47 We thank Catherine Stanton for this point.
48 *Re AA* (n 7) Proceedings.
49 s 1(6); Department of Constitutional Affairs, *Mental Capacity Act Code of Practice* (TSO 2007) 27.
50 Walmsley (n 45) 139.
51 DCA (n 49) 20-24.

taken without AA, and her voice, as in some of the 1990s cases, is lacking. Additionally, there is no evidence in the judgment as to if or how the MCA's tests for capacity were applied. However, if AA was being treated under section 3 of the MHA then her schizophrenia would not necessarily eliminate her capacity to make decisions.[52] Thus, if we ask whether the 'heavy boots of the law' trampled over AA's private choice,[53] the answer here is 'yes'.

***In the matter of P* [2013]**[54]

The boots are, we suggest, also evident here. P was 36, in the final stages of her fourth pregnancy, and was compulsorily admitted to a psychiatric hospital in November 2013. Her first two children were delivered vaginally and subsequently taken into care, and her third was delivered via caesarean and did not live with P. P was thought to suffer from paranoid schizophrenia and was, at times, psychotic. Due to her diabetes, AA was carrying a large baby and an excessive amount of amniotic fluid. P did not always co-operate with her doctors or reliably take her medication for schizophrenia, and four senior psychiatrists agreed that she lacked the capacity to make decisions about her obstetric care. The Trust sought a declaration that it would be lawful to induce P's labour and, if necessary, perform a caesarean. The declaration was granted, with Jackson J deciding that P lacked capacity to make decisions relating to delivery, and that it was in her best interests to safely deliver her baby as it would have 'extremely adverse effects' on her if 'the child was not born safely or was born with some avoidable disability as a result of a lack of obstetric care'.[55]

P was in hospital and was 'relatively calm and accepting of the idea of being induced'[56] by having her waters broken and 'instrumental delivery'.[57] Nevertheless, the Trust sought a declaration in anticipation of any problems during delivery, and wanted authorisation to induce P's labour and perform a caesarean if this was required to 'avoid significant bleeding', particularly from her existing section scar, or to 'avoid foetal distress'.[58] The risk of bleeding was said to be 'small, but not insignificant'.[59] In contrast to

---

52 See, e.g., *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.

53 We leave aside here the question of whether she could, in fact, make a private choice given that we do not know how her capacity as assessed and on what evidence.

54 *P* (n 7).

55 *ibid* [17].

56 *ibid* [4].

57 *ibid* [3].

58 *ibid* [3].

59 *ibid* [16].

Re AA this was not an emergency, but Jackson J only 'heard from the parties' advocates, (…) three consultant doctors by telephone link, and (…) the Official Solicitor's case manager'.[60] Even though sections 4(6) and (7) of the MCA require that the views of the patient and those close to her regarding her ascertainable past and present wishes and feelings are considered as part of the best interests assessment, it is noticeable that neither P nor her relatives were heard by the judge. The requirements of section 4 were, however, noted, and Jackson J stated that P was 'very opposed' to a caesarean, which 'conflicts with her strong views'.[61] It is unclear how this information was obtained, and there is no discussion of the effect on P of ignoring her wishes. Jackson J merely stated that he had given 'full weight to what she feels and believes' but that the declaration sought would give P 'a good chance of having a normal labour' and 'provide her with safety if it were to be necessary'.[62] He did not mention the views of her family or other carers, and it is not clear whether those who would be responsible for caring for her during labour were in favour of the proposed course of action. Indeed, in his evidence Mr B, a consultant obstetrician, merely set out the options available.[63]

As with *Re AA*, minimal account was taken of P's views, and those of her relatives or friends do not appear at all. The focus was on medical best interests relating to P's physical health and her mental health if 'the unborn child' was adversely affected.[64] A wider consideration of best interests was, again, absent. It is thus easy to see how the law can slip, almost blindly, into policing delivery options at the end of a pregnancy. P was found to lack capacity to decide for herself, and her objections to the caesarean were overruled with a minimum of fuss. The law, in this case at least, did not refrain from interfering in delivery decisions and thereby policing pregnancy.

***Great Western Hospitals Foundation Trust v AA* [2014]**[65]

AA was 25 and 38 weeks pregnant with her first child. She had a history of bipolar disorder, substance and alcohol abuse, and had been prescribed a 'battery of antipsychotic medication'.[66] She and her partner (BB) welcomed the pregnancy and complied with the antenatal care provided. At the time of the application, AA's father described her as being in

60 *ibid* [6].
61 *ibid* [15].
62 *ibid* [18].
63 *ibid* [12].
64 *ibid* [17].
65 *Great Western* (n 7).
66 *ibid* [3].

the worst state that he had seen her in, and when she arrived at hospital on 26 January 2014 she was 'confused and disoriented', and her membranes had ruptured though she was not in labour.[67] On 27 January she was detained under section 5(2) of the MHA,[68] and was 'highly agitated and (…) largely uncooperative with almost every aspect of her care'.[69] The concern was that, because of her pregnancy, AA had not been able to receive appropriate antipsychotic medication. As her waters had already broken there was an increased risk of maternal and foetal infection until delivery was complete. Standard practice was to induce labour via an IV drip, but there was unanimity that AA would not co-operate with this, and she had previously removed IV lines.[70]

On 27 January 2014 Moor J made an interim order, because AA was unrepresented, authorising a caesarean section if AA went into labour or began to show signs of infection before the full hearing on 28 January.[71] She did not go into labour, and at the full hearing Hayden J heard that AA had become more distressed and had 'run at the window and tried to get out', stating that she 'wanted to go to heaven'.[72] There were two alternatives available: medically inducing labour or a planned caesarean. As already noted, there were concerns about induction, and the court heard that in a quarter to a third of cases where labour is induced an emergency caesarean is required.[73] This would be particularly dangerous in this case, and could result in infection and sepsis leading to the foetus dying or being brain damaged, and there were risks of shock or haemorrhage to AA. The Trust thus concluded that a planned caesarean under general anaesthetic was the best option.[74]

AA appeared to lack capacity at the time the decision needed to be made, the decision was relatively urgent, she seemingly wanted a healthy baby, but was acting in a way contrary to this. It is thus understandable why a court might support performing a caesarean, regardless of AA's consent. But it is notable that a different approach is identifiable here from the outset. While Hayden J said that it was 'self-evident' that AA did not have the

---

67 *ibid* [6].

68 Section 5 provides for the admission to hospital of patients who are already in-patients at a hospital (for example, where a patient is detained for assessment but the clinicians want to detain for treatment) and s 5(2) provides a doctor with a 72 hour period in which to detain the patient while a report is prepared in support of the application.

69 *Great Western* (n 7).

70 *ibid* [7].

71 *Great Western Hospitals NHS Foundation Trust v AA* [2014] EWHC 166 (Fam).

72 *Great Western* (n 7) [9].

73 *ibid* [10].

74 *ibid* [11].

capacity to make the decision about delivery for herself, he still spent time explaining *how* he reached that conclusion.[75] He explored the MCA's requirements in the context of the medical evidence available to him, and so this was more than a mere declaration that AA had been assessed and declared to lack capacity. Rather, Hayden J engaged with the evidence, including from her father, and his conclusion that AA's level of agitation meant that she was unable to absorb, retain or process information mirrored the opinions of the doctors and her father.[76] Furthermore, a caesarean was not the only option considered by the court, but it was, ultimately, determined to be the best option.

On the face of it, the case for a caesarean seems stronger here than in *Re AA* and *P*, but the court approached the issue in a very different way. In relation to best interests, Hayden J stated that '[w]hen I consider the best interests of AA here, I do so by evaluating the clinical alternatives keeping her medical interests in focus. *But a best interests decision requires a broader survey of the available material*'.[77] He heard from BB *and* AA's father, and interpreted their evidence as meaning that if AA were lucid she would follow the medical advice and have a caesarean.[78] Although sections 4(6) and (7) of the MCA were not explicitly mentioned, it is clear that Hayden J was cognisant of them and so he gave weight to what AA would have wanted if she had capacity. His reasoning, therefore, is an example of best practice as there was a serious and successful attempt to give weight to AA's views and to engage with those of her family. It is, of course, easier to do this when these seem to accord with the recommendations of the doctors, but the law was correctly and appropriately applied, and the decision and the reasoning should thus be welcomed. It would, of course, be interesting to know if the same approach would have been adopted if, for example, AA's father had not supported the medically recommended course of action. Nevertheless, in this case the heavy boots of the law did not trample on AA. Rather, the law supported her and the 'police' were, for once, on her side.

***NHS Trust 1, NHS Trust 2 v FG* [2014]**[79]

Finally, FG was 24, in the later stages of her first pregnancy, and was detained under section 3 of the MHA with a schizoaffective disorder. The Trust sought a declaration that she lacked

---

75 *ibid* [18]. Capacity is discussed at [18]-[20].
76 *ibid* [20].
77 *ibid* [16], emphasis added.
78 *ibid*.
79 *FG* (n 7).

the capacity to make decisions about her medical treatment and that it was in her best interests for a number of medical procedures to be undertaken, if necessary, when she went into labour. These included taking blood, inserting needles for IV access, and 'instrumental or operative delivery'.[80] Keehan J held that FG lacked the capacity to make decisions about medical treatment, and, having set out sections 1 and 4(1)-(4) and (6) of the MCA,[81] concluded that the orders sought by the Trust were in FG's best interests.[82] Although this is a lengthy judgment, 130 paragraphs in total and 24 paragraphs of guidance in an Annex, there is nothing to explain how Keehan J reached his conclusions, beyond the simple acceptance of all of the medical evidence. Indeed, there was no input from other voices, as required by section 4(7) MCA.

Nevertheless, this case is notable because of the guidance which Keehan J set out for cases 'where a pregnant woman who lacks, or may lack, the capacity to make decisions about her obstetric health (…) resulting from a diagnosed psychiatric illness, falls within one of four categories of cases'.[83] These are where the proposed interventions 'probably amount to serious medical treatment' in the meaning of COP Practice Direction 9E,[84] there is 'a real risk that P will be subject to more than transient forcible restraint', there is a 'serious dispute as to what obstetric care is in P's best interests' or there is 'a real risk that P will suffer a deprivation of her liberty'.[85] 19 points are made relating to assessment and application, including that once an individual is identified as being the possible subject of an application to the court the Acute and Mental Health Trusts should liaise to arrange an assessment of her capacity and best interests,[86] if capacity is likely to fluctuate it should be 'kept under review',[87] and once a decision to go to court has been made, the application should be made 'at the earliest opportunity',[88] if possible 'no later than' 4 weeks before the baby is due,[89] to give the Official Solicitor as much time as possible to 'undertake any necessary investigations'.[90] And "emergency" applications should only be made if there is a 'genuine

---

80 *ibid* [17].
81 *ibid,* [30], [32] respectively.
82 *ibid* [54].
83 *ibid* Guidance [2].
84 Court of Protection, Practice Direction 9E Applications relating to serious medical treatment (15 May 2014).
85 *FG* (n 7) Guidance [3].
86 *ibid* Guidance [7].
87 *ibid* Guidance [9].
88 *ibid* Guidance[18].
89 *ibid* Guidance [19].
90 *ibid.*

medical emergency'.[91] Some of these are similar to the *St George's* guidelines, but it is notable that the *FG* guidelines do not require attempts to be made to involve the patient in the process, only that her ascertainable wishes are to be provided to the court for consideration.[92] Thus, while the guidelines may be read as building on the lessons from the other more recent cases, the reasoning of Hayden J in *Great Western* does not, unfortunately, appear to have been recognised and developed.

Conclusion

So, where are we now with policing pregnancy? In some ways we are experiencing déjà vu. A case concerning liability for foetal injury has recently been heard by the courts, as has a series of cases involving the delivery options of women under the auspices of the MHA who are judged to lack the capacity to decide for themselves. In some of these cases, despite the requirements of the MCA, the capacity of the women was minimally considered,[93] and their voices absent in the decision-making process.[94] Yet the reasoning in *Great Western Hospitals* stands out and is to be praised, and the *FG* guidelines may help to minimise the number of cases involving women under the MHA reaching court. Indeed, the *St George's* guidelines appear to have helped to stop the policing of pregnancies of women with capacity, and the same may be the result of the FG guidelines for women under the MHA. We can but hope that this occurs, because it appears that law's gaze has shifted to this category of pregnant women. This is concerning, as is the misapplication of the MCA in some of the recent cases.

We suggest that Brazier's diagnosis of why the decision in *St George's* was unlikely to be the last forced caesarean case, because we had yet to resolve issues where procreative responsibility and liberty come into conflict, is still valid today. The question of *how* we address moral duties to the foetus without seeing them leak into legal ones remains unanswered. This has not gone unnoticed by others, and Ken Mason and Graeme Laurie, for example, have commented that the MCA was 'silent on the challenges thrown up by the pregnant woman' and that 'reinforcement of the pregnant woman's absolute right to refuse

---

91 *ibid* Guidance [19].
92 *FG* (n 7) Annex para 23(f).
93 *Re AA* (n 7); *FG* (n 7).
94 *P* (n 7); *FG* (n 7); *Re AA* (n 7).

through the *Code of Practice* may have been welcomed on a number of fronts'.[95] We agree, and suggest that without such law's heavy boots may continue to be in evidence in the policing of some pregnancies.

[95] John K Mason, Graeme T Laurie, *Mason and McCall Smith's Law and Medical Ethics* (9th edn, Oxford University Press, 2013) 92.