Browne Jacobson

Capacity at birth – care planning, contingent and anticipatory declarations

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Watch our video for a short summary on United Lincolnshire Hospitals NHS Trust v CD here.

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Background

CD is a young woman who was pregnant and detained under s.3 Mental Health Act 1983 (paranoid schizophrenia and emotionally unstable personality disorder). At the time of the initial application she was floridly psychotic with particular delusional beliefs around caesarean section and use of cannulas. She lacked the capacity to make decisions about the mode of delivery of her child, and we applied to the Court of Protection (CoP) for a best interests decision.

Happily, CD's condition improved with treatment. Shortly before the final hearing she was assessed to have regained the requisite capacity (though still lacking litigation capacity) by both the obstetric and the mental health teams.

Unhappily, between the application and the final hearing, CD developed significant polyhydramnios (excess amniotic fluid). This meant moving the final hearing forward with urgent plans for artificial rupture of membranes, possible induction and an increased risk of caesarean section.

The difficulty was that whilst CD had capacity to make decisions about delivery (and was hesitantly agreeing to cannulas and caesarean section), based on her history, there was a substantial risk that she may become incapacitous at the critical moment in her labour. Malpresentation or cord prolapse were obstetric emergencies requiring swift action.

Orders sought

The Trust sought anticipatory and contingent declarations in the following terms:-

- CD has capacity to make decisions regarding her obstetric care and the delivery of her baby.
- Once CD's membranes have ruptured (either spontaneously or artificially) and in the event that CD is assessed as lacking capacity to make decisions about her obstetric care and labour and the delivery of her baby it is lawful for the applicant to deliver care and treatment to her in accordance with the care plan.
- To the extent that the arrangements and the care plan amount to a deprivation of CD's liberty, this is authorised, providing always that any measures used to facilitate or provide the arrangements shall be the minimum necessary to protect the safety of CD and those involved in her transfer and treatment, and that all reasonable and proportionate steps are taken to minimise distress to CD and to maintain her dignity.

The decision

A lack of capacity is the gateway to the court and it was faced with a challenge of applying the correct framework to a perilous clinical situation. 5 options were discussed in court:-

- an order bringing CoP proceedings to an end on the basis that CD has capacity to make decisions about the birth;
- an interim order adjourning the proceedings for a short period to enable the applicant to come back for an urgent order should CD's capacity deteriorate;
- an interim order which would enable the applicant to implement the care plan pursuant to section 4B of the MCA (i.e. where a deprivation of liberty is authorised whilst court approval is sought with, effectively, final s.16 declarations after the event).
- a final order declaring, pursuant to section 15 (1)(c) that, in the event CD is assessed at some later date as lacking the capacity to make decisions about the birth, the implementation of the care plan would be lawful;
- an order pursuant to the inherent jurisdiction.

It was arguable that the CoP no longer had jurisdiction, but there was a very real prospect that CD would lose capacity. At that point a renewed application would cause unacceptable delay with potentially catastrophic consequences to CD or leave the treating team in the invidious position of possibly carrying out invasive surgery and treatment without lawful authority. The practical time limits in the event of an obstetric emergency also left insufficient time for an emergency order to be obtained, even if the case was adjourned, and though the judge (unusually, and kindly) gave his personal mobile number and agreed to be effectively "on call" to deal with the case.

Relying on s.4B would involve adjourning a court decision until after delivery which the court stated was "*entirely artificial since it is in relation to treatment **during labour** that the issue arises*", and the court was aware of the case now.

Finally, in determining that the court should use the MCA framework wherever possible (and thus discounting the use of the inherent jurisdiction), the court considered the correct approach was to use s.15 MCA to make the contingent and anticipatory declarations described above.

The significance

This case is particularly significant because it is the first reported case that helpfully makes anticipatory declarations in the event that a person predictably loses capacity, instead of leaving this to be dealt with in an emergency.

Our team is regularly instructed to advise on cases like this. If it would be helpful to discuss this case or its implications, please get in touch.

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