Neutral Citation Number: [2023] EWCOP 25

Case No: 14090768

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/06/2023

Before :

MR JUSTICE MOSTYN

- -

Between :

SOMERSET NHS FOUNDATION TRUST	**Applicant**
- and -	
AMIRA	**Respondent**
(by her litigation friend, the Official Solicitor)	

- -
- -

Scott Matthewson (instructed by Bevan Brittan LLP) for the Applicant
Elizabeth Fox (instructed by the Official Solicitor) for the Respondent

Hearing date: 8 June 2023

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Approved Judgment

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MR JUSTICE MOSTYN

This judgment was delivered in public but is subject to a Reporting Restriction Order the terms of which must be strictly observed

Mr Justice Mostyn

1. This case concerns the obstetric care of the Respondent, to whom I give the pseudonym Amira. On the day of the hearing, 8 June 2023, she was heavily pregnant and was due to give birth on that day.

2. She is diagnosed with hebephrenic schizophrenia.

3. Before me is the application made by the applicant trust dated 26 May 2023 concerning the healthy and safe delivery of Amira's child. The application was made on the basis that while Amira had capacity to make decisions as to her medical care and to conduct legal proceedings, it was apprehended that as the delivery approached she would lose capacity in both spheres. Accordingly, "anticipatory" declarations and orders were sought. On 7 June 2023, the day before the hearing (and also the day before Amira was due to give birth) the medical opinion on Amira's capacity changed to assess her as lacking capacity in both spheres. The applicant trust accordingly reconstituted its application immediately prior to the hearing.

4. As the trust brought its application on the basis that Amira had capacity to conduct litigation and to make decisions about her obstetric care, it sought a declaration on an anticipatory basis that should Amira lose capacity to make decisions about her obstetric care during labour, delivery and/or the postpartum period, that it shall be lawful and in her best interests to be treated in accordance with the trust's care plan.

5. The trust's care plan was devised at a time when Amira was assessed to have capacity and she was involved in its formulation. The care plan sets out four options for delivery in order of preference for Amira, but reflecting the potential problems that can arise in any birth. The first option is a midwifery led water birth; the second is instrumental delivery (use of forceps, for example); the third is an emergency caesarean section in the operating theatre; the last is a combination of the first three options, starting with a low-risk birth pathway and resulting in an emergency caesarean section.

6. The hearing on 8 June 2023 proceeded as a final hearing for me to determine:

    i) whether Amira lacks both capacity to conduct proceedings and capacity to make decisions about her obstetric care;

    ii) whether it is lawful and in Amira's best interests to treat Amira in accordance with the trust's care plan; and

    iii) whether it is lawful and in Amira's best interests to restrain her to give effect to the trust's care plan, and therefore whether the court should authorise a deprivation of Amira's liberty in this regard.

7. The trust also sought a reporting restrictions order given the exceptionally private and personal nature of a case which concerns serious medical treatment of Amira. After having undertaken an intensely focussed balancing exercise of Article 8 and Article 10 of the ECHR, I was satisfied that a reporting restrictions order should be made. The order was duly made on the day of the hearing. It prevents the identification of Amira or the treating physicians, or the hospitals where she has been and will be treated. It will last until 31 December 2024 unless foreshortened or extended in the meantime.

Background

8. Amira is 25 years old and is pregnant with her first child. She has been in a relationship with her partner for over one year.

9. Amira was detained at hospital on 4 January 2023 under Section 131 of the Mental Health Act 1983. She was transferred to this hospital from prison following being remanded in custody in October 2022 for an offence of ABH against her own mother.

10. Amira is diagnosed with hebephrenic schizophrenia for which she presently complies with the medication requirement and her symptoms, until very recently, are said to be generally well controlled.

11. Amira has been in contact with mental health services since age 15. Her first psychiatric hospital admission was in 2019 and her longest admission was for approximately 2 years between 2020 and 2022.

12. Amira has historically suffered from relapses of her illness. Dr A described severely disturbed behaviour including physical aggression, emotional dysregulation and hallucinations. Her most recent relapse was mid-2022 following non-compliance with her prescribed antipsychotic medication.

13. During her period on remand in prison from October 2022 to January 2023, Amira endured severe symptoms of psychosis including hallucinations. These triggered her transfer to a mental health facility. Following her admission to hospital on 4 January 2023, Amira's overall clinical presentation is said to have gradually improved to the extent that she has engaged in appropriate conversations with reviewing staff.

14. In the opinion of the treating psychiatrist, Dr A, over recent weeks until the day prior to her due date, Amira's mental state had improved significantly. In his (second) witness statement made on 7 June 2023, and in his oral evidence given at the hearing, he explained that her mental state was stable until the 48-hour period immediately prior to the hearing. He had assessed Amira on the morning of 7 June 2023, and found her mental state to have deteriorated significantly, it now being characterised by anxiety, distress and paranoia. He explained that her paranoia was prominent; she was extremely distressed and was not engaging. When Dr A sought to discuss the trust's care plan with her, she was unable to understand the information, let alone to weigh up the advantages and disadvantages of the information. Dr A stated that he had spoken to Amira during that day, and that while he had not spoken with her that morning, the social worker had, and had reported to Dr A that Amira's presentation had not changed.

15. Dr A explained that Amira's significantly deteriorated mental state was partly due to her being told of the local authority's plan for her baby immediately after the birth and that following the birth she will have to return to the secure mental health facility where she had been detained.

16. Due to the immediate change in the assessment of Amira's capacity, the Official Solicitor ("OS") was instructed on 7 June 2023. Ms Fox acting on behalf of Amira complained that the OS was placed at a considerable disadvantage because the trust had delayed in bringing their application and that the evidence in support was limited. Further, the delay meant that there was no time for the OS to commission a report from

an independent psychiatrist. The supporting evidence, such as it was, was constituted by a witness statement made on 19 May 2023 by Amira's treating psychiatrist Dr A to which he attached a short report dated 8 March 2023 which stated:

> "In my opinion it is reasonable to suspect that changes in [redacted]'s medical condition, state of pregnancy, and the delivery, might well trigger a significant deterioration of her mental state. She has a clear history of abruptly changing symptoms and resulting risk, including physical aggression, in the context of perceived stress.
>
> During the initial phase of [redacted]'s current admission when her symptoms of psychosis were more severe her decision-making capacity surrounding her pregnancy was impaired. During this phase she declined follow up with midwives and declined ultrasound scans. This contrasts markedly with her more recent level of engagement with obstetric follow in the context of her improving mental health.
>
> Clearly, it will be necessary to evaluate [redacted]'s decision making capacity contemporaneously in relation to any future medial issue that might arise. However, if her mental state worsens, based upon what is currently known about her psychiatric history, it is reasonable to conclude that her symptoms will significantly impair her capacity to understand information, impair her capacity to retain information, and impair her capacity to weigh-up information. Additionally, relapses of her psychotic illness are characterised by severe communication difficulties and lengthy period of mutism."

Clearly, on the basis of that evidence, Amira did not lack capacity in either sphere on 8 March 2023 (the date of the report), or on 19 May 2023 (the date of the witess statement which identified no change since the date of the report), or on 26 May 2023 (the date of the trust's application which likewise identified no change).

17. Ms Fox submits that not only should the trust have brought their application at the earliest opportunity after 8 March 2023, but it should somehow have obtained a hearing date earlier than 8 June 2023. Further, had the application been made in a timely manner, Amira would have had capacity to conduct litigation and would have been able to participate fully in these proceedings. That is true, but if the application had been made then, Amira would not have lacked capacity to make the decisions about her care and so there would not have been any valid issue for the Court of Protection to decide (as I explain below).

18. The applicant instructed solicitors on 13 February 2023 when Amira was 23 weeks pregnant. Those solicitors filed a witness statement on 8 June apologising to the court and the OS for their delays, although as I will explain below, I am not sure whether they were in fact guilty of any.

Anticipatory declarations

19. The application made by the trust on 26 May 2023 sought the following relief:

> 1. A contingent declaration under section 15(1)(c) Mental Capacity Act 2005 that, in the event that Amira loses her capacity to make decisions about her obstetric care during labour, delivery and/or the postpartum period, it shall be lawful and in her best interests to be treated in accordance with the care plan exhibited to the statement of Dr HT dated 19 May 2023.
>
> 2. A contingent declaration under the inherent jurisdiction of the High Court that, in the event that Amira loses her capacity to make decisions about her obstetric care during labour, delivery and/or the postpartum period, it shall be lawful and in her best interests to be restrained and/or otherwise deprived of her liberty so as to give effect to the declaration made above.

20. In support of these orders the applicant relied on *Guys and St Thomas NHS Foundation Trust & Anor v R* [2020] EWCOP 4 (Hayden J); *United Lincolnshire Hospitals NHS Trust v CD [2019]* EWCOP 24 (Francis J); and *North Middlesex University Hospital NHS Trust v SR* [2021] EWCOP 58 (Katie Gollop KC). In each case anticipatory or proleptic orders had been made in respect of persons who were capacitous at the time that the order in question was made.

21. In *United Lincolnshire Hospitals NHS Trust v CD [2019]* EWCOP 24 Francis J stated at [16(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 power to make an anticipatory declaration of lawfulness, contingent on CD losing capacity, pursuant to section 15(1)(c)"

22. In *Guys and St Thomas NHS Foundation Trust & Anor v R*, Hayden J put it this way:

> "29. In contrast to Section 16 (2), the power to make declarations of lawfulness, pursuant to Section 15 MCA, is not expressly curtailed by any requirement of incapacity. Section 15 (1) (see paragraph 23 above) enables the Court both to determine **whether** an individual has or lacks capacity and the lawfulness of any act done or **'yet to be done'**. The wording here contrasts markedly with Section 16 and cannot be said to be explicitly confined to those lacking capacity. On the contrary, this section contemplates consideration and determination of the issue of capacity. Furthermore, there is nothing in Section 15 (1) (c) which inhibits or restricts the Court's declaratory powers to

> those individuals assessed as lacking in capacity (i.e. on any particular issue). …
>
> 32. … There is nothing here, in my judgement, which requires a construction of Section 15 which restricts its declaratory relief to those whom the Court has found to lack capacity. Of course, the section must be construed in the schematic context of the MCA generally. The legislation is intended to protect and guard the autonomy of those who lack decision making capacity in whatever sphere. …
>
> 36. Any declaration relating to an act **'yet to be done'** must, it seems to me, contemplate a factual scenario occurring at some future point. It does not strain the wording of this provision, in any way, to extrapolate that it is apt to apply to circumstances which are foreseeable as well as to those which are current. There is no need at all to diverge from the plain language of the section. In making a declaration that is contingent upon a person losing capacity in the future, the Court is doing no more than emphasising that the anticipated relief will be lawful when and only when P becomes incapacitous. It is at that stage that the full protective regime of the MCA is activated, not before.
>
> 48. Having analysed the jurisdictional basis for the Trust's applications, I consider that Ms Dolan and Ms Roper are correct, in their written argument, to confront the circumstances in which such contingent declarations should be made. All agree that they should be made sparingly. The case law, to which I have referred, emphasises the 'exceptional' circumstances of the particular cases. …" (original emphasis)

23. In *North Middlesex University Hospital NHS Trust v SR* [2021] EWCOP 58 Ms Gollop KC took it as read that the power to make an anticipatory declaration existed, but added:

> "41. That said, I would venture some observations. First, the making of contingent declarations will almost always be an interference with, or have the potential to interfere with, the Art 8 ECHR rights of the individual concerned to respect for their private and family life, including their autonomous decision making about what is done to them physically. That potential exists even where, as here, the contingent declaration made accords with, promotes, and facilitates the person's current, capacitous decisions, and thus their autonomy. It exists even in those circumstances because, whether capacitous or incapacitous, people have the right to reconsider their positions and change their minds. Indeed, in an evolving healthcare situation, the changing clinical picture may require reconsideration of previously made decisions. Ideally, everyone should have access to the full range of options when the time comes to put into effect a decision about their private and family life but a contingent declaration or order, restricts that full

> range. It is for this reason that such relief should only be granted where it is necessary, justified and proportionate, and why the power to grant relief should be used sparingly, or only in exceptional circumstances."

24. I turn to the application before me.

25. I assume that the reason that the second declaration (to be made pursuant to the High Court's inherent power) is sought by the applicant is because s.4A(3) and (4) of the 2005 Act only permit a deprivation of liberty to be authorised under the Act where an order has been made under s.16(2)(a). A declaration under s.15 will not suffice. Therefore, the authorisation would have to be made in the High Court under its inherent power.

26. The proposed declarations do not state how, or by whom, the future loss of capacity foreshadowed in each of these declarations is to be determined. This seems to me to be a fundamental flaw in the logos of the concept. Such a flaw was recognised by Lieven J in *A Local Authority v PG & Ors* [2023] EWCOP 9 at [37], [38] and [43] where she declined to make an anticipatory order, as it would be unworkable. She was, however, just satisfied that there was sufficient evidence to declare that P in that case lacked capacity on the "longitudinal" basis.

27. I have to say, with great respect to my colleagues, that I am extremely doubtful that either declaration can lawfully be made, for the following reasons.

28. I address the first proposed declaration. The preamble to the Mental Capacity Act 2005 states that it is **"An Act to make new provision relating to persons who lack capacity"**. Part I of the Act, which covers ss 1 – 44, is headed **"Persons who lack capacity".** It is to state the obvious that, with the exception of the emergency situation described ss. 5 and 6, none of the provisions in Part 1 can apply in any shape or form to a person who has capacity at the time that the matter is being considered by the court. This applies equally to those persons who have capacity now but are never likely to lose it, as it does to those who have capacity now, but who might lose capacity at some point in the future.

29. The very first principle that applies for the purposes of the Act is that "a person must be assumed to have capacity unless it is established that he or she lacks capacity": see s.1(2). Sec 1(2) uses the verb "lack" only in the present tense; there is no future subjunctive alternative. It does not say "a person must be assumed to have capacity unless it is established either that he or she lacks, or were later to lack, capacity".

30. Ss. 5 and 6 put on a statutory footing the common law doctrine of necessity as it applies to the care or treatment of persons who are believed to lack capacity. They address the emergency situation where "D" does an act in connection with the care or treatment of "P". Provided that before doing the act D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and when doing the act, D reasonably believes both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done, then D does not incur any liability in relation to the act that he would not have incurred if P had capacity to consent in relation to the matter, and had consented to D's doing the act. If the act is to restrain P then, in addition, D must reasonably believe that it is necessary to do the act in order to prevent harm to P

and that it is a proportionate response to the likelihood of P suffering harm, and to the seriousness of that harm.

31. Therefore, in such an emergency situation, and only in such an emergency situation, Part 1 of the Act will apply to someone who may yet be shown not to lack capacity at the time that the act in question was done in relation to his or her care or treatment. But that is the only circumstance where someone who is in fact capacitous falls within the terms of Part 1 of the Act.

32. Part 2 of the Act is headed "The Court of Protection and the Public Guardian". The power to make an interim order is found in this Part and is set out in s.48 under the sub-heading "Supplementary powers". S. 48 allows an interim order to be made without delay where there is "reason to believe" that P lacks capacity. I have explained in *A Local Authority v LD & Anor* [2023] EWHC 1258 (Fam) that such a finding is not a "light" finding of incapacity but rather is a predictive finding that there is a real prospect that incapacity will be proved at the final hearing. That prediction, by its nature, recognises that there is a real prospect, even a greater likelihood, that incapacity will not be proved at the final hearing. That is as close as the Act gets to extending its powers to people with capacity.

33. I turn to the terms of s. 15.

34. A declaration under sec. 15(1)(a) or (b) can be made as to whether a person has, or lacks, capacity to make a decision or decisions on specified matters. If the declaration is in favour of capacity then no provision in Part 1 of the Act can apply to that person. This must be indisputable.

35. Therefore, in my judgment, a declaration under s. 15(1)(c) concerning the lawfulness of a future act can only be made in relation to a person who, at the time the declaration is made, lacks capacity as regards the subject matter of the declaration. In my judgment, the court cannot make a proleptic finding of incapacity, saying, pursuant to s2(4), that it is satisfied that it is more likely than not that at some point in the future that the person will lose capacity. This is because Part 1 of the Act only applies to persons who are presently incapacitated, not to persons who are not incapacitated but who might become at some point in the future incapacitated.

36. Therefore, in my judgment, s. 15(1)(c) has to be interpreted to apply only to persons who are incapacitated. A literal interpretation would give rise to absurd results. It would allow the Court of Protection to declare, for example, that a person had capacity in all respects but that it would nonetheless be unlawful for a medical procedure, to which she consented, to be performed on her. The procedure may well be unlawful but whether it is, or it is not, is not within the jurisdiction of the Court of Protection and a declaration to that effect would not be worth the paper it was written on.

37. For these reasons I conclude that the Court of Protection has no jurisdiction to make the first declaration. For the reasons given below, I do not consider that the High Court has an inherent power to authorise a deprivation of liberty of a capacitous person, and that therefore there is no jurisdiction to make the second declaration either.

38. If, contrary to the above, I am quite wrong and the Court does in fact have power to make an anticipatory or proleptic declaration, the next question is: how does it work?

The proposed order says: **"In the event that Amira loses capacity to make decisions about her obstetric care during labour, delivery and/or the postpartum period …"** How will the applicant trust know whether the person has moved from capacity to incapacity during the birthing process? Will Dr A be on stand-by to say that in his or her opinion the person has lost capacity?

39. Assume that during the birthing process it appears to the obstetric team that Amira has lost capacity to consent to the procedures necessary for a safe birth. Dr A, a forensic psychiatrist, is summoned and asked to give his opinion. He assesses Amira and duly opines that Amira's capacity has been lost. In reliance on that opinion, the obstetric team restrains Amira to enable a literal vital act, namely a birth safe to both Amira and the child.

40. It would be argued, I suppose, that such an opinion would conclusively satisfy the condition precedent within the anticipatory declaration namely that **Amira [has lost] capacity to make decisions about her obstetric care during labour, delivery and/or the postpartum period …"** That may be true, but what cannot be gainsaid is that such an opinion would unquestionably satisfy the terms of s. 5(1) and 6 (and if the restraint amounted to a deprivation of liberty, s.4B also[1]) thereby giving the obstetric team a complete defence to any later complaint by Amira that she had been the victim of battery or trespass to the person.

41. I admit to being at a loss as to why the ss 4B, 5 and 6 route to obtain immunity from a later complaint by P about an act done in connection with her care or treatment is not routinely used. It is specifically legislated for in the Act. In contrast, the device of a proleptic declaration under s. 15(1)(c) is in my judgment directly contrary not only to the wording of the Act, but also to its essential scheme.

42. In this case, as I have explained, the day before the hearing the applicant filed a further witness statement from the treating psychiatrist Dr A. This opined that in the previous 24 hours Amira had moved from capacity to incapacity in both spheres. As a result Mr Matthewson reconstituted the trust's application to seek immediate declarations and orders.

43. Both counsel agreed that the evidence is now sufficient to allow me to consider whether to make a final finding that in both spheres Amira has now lost capacity. Mr Matthewson for the applicant strongly urged me to find that the threshold had been passed in both respects; Ms Fox, for the OS representing Amira, adopted a neutral stance (but in reality must be taken to recognise the incapacity of Amira to conduct litigation because it is only on such a footing that the OS can act as litigation friend of Amira).

[1] For completeness I should record my opinion that the words "there is a question about whether D is authorised to deprive P of his liberty under section 4A" in s. 4B(2) must mean "there will be a question to be decided by the court whether D should be authorised to deprive P of his liberty under section 4A." This is because s. 4A(3) and (4) provide that D may deprive P of his liberty if, by doing so, D is giving effect to a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare. If such an order has already been made there could never be a "question" whether D "is authorised" to deprive P of his liberty under section 4A. The authorisation in the order will be plain on its face and there could be no question about it. Therefore s. 4B(2) must be seen as stipulating a requirement that D intends, after the emergency is over, to obtain an order authorising the deprivation of liberty of P. The other, more literal interpretation, makes no sense to me.

44. If I find that Amira lacks capacity in both spheres then the anticipatory-declaration problem disappears and it is not necessary to think about the immunity of the applicant under ss. 4B, 5 and 6. This is because there will be a declaration of incapacity in both spheres as well as a declaration that it is lawful to implement the care plan. In addition an order will be made under s. 16(2)(a) (read with s. 4A(3) and (4)) providing that the Court (making the decision on behalf of Amira) directs that she shall be treated in accordance with the obstetric care plan, which may include performing delivery by way of Caesarean section and the provision of sedation and restraint as set out in that care plan and, further, that the order entitles the applicant to deprive Amira of her liberty.

45. Such an order is indispensable where a deprivation of liberty under s. 4A is sought to be authorised.

Section 48

46. Assume for the sake of argument, that the evidence is not sufficient for me to find that Amira lacks capacity in the first sphere, and that an adjournment is necessary to obtain fuller expert evidence on the issue. In that event the matter would have to be dealt with under s.48. It cannot be gainsaid that the evidence is amply sufficient to satisfy the terms of s.48. On any view, there is reason to believe that Amira lacks capacity in both spheres. Under s. 48 an order could be made in the terms set out in para 44 above but it would not be an order under s16(2)(a) and so the authority to deprive P of her liberty under s.4A(3) and (4) would not bite.

47. It rather looks as if the assumption made by me and by counsel in *A Local Authority v LD & Anor* that there is power to authorise a deprivation of liberty under s.48 may well not be correct. If that is so, then the necessary authorisation of a deprivation of liberty will have to be made under the inherent jurisdiction of the High Court. The question then is whether the finding under s. 48 that there is "reason to believe that P lacks capacity", meets the definition of "persons of unsound mind" in Article 5 of the European Convention on Human Rights?

48. I incline to the view that it must, because if it did not Amira would have to be treated for all purposes as capacitous (having regard to the presumption in favour of capacity) with the result that an order could not be made under the inherent jurisdiction depriving her of her liberty: see *Wakefield Metropolitan District Council and Wakefield Metropolitan Clinical Commissioning Group v DN and MN* [2019] EWHC 2306 (Fam), [2019] COPLR 525, para 49, at paras 27, 37, 48 where Cobb J explained why the inherent jurisdiction cannot be used to deprive a vulnerable but capacitous adult of his liberty[2].

49. I think it unlikely that there is a complete absence of power to authorise a deprivation of liberty, whether under the 2005 Act or the inherent jurisdiction, where the Court is proceeding without delay in an emergency under s.48.

50. It is worth recalling that in the foundational case of *Winterwerp v Netherlands* (1979) 2 EHRR 387 the Court of Human Rights held at [39]:

[2] See also Sir James Munby's lecture to the Court of Protection Bar Association on 10 December 2020: *Whither the inherent jurisdiction? How did we get here? Where are we now? Where are we going?* https://www.cpba.org.uk/wp-content/uploads/2020/12/2020COPBA.pdf

> "In the Court's opinion, **except in emergency cases**, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind". The very nature of what has to be established before the competent national authority - that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder" (emphasis added)

51. In that case the complainant had been detained for 3 weeks by the Burgomaster, extended to 6 weeks by the public prosecutor, without any medical evidence having been provided. In para 42 the court held:

> "In the Court's view, the events that prompted the burgomaster's direction in May 1968 (see paragraph 23 above) are of a nature to justify an "emergency" confinement of the kind provided for at that time under section 14 of the Netherlands Act. While some hesitation may be felt as to the need for such confinement to continue for as long as six weeks, the period is not so excessive as to render the detention "unlawful". "

52. It is true that the emergency exception has been required to be construed narrowly by later decisions but there is no doubting its continued existence. In my opinion, in an emergency, provided that the court is satisfied that there is reason to believe that P lacks capacity, the court can lawfully authorise a temporary deprivation of liberty under the inherent jurisdiction to endure for a very short period until the question of capacity can be finally determined, and, if capacity is found to have been lost, an order made under s.16(2)(a), which in turn triggers s.4A(3) and (4).

53. Finally, in relation to s.48 I record that after the judgment in *A Local Authority v LD & Anor* was handed down I considered the commentary on it in the 39 Essex Chambers Mental Capacity Report of June 2023 which correctly observed that I had inadvertently made no mention of s.2(4) of the Act, which provides:

> "In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities."

54. It is plain that this is a purely confirmatory provision which does no more than to underscore that the normal civil standard of proof applies to the threshold question of incapacity. If s. 2(4) did not exist the general law would apply that same standard to that question anyway. To be clear, it is my opinion (which is consistent with that of Mr Ruck Keene KC, as well as with the decision of the Court of Appeal in *Jirehouse Capital v Beller* [2008] EWCA Civ 908, [2009] 1 WLR 751) that the question whether the court has "reason to believe that P lacks capacity" for the purposes of s.48 is <u>not</u> "a question whether a person lacks capacity within the meaning of the Act." S.2(4) applies where the Court is determining substantively whether or not a person lacks capacity. Under s.48 the Court is doing something quite different, namely making a preliminary prediction, using the applicable degree of likelihood, whether in due course that finding will be made. The argument of Mr Neil Allen, as referred to in the commentary, appears

to be that in order to satisfy the terms of s.48 (taken with s,2(4)) the court has to make a finding along the lines of: "Although the evidence does not satisfy me today that it is more likely than not that P lacks capacity it does satisfy me that it is more likely than not that at a later date I will be so satisfied." To me, that is internally contradictory and almost impossible to operate as a test.

Decision on capacity

55. Sections 2(1) and 3(1)(b) & (c) of the Mental Capacity Act 2005 state, for the purposes of this case:

> "A person lacks capacity in relation to a matter if … she 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."

and

> "A person is unable to make a decision for himself if she is unable …to retain [the] information [relevant to the decision], or to use or weigh that information as part of the process of making the decision."

56. Dr A gave very clear evidence that, based on his assessments of Amira made the day before the hearing, these criteria were fully satisfied.

57. His oral evidence was as follows:

> "Mr Matthewson: You assessed her capacity yesterday morning?
>
> Dr A: Yes.
>
> Mostyn J: The best thing to do is to focus on weighing. It always comes down to weighing. If you could tell me her capacity to weigh the information.
>
> Dr A: That is the key issue with Amira, her deterioration of her mental health has impaired her capacity to weigh the information. She was stable until 48 hours ago. She could consider, understand, weigh up the pros and cons, we had meetings together with the obstetrician. She has increasingly become distressed. She is preoccupied and fixated on two areas. One is the deep understanding that she will not be with her baby after its birth and secondly returning to our hospital here, which is a secure mental health facility.
>
> Mostyn J: Has she been told what the local authority's plans are in relation to this baby?
>
> Dr A: Yes … [*words redacted*]

> Mostyn J: [*words redacted*] Weighing that dispassionately and objectively would be very difficult, you would have thought, for someone who was not mentally ill [let alone someone who was].
>
> Dr A: The 48-hour deterioration is not distinctly linked to knowing that information, it is knowing that is going to happen imminently. They are the stressors. With her mental health her level of anxiety, distress, and paranoia, not a delusion, she can't entertain the information, she does not want to focus on it and she cant weigh it up. She can't judge the information. I saw her again yesterday morning and I mentioned having to discuss this information again, aspects concerning her capacity to litigate and the birth plan, she stood up and walked out and said she can't cope with this. My view is on balance she can't weigh up the information and she cannot fully explain her thought process because of her mental health disorder."

58. Dr A was extensively cross-examined by Ms Fox but no inroads were made into the force of his opinion.

59. I am satisfied on a strong balance of probability that Amira lacks capacity to make decisions as to her obstetric care or to conduct litigation about that very issue. That lack of capacity only arose the day before the hearing when Dr A made his revised capacity assessment. Therefore, neither the trust nor its solicitors were guilty of any delay in notifying the Official Solicitor. Before that point there was nothing to notify the Official Solicitor about.

60. If I am wrong, and there is a power to issue, in respect of people with capacity, anticipatory declarations to take effect if and when they lapse into incapacity, then it would appear that the trust and its solicitors were at fault in not notifying timeously the Official Solicitor of their intention to seek such proleptic declarations. The trust's solicitors have apologised for the delays.

61. If my construction is correct, this may well have the result, were capacity to be lost very shortly before the birthing process begins, that it would be very difficult in the short time available for an NHS Trust such as the applicant to obtain orders under ss.16(2)(a) and 4A(3) and (4) (or even an order under s.48 backed up by a High Court authorisation of deprivation of liberty) giving absolute, court-ordered, immunity. I recognise why, in a litigious world, trusts would want to have the gold standard of immunity. I also recognise just how challenging it is to prepare an application for such relief and to get it heard by a High Court judge at very short notice.

62. However, for the reasons I have given, I cannot see why equivalent immunity would not be obtained in such cases by going down the ss. 4B, 5 and 6 route I have identified. This route appears to have fallen into disuse (if it was ever in fact used) but it seems to me to be the route which Parliament intended to be used in such circumstances.

Best interests

63. When assessing Amira's best interests under s. 4 of the Act, I must have regard to all the relevant circumstances, including:

i) The strong presumption that it is in a person's best interests to stay alive (although this is not absolute) and that therefore it is not normally in someone's best interests to engage in risky conduct that imperils life;

ii) Amira's own wishes and feelings;

iii) Amira's overall prognosis;

iv) The views of Amira's treating clinicians of her best interests.

64. I heard oral evidence from the consultant obstetrician Dr HT and from the consultant anaesthetist Dr B, both of whom elucidated the care plan and were thoroughly cross-examined on it.

65. In my recent decision of *Gloucestershire Hospitals NHS Foundation Trust & Anor v Joanna* [2023] EWCOP 21 I stated as regards the first circumstance:

> "19. I address first the starting point that it is in a person's best interests to live, save in those rare cases where it is objectively demonstrable that it is not in a person's best interests to receive life sustaining treatment. This starting point is applicable here given the potential consequences of non-compliance or aggression during a vaginal delivery and the required antenatal care. Without appropriate management of the situation this has the potential to be life-threatening to both Joanna and her child. Dr A considers it very unlikely that Joanna will be able to comply with the care and interventions that may be needed. This could lead to an emergency caesarean section which carries a greater risk to Joanna and her child than a planned caesarean section."
>
> 20. The next point is that, regardless of whether Joanna has the capacity to make decisions for herself, she is entitled to protection under the European Convention of Human Rights, particularly, in these circumstances, under Article 8. Furthermore, s. 4 requires me to focus on Joanna's wishes and feelings. In *Aintree v James* [2013] UKSC 6 at [39] and [45], Baroness Hale stated:
>
> > "[39] The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are

> interested in his welfare, in particular for their view of what his attitude would be.
>
> …
>
> [45] Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."

66. There is no evidence in this case that Amira would wish to be exposed to risks that imperilled the life of her or the unborn child. The terms of the care plan, insofar as they incorporate possibility of restraint and deprivation of liberty, are therefore reasonable and consistent with this presumption.

67. The terms of the care plan are also fully consistent with Amira's own wishes and feelings, she having engaged with their formulation. They are strongly considered by both Dr HT and Dr B, as well as Dr A, not merely to be consistent with Amira's best interests but actively to promote them.

68. I am fully satisfied that for Amira to be treated during the birthing process in accordance with the terms of the care plan is in her best interests and I so declare and order.
