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ANTICIPATING ISSUES WITH CAPACITOUS PREGNANT WOMEN: *UNITED LINCOLNSHIRE NHS HOSPITALS TRUST V CD* [2019] EWCOP 24 AND *GUYS AND ST THOMAS' NHS FOUNDATION TRUST (GSTT) AND SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST (SLAM) V R* [2020] EWCOP 4

ABSTRACT

In United Lincolnshire NHS Hospitals Trust v CD and Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R, the Court of Protection was asked to make anticipatory and contingent declarations relating to the obstetric care and mode of delivery for currently capacitous women who were near to their due date but not yet in labour. In this case note I explore the judges' reasoning on the legal basis for these declarations. In so doing, I consider the wider implications of employing this seemingly new addition to the Court of Protection's armoury.

Keywords: Anticipatory and contingent declarations, autonomy, capacity, consent, Mental Capacity Act 2005, pregnancy

I INTRODUCTION

In June 2019, Francis J was asked to grant an 'anticipatory and contingent' declaration relating to the delivery decisions of a pregnant woman who was detained under section 3 of the Mental Health Act 1983 and had, at that time, the capacity to make decisions for herself.[1] Just over four months later, Hayden J was asked to make similar declarations in similar circumstances,[2]

[1] United Lincolnshire NHS Hospitals Trust v CD [2019] EWCOP 24 (CD).

[2] Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R [2020] EWCOP 4 (R).

and in both cases the declarations were granted. While court-authorised delivery decisions are not as rare as they might be thought to be,[3] making anticipatory and contingent declarations are a relatively new way of obtaining such approval. Given this, my focus here is on the courts' identification of and justification for applying the legal framework which enabled them to make such declarations relating to women who, when the cases were heard, had the capacity to make decisions for themselves.

II United Lincolnshire NHS Hospitals Trust v CD: Facts and decision

In CD, P[4] was 35 weeks pregnant, had polyhydramnios (excess amniotic fluid in the amniotic sac), and 'a diagnosis of paranoid schizophrenia and emotionally unstable personality disorder'.[5] She was detained under section 3 of the Mental Health Act 1983 (MHA). The obstetric team confirmed that the polydramnios was increasing and 'severe', which 'significantly increases the risk of an obstetric emergency'.[6] This included cord prolapse (where the cord is delivered first and the foetus must be delivered within 15 minutes to survive)

[3] In the last decade, see, for example, Guys and St Thomas' NHS Foundation Trust v X [2019] EWCOP 35; NHS Trust v JP [2019] EWCOP 23; The NHS Acute Trust, The NHS Mental Health Trust v C [2016] EWCOP 17; Re CA (Natural delivery or caesarean section) [2016] EWCOP 51; Great Western Hospitals NHS Trust v AA [2014] EWHC 132 (Fam); The Mental Health Trust, The Acute Trust and The Council v DD and BC [2014] EWCOP 11; Royal Free NHS Foundation Trust v AB [2014] EWCOP 50; North Somerset Council v LW, University Hospitals Trust Bristol NHS Foundation Trust, North Bristol NHS Trust, Avon and Wiltshire Mental Health Partnership NHS Trust [2014] EWCOP 3; NHS Trust 1, NHS Trust 2 v FG [2014] EWCOP 30.

[4] I adopt throughout the practice in the Court of Protection and use 'P' to refer to the woman who was the subject of the proceedings: Court of Protection Rules 2017, SI 2017 No. 1035, r 2.1

[5] CD at [1].

[6] CD at [8].

or malpresentation (where a part of the foetus's body and not the head is delivered first).[7] If the latter occurred, this could result in bleeding, rupture of the uterus, and pain for P, and there was a 'very real risk for baby in both scenarios of death'.[8] According to P's consultant obstetrician and gynaecologist, if either cord prolapse or malpresentation occurred, the risk to P was 'mostly about the psychological impact of the emergency and the risk that her baby will be damaged/die'.[9]

It was agreed that P did not have the capacity to litigate and she was represented by her litigation friend, the Official Solicitor.[10] When proceedings were initiated on 17 May 2019, P was assessed not to have the capacity to make decisions about her obstetric care and delivery,[11] but on 29 May a consultant psychiatrist determined that she did have the capacity to decide for herself.[12] The case was due to be heard on 7 June but was actually heard on 3 June 'as an emergency application'.[13] At that point, it was agreed that P had capacity to decide for herself.[14] Nevertheless, because of her history there was a 'substantial risk' that her capacity might fluctuate again, such that she was unable to make delivery decisions 'at a critical moment in her labour'.[15] Once her waters had broken or her membranes had ruptured, it was agreed that there would not be time to go to court if P was assessed at that point to lack the capacity to

[7] CD at [8].

[8] CD at [9].

[9] CD at [9].

[10] CD at [1].

[11] CD at [5].

[12] CD at [6].

[13] CD at [1].

[14] CD at [3].

[15] CD at [3].

decide for herself. Thus, an anticipatory and contingent declaration was sought that, in that situation, it would be lawful to deliver care and treatment in accordance with the care plan.[16]

It appears that P had no close family or friends as an Independent Mental Capacity Advocate or Independent Mental Health Advocate (IMCA/IMHA) was appointed for her.[17] The IMCA/IMHA, along with a nurse from the Trust, said that P's priority 'was the health of her baby' and that she would engage in any intervention, whether she liked them or not, 'for the sake of her baby'.[18] Furthermore, P had 'consistently expressed the wish to have a vaginal delivery' but, if this was not possible, she wanted a general anaesthetic, rather than an epidural, and a caesarean section.[19]

Francis J was clear that the case was to be heard under the MCA and not the inherent jurisdiction of the High Court,[20] and, as identified by the Official Solicitor, he noted five possible orders which the court could make: ending the proceedings, adjourning the proceedings, granting an interim order to enable the care plan to be implemented under section 4B of the MCA, an anticipatory and contingent declaration as the final order, or an order under the inherent jurisdiction.[21] The latter option was easily dismissed because Francis J had already

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[16] CD at [3].

[17] Independent Mental Capacity Advocates or Independent Mental Health Advocates are instructed to represent someone where there is no one independent of services, such as a family member or friend, who are able to represent them: see s 35-37 MCA, Department for Constitutional Affairs (DCA), *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office, 2007), ch 10.

[18] CD at [5].

[19] CD at [7].

[20] CD at [11].

[21] CD at [10].

explained that he 'must work within the Mental Capacity Act 2005 if at all possible'.[22] However, if that was not the case then he would have had 'no hesitation' in making an order under the inherent jurisdiction 'if faced with a situation where the choice is to make such an order or to risk life itself'.[23]

Ending the proceedings was also not an option because those treating P thought it was 'very likely' that she would lose capacity and not be able to make delivery decisions, and this would become 'an urgent situation where a renewed application would cause unacceptable delay with potentially catastrophic consequence'.[24] Furthermore, 'it would be dangerous and plainly wrong to do nothing' and 'this court cannot and will not take what is regarded by all as an unacceptable risk'.[25] The proceedings could not be adjourned because it would mean 'leaving things too late and [there would be] insufficient time for an emergency order to be obtained',[26] and an interim order under section 4B of the MCA was not 'the appropriate route to take here'.[27]

Having considered the five options, Francis J 'accede[d] to the Trust's application'[28] and granted the anticipatory and contingent declarations, seemingly with the Official Solicitor's approval.[29] These were that P currently had capacity; that if she subsequently did not, care and treatment could be delivered according to the care plan; and that if that plan amounted to a

[22] CD at [17].

[23] CD at [17].

[24] CD at [13].

[25] CD at [13].

[26] CD at [14].

[27] CD at [15].

[28] CD at [18].

[29] CD at [16] iv).

deprivation of liberty, it was authorised if certain conditions were met.[30] Details of the care plan are not included in the case report, but Francis J noted that the plan included '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'.[31] Restraint might be needed to transfer P to the maternity suite, insert a cannula, or deliver the general anaesthetic for a caesarean section. A caesarean was 'very much a last resort', as if P no longer had capacity it would be in her best interests to try for a vaginal delivery ('if possible and this is consistent with either CD's expressed wish or best interests').[32]

III GUYS AND ST THOMAS' NHS FOUNDATION TRUST (GSTT) AND SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST (SLAM) V R: FACTS AND DECISION

R came to court on 30 August 2019 on the 'Urgent Applications List'.[33] P was 39 weeks and 6 days pregnant, had a diagnosis of Bipolar Affective Disorder with psychotic episodes, and was detained in a psychiatric ward under the MHA 1983.[34] This was her sixth pregnancy and, according to the available records, she had not delivered any child by caesarean section.[35] As in CD, P had polyhydramnios, the foetus was also large and it was uncertain how it was presenting (head down, or transverse, breech or unstable presentation).[36] There were thus medical risks for P and the foetus, and P 'might have entered labour at any moment',[37] so

[30] CD at [3].

[31] CD at [16] iv).

[32] CD at [16] iv).

[33] R at [1].

[34] R at [1].

[35] R at [12].

[36] R at [4].

[37] R at [2].

continuous monitoring was recommended.[38] There was 'a real risk' that a caesarean would be needed 'to ensure the safe delivery of the baby'; however, on the basis of her previous behaviour (not outlined in the judgment), there was said to be a 'manifest risk' that P might not co-operate or might resist if urgent delivery was required.[39] Indeed, 10 days before the hearing she had stopped taking her anti-psychotic medication, which 'manifestly required a re-evaluation of the risk and the need to re-assess the birth plan'.[40]

P's capacity to make decisions for herself was assessed in June, July and August 2019,[41] and it was agreed that she had capacity to make decisions about her antenatal and obstetric care. However, there was 'a substantial risk'[42] that her mental health would deteriorate and that she would lose capacity while in labour.[43] P told the medical staff that a caesarean was 'the last thing she would want',[44] but the Official Solicitor had not had the chance to speak with her 'to achieve greater clarity as to her wishes and feelings'.[45] The application for anticipatory declarations was thus made 'in the face of opposition' by a capacitous P,[46] who had 'always asserted' that there would be no need for a caesarean.[47] The views of others, including an IMCA

[38] R at [4].

[39] R at [4]. See also [2].

[40] R at [6].

[41] R at [3].

[42] Also described as 'a high risk' by the consultant psychiatrist: R at [3].

[43] R at [2].

[44] R at [53].

[45] R at [58].

[46] R at [17].

[47] R at [12]. Note that P was ultimately correct in this assertion as she delivered 'by spontaneous vertex vaginal birth' on 8 September 2019: R at [12].

or IMHA, were not included in the judgment, and P was not represented in court. There was said to be no time or opportunity to appoint the Official Solicitor; nevertheless, 'self-evidently, a decision had to be made'.[48] Thus, an 'Advocate to the Court' was appointed, which 'involves very different obligations and is not to be conflated with the role of the Official Solicitor as litigation friend'.[49]

Before giving his judgment, Hayden J considered whether anticipatory decisions could be made under the MCA or the inherent jurisdiction, and noted the decisions in CD and Wakefield MDC and Wakefield CCG v DN and MN.[50] DN involved anticipatory declarations relating to residence and/or care, and Hayden J said that in that case 'the scope and ambit of the applicable law appears to have been agreed between the parties', with the declarations made under sections 15 and 16 of the MCA.[51] In R, Hayden J similarly proceeded on the basis that the MCA applied, at least for some of the elements of the declarations - with the inherent jurisdiction engaged in relation to the question of P's deprivation of liberty.[52] However, in the light of the uncertainty about the applicable law which allowed anticipatory declarations to be made, he directed the legal teams to make written submissions on that matter.[53]

[48] R at [6].

[49] R at [5].

[50] [2019] EWHC 2306 (Fam). See R at [8]-[10].

[51] R at [10].

[52] R at [47]. Also, [44].

[53] R at [11].

As this was an urgent application, Hayden J gave an ex tempore judgment on 30 August 2019[54] with the case reported on 29 January 2020. Hayden J granted the declarations sought as being in P's best interests:[55] that P presently had capacity and an anticipatory declaration could be made under section 15 of the MCA; it was lawful for care and treatment to be delivered to her according to the obstetric care plan; and if the arrangements amounted to a deprivation of liberty, that this was authorised providing certain conditions were met.[56] He said that '[t]he right of all individuals to respect for the bodily integrity is a fundamental one. It is every bit the right of the incapacitous as well as the capacitous'.[57] However, while the latter can behave in ways which are 'unreasonable or "morally repugnant"', including 'jeopardis[ing] the life and welfare of her foetus', when the court is involved for the former, '[i]t should not sanction that which it objectively considers to be contrary to P's best interests'.[58] Such behaviour was prohibited by the MCA's 'specific insistence on "reasonable belief" as to where P's best interests truly lie'.[59] Thus, although '[i]t is important that respect for P's autonomy remains in focus … it will rarely be the case … that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus'.[60] Indeed, 'the delivery of her healthy unborn baby will be an intrinsic factor' in deciding where P's best interests lie.[61]

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[54] R at [11].

[55] R at [6].

[56] R at [7]. The legal basis for authorising a deprivation of liberty in an anticipatory declaration were discussed at [37]-[47].

[57] R at [48].

[58] R at [63].

[59] R at [63]. Also, [62].

[60] R at [63].

[61] R at [62].

Hayden J considered what P meant when she said that a caesarean was the last thing she would want, and concluded that it would not be 'morally or intellectually honest' of him to interpret this as meaning 'very literally as being an option only to be contemplated "last" of all'.[62] Furthermore, '[t]o 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 position'.[63] Notably, Hayden J said that doing so would be redolent of the actions of 'judges in the past [who] 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'.[64] He also considered whether P's statement could be viewed as an advance decision, and said that it could not because it did not comply with sections 24-26 of the MCA which apply to such decisions.[65] With regard to this, the fact that P expressed her wishes 'in lay terms' was not an issue; rather, her statement was not 'sufficiently choate'.[66]

Hayden J recognised that the birth process was 'highly dynamic', and that during it many women changed their minds about matters such as pain relief and mode of delivery.[67] He was thus concerned that those who no longer had capacity did not 'lose the opportunity to express a changed decision', and said that this needed to be balanced with the 'inclination' to protect

[62] R at [56].

[63] R at [56].

[64] R at [56].

[65] R at [65].

[66] R at [65].

[67] R at [57].

P's autonomy over her own body (in the line with her expressed wishes while capacitous).[68] He was, however, concerned that if a court had declared an intervention to be unlawful, it was not clear how medical staff would respond to a P who was now incapacitous but was asking for assistance, as there would not be time to go to court.[69] In the light of all of the above, Hayden J granted the anticipatory declarations sought.

IV THE LEGAL FRAMEWORK FOR MAKING ANTICIPATORY AND CONTINGENT DECLARATIONS

As noted above, the judges in CD and R considered the legal basis on which they could make anticipatory declarations under the MCA relating to a woman who, at the time of the hearing, had the capacity to make decisions for herself. Hayden J, in R, said that anticipatory declarations had to be 'rooted very securely in law', and the case report of 29 January 2020 includes his consideration of the legal teams' written submissions on the applicable law which allowed him to make the declarations sought.[70]

That such clarification was required was evidenced by Francis J's 'surprise' in CD that the possibility of an anticipated declaration had not been included in other reported decisions.[71] He was, however, referred to an unreported case included in a note in the Court of Protection Practice 2019 which mentioned such a declaration.[72] Alongside this, Francis J looked to the

[68] R at [57].

[69] R at [57].

[70] R at [11].

[71] CD at [16] v).

[72] 'the circumstances of this case were very unusual, it being held by the court that the individual in question suffered from a particularly acute form of PTSD which would be triggered by certain clearly identifiable events linked to the prospect of hospital admission and would render her incapable of taking decisions as to whether she required such admission in the event of medical emergency. It is therefore a limited, but it is suggested sound,

MCA for guidance on the legal basis for anticipatory declarations, with two sections considered to be relevant: section 15 and section 16. He determined that section 16 was not applicable as it only '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'.[73] In CD, P did not lack capacity at the time of the hearing and so section 16 could not apply.

In R, Hayden J also discounted the proposition that section 16 could be the basis for anticipatory declarations for the same reason.[74] That section could only be interpreted as applying to those who once had capacity but no longer did, by reading the word "if" as "when". However, this would be 'beyond "purposive"' and would require 'a complete distortion of what is … the pellucidly clear wording of the statute'.[75] Additionally, 'a further and central principle' of section 2 of the MCA is that the test for capacity is both issue and time specific, and 'the cardinal principle' of section 1 is that someone should not be treated as unable to make a decision unless all practical steps have been taken to help them do so.[76] Given this, '[l]ogically, such steps could not have been taken with an individual who remained capacitous at the time of the application', and so section 16 cannot apply.[77] It is difficult to dispute this reading of section 16.

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foundation upon which to build a general statement of principles …': note 7 to #1.483 Court of Protection 2019 as cited to in CD at [16] v)

[73] MCA, section 16 (1), emphasis added.

[74] R at [28]

[75] R at [26], emphasis in original.

[76] R at [28].

[77] R at [28].

With regard to section 15, in CD Francis J held that section 15 (1)(c) applied because it enables the court to make declarations as to 'the lawfulness or otherwise of any act done, or yet to be done, in relation to that person'.[78] In R, Hayden J agreed that anticipatory declarations could be granted under section 15,[79] because subsection (1) '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"', and nothing in section 15 (1)(c) 'inhibits or restricts' the court's declaratory powers to those who lack capacity.[80] Applying 'the basic rules of statutory construction', particularly the literal rule,[81] 'where the words of the statute are plain and unambiguous, the Court ought to give effect to that plain meaning'.[82] With regard to the phrase "yet to be done", Hayden J said that this 'must … contemplate a factual scenario occurring at some future point' and '[i]t 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'.[83] Thus, '[i]n 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'.[84]

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[78] CD at [16] i), emphasis in original. Section 15 (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.

[79] Counsel for the Trust's arguments were considered at [29]-[31].

[80] R at [29], emphasis in original. Also, [32].

[81] See Duport Steels Ltd v Sirs [1980] 1 WLR 142.

[82] R at [34].

[83] R at [36].

[84] R at [36].

While this reading of section 15 appears to be correct, my struggle is with how this interpretation sits alongside other key provisions and principles in the MCA – particularly the fact that, as Hayden J himself noted in his discussion of section 16, the Act is premised on the basis of capacity being both issue and time specific.[85] This is made clear in section 2(1): '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 a disturbance in the functioning of, the mind or brain' (emphasis added). As Hayden J noted himself in R, '[t]he MCA emphasises the importance of identifying P's capacity to take individual decisions',[86] and the Code of Practice which accompanies the Act highlights the fact that 'a person's capacity must be assessed at the time when the decision needs to be made'.[87] The MCA is also underpinned by five principles set out in section 1, with three of relevance here:

cognisant

> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
>
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

[85] n 76 above.

[86] R at [48], emphasis added.

[87] DCA n 17 above at paras 4.4, 4.26 and 4.27 as cited in R at [20], emphasis in original.

It is unclear how and when (at the time of the court hearing or at the time P actually lacks capacity) these principles and the requirements in section 2(1) can be met in advance while P has the capacity to make decisions for herself, as must be the case with anticipatory declarations. With such declarations a judge is being asked to agree that P has the capacity to decide for herself now but declares that if she lacks that capacity at some time in the future, it will be in her best interests for certain procedures or treatments to be provided. The judge is thus not, as section 2(1) requires, looking at P's capacity 'at the material time', which is the time at which the decision needs to be made, because at the time the case is being heard P has capacity. Rather, the judge is being asked to make a declaration about an unknown time in the future, when P lacks capacity for unknown reasons, and to decide now what will be in her bests interests at that unknown point in time. And this is all supposed to be 'in relation to the matter', but the judge cannot know at the time of the hearing exactly what that matter will be. And, of course, as Hayden J noted, things can change during the 'highly dynamic' birth process.[88]

He discussed these matters when considering whether section 16 of the MCA was the legal basis for anticipatory declarations and, he held that the wording of that section precluded its application, as did the requirements of section 2(1) and the principle set out in section 1 (3).[89] What is not clear, however, is why the latter two provisions do not also apply to anticipatory declarations made under section 15. It is hard to see why they would not because while declarations can be made under that section relating to anyone, regardless of their capacity, anticipatory declarations will only come into operation once P lacks capacity.[90] At that point, the other provisions of the MCA are also presumably 'switched on'. If this is incorrect, then is

[88] n 67 above.

[89] n 74-77 above.

[90] R at [36].

this because P does not lack capacity at the time the anticipatory declaration is sought and so the other requirements of the MCA cannot apply? But that would mean that anticipatory declarations under section 15 have, in essence, no boundaries as a judge would not need to comply with key provisions in the MCA, such as acting in P's best interests. This cannot be right.

Perhaps a driver for determining that anticipatory declarations were lawful was the fact that in both judgments there is a sense that in order to ensure that a healthy baby was delivered, there must be something that can be done to deal with women who currently have capacity but might not once labour had started. For example, in CD Francis J said that 'if the unusual circumstances of this case are not covered by [the MCA], I would have no hesitation in making the 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'.[91] Furthermore, '[t]he practical position' was that if something was not done now while all was ok and P had capacity, by the time she no longer had capacity it would be too late and 'potentially catastrophic consequences' might ensue.[92] Indeed, the factual circumstances were such that there was a 'substantial risk' that if he did not address the matter now, Francis J 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'.[93] He was 'not prepared to take that risk' but was '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)'.[94]

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[91] CD at [16] v).

[92] CD at [13]. See n 24-25 above.

[93] CD at [16] iii).

[94] CD at [16] iii).

This might seem reasonable given that P was close to her due date and, presumably, wanted to safely deliver. But it is not clear why a declaration was required in this situation, because if P was determined to lack capacity during labour and a medical emergency subsequently eventuated, then the health professionals would surely owe her the same duty of care that they would owe to any patient in an emergency situation. That is, they would need to act in her best interests and perform that which was necessary. In CD Francis J said that 'treating clinicians would find themselves in the invidious position of possibly carrying out invasive surgery and administering anaesthetic or other drugs without lawful authority',[95] but this conclusion is questionable.

In R, Hayden J also looked beyond sections 15 and 16 of the MCA and said that as capacity was not 'a static concept', the court may be concerned with a P who may have capacity in relation to some issues but not others, and on some days but not others. Thus, '[i]t 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'.[96] He noted Keehan J's guidelines in NHS Trust 1 and NHS Trust 2 v FG[97] about the importance of careful planning and avoiding delay in bringing obstetric care cases to court, and said that 'the court will need to be involved in a way which anticipates rather than being merely reactive to crisis or emergency'.[98] Anticipatory declarations were, therefore, a necessary part of the court's armoury. In terms of when such declarations should be made, while Francis J in CD talked in terms of the 'exceptional"

[95] CD at [16] iv), emphasis added.

[96] R at [35].

[97] [2014] EWCOP 30 at [19]-[22], as cited in R at [14]-[16].

[98] R at [16].

circumstances' of the case,[99] Hayden J noted that most cases that come before the Court of Protection could be described in those terms and so it was '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'.[100] Thus, contingent declarations 'should be made sparingly'.[101]

While we only have three reported cases where anticipatory declarations have been sought and made, it is noticeable that two of the cases involved pregnant women who were detained under the MHA 1983 and were near to their due date. In both of these cases, the existence and interests of the 'foetus', 'unborn child' or 'unborn baby' was noted in the judgments, along with, in R, a discussion of the legal status of the foetus and of previous cases involving women's delivery decisions.[102] Equally, in CD Francis J, as I have noted above, said that he had to 'address the matter now' as P's welfare and possibly life might be at risk, as well as 'the life of her as yet undelivered baby'.[103] Furthermore, '[w]hilst it is of course the case that the unborn child's best interests cannot be taken into account per se, it is obvious both from the evidence received and as a matter of common sense that the loss of the baby would have a profound negative impact

[99] See n 94 above.

[100] R at [48], emphasis in original.

[101] R at [48].

[102] R at [49]-[55] and [57], [59]-[61]. The cases are Re S (Adult: Refusal of medical treatment) [1992] 4 All ER 671; Tameside and Glossop Acute Services Trust v CH [1996] 1 FCR 753; Norfolk and Norwich Healthcare (NHS) Trust v W [1997] 1 FCR 269; Rochdale Healthcare (NHS) Trust v C [1997] 1 FCR 274; Re L (Patient: Non-consensual treatment) [1992] 2 FLR 837; Re MB (Medical treatment) [1997] 2 FLR 426, CA; St George's Healthcare NHS Trust v S; R v Collins, ex parte S [1998] 3 WLR 936, CA; Bolton Hospitals NHS Trust v O [2003] 1 FLR 824.

[103] See n 93 above. CD at [16] iii).

on CD'.[104] And in R, Hayden J noted that P's best interests were inextricably linked to the delivery of a 'viable and healthy foetus',[105] such that 'risk to the health or life of the unborn child is … rarely likely to be in the mother's interests'.[106] Thus, while Hayden J lamented the behaviour of judges in previous delivery cases for 'strain[ing] to conclude' that P lacked capacity in order to protect her life and that 'of her unborn child',[107] a similar comment could not unreasonably be made about the decisions in both CD and R with regard to the legal basis for anticipatory decisions. This seeming confession that the courts 'bent' the law in earlier delivery cases, does not prevent (it seems to me) Hayden J from doing likewise in R.

V AUTONOMY AND ANTICIPATORY DECLARATIONS

Within his discussion of the legal basis for anticipatory declarations in R, Hayden J recognised that P's autonomy was being challenged by such declarations. He noted that 'the court is being invited to make orders of a profoundly intrusive nature which also contemplate a deprivation of liberty', that this 'should give any court real concern for the autonomy of the individual at the centre of the process',[108] and that '[t]he case law emphasises the importance of individual autonomy'.[109] Furthermore, the MCA 'is intended to protect and guard the autonomy of those who lack decision making capacity in whatever sphere';[110] thus, P's autonomy must remain 'in focus'.[111] At the same time, and as previously noted, Hayden J said that it would rarely be in

[104] CD at [4].

[105] See n 60 above. R at [63]. Also, [62].

[106] R at [42].

[107] See n 64 above. R at [56].

[108] R at [17].

[109] R at [66].

[110] R at [32].

[111] See n 60 above. R at [63].

P's best interests to allow an otherwise viable and healthy foetus to receive brain damage or to die.[112] Seemingly then, P's autonomy must sit with or alongside the foetus' welfare, but given that P's wishes are not 'synonymous' with her best interests,[113] it is not clear whether or how P's autonomy is being respected.

Furthermore, Hayden J seems to imply that that it is a requirement of the MCA 2005 that P's wishes are 'reasonable': 'P's expressed wishes … are not regarded, within the statutory framework, as synonymous with P's best interests. In particular, the provisions introduce the concept of "reasonableness"'.[114] He then set out the provisions in section 4 of the Act, where the word reasonable or variants of it are included in subsections (4) (6), (8)(b), (9), and (11) (a). Although nowhere in that section, or any other provision of the MCA, is it stated that P's wishes themselves must be reasonable, Hayden J said that a court 'should not sanction that which it objectively considers to be contrary to P's best interests' because this is prohibited by the Acts 'specific insistence on "reasonable belief" as to where P's best interests truly lie'.[115] There seems to be some confusion here because 'reasonable belief' in this context is only required in section 4 (9), which is relevant to 'an act done, or a decision made, by a person other than the court' (emphasis added). The section also continues, 'there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to

[112] See n 60 above. R at [63].

[113] R at [62]. Note that one of the conclusions in the House of Lords' post legislative scrutiny report on the MCA, was that P's wishes and feelings were not 'routinely prioritised': House of Lords, Select Committee on the Mental Capacity Act 2005, Mental Capacity Act 2005: post-legislative scrutiny, Report of Session 2013-14, HL Paper 139, para 104.

[114] R at [62], emphasis added.

[115] R at [63], emphasis added. See n 59 above.

(7)) he reasonably believes that what he does or decides is in the best interests of the person concerned'. The translation of this provision into a requirement for P's wishes to be reasonable is neither clear nor obvious. Nevertheless, if Hayden J is correct, then it would be an additional challenge to P's autonomy.

Despite all of this, Hayden J framed his decision in R as being autonomy protecting, and suggested that '[t]he 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 baby based on access, at all stages, to the complete range of options available to her'.[116] He was concerned that '[l]oss of capacity in the process of labour may crucially inhibit a woman's entitlement to make choices',[117] and so 'the Court is required to step in to protect her'.[118] This is an extraordinary way to view anticipatory declarations relating to a capacitous person, as the claim seems to be that 'we are deciding now what will be in your best interests when you no longer have capacity, and we are doing this to protect your autonomy (that you have expressed in terms of 'reasonable' wishes) and to keep your options open'. How such declarations can be interpreted as autonomy protecting is a mystery. Furthermore, the notion of 'keeping options open' can only work in one way because it would be impossible for a capacitous person who is consenting, to refuse to consent once they no longer have capacity. Having said that, one highlight in the decision is the apparent acknowledgment that if P had properly constructed an advance decision under the MCA, it would be binding on the court.[119] Indeed, 'the capacitous adult who has prepared a

[116] R at [67].

[117] R at [67]. Also, see n 68 above - R at [57].

[118] R at [67].

[119] R at [65].

statutory compliant Advanced Decision, has consciously waived the right to change her mind upon loss of capacity'.[120]

VI CONCLUSION

Delivery decisions for any woman are intensely personal and the mode selected may well involve 'the invasion of her own body'.[121] That two cases were heard within six months where Trusts requested a judge to make anticipatory and contingent declarations relating to women who had the capacity to make decisions for themselves at the time of the hearing, is of great concern – along with the fact that in both cases the declarations were made as requested. Unfortunately, neither Francis J nor Hayden J clearly set out the parameters for using anticipatory declarations in the future, with the latter saying no more than 'they should be used sparingly'.[122] Without more, the possibility is left open that an application for anticipatory declarations can be made in relation to, at the very least, any capacitous pregnant woman. But why stop there? As these declarations appear to be seen to be required to cover the event that a patient who currently has capacity might, at some point during their course of treatment, no longer have the capacity to make decisions for themselves, then why could they not be applied for in relation to anyone of us? Or are anticipatory declarations only suitable for pregnant women, and/or pregnant women who are detained under the MHA? Without, at the very least, further guidance on the use of anticipatory declarations, their addition to the Court of Protection's armoury is not a cause for celebration.

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[120] R at [65].

[121] R at [57].

[122] R at [48].