Neutral Citation Number: [2024] EWCOP 69 (T3)

Case No: 20005396

IN THE COURT OF PROTECTION

IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 1 November 2024

Before :

MR JUSTICE CUSWORTH

- -

Between :

MID YORKSHIRE TEACHING NHS TRUST **Applicant**

- and -

(1) SC **Respondents**

(BY HER LITIGATION FRIEND, THE OFFICIAL SOLICITOR)

(2) SOUTH WEST YORKSHIRE PARTNERSHIP

NHS FOUNDATION TRUST

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Vikram Sachdeva KC instructed by the **Applicant**
Janet Bazley KC (instructed by **The Official Solicitor**) for the **First Respondent**
Vikram Sachdeva KC instructed by the **Second Respondent**

Hearing date: 1 November 2024

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JUDGMENT

This judgment was handed down remotely at 10.30am on 28 November 2024 by circulation to the parties or their representatives by e-mail and by release to The National Archives.

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Mr Justice Cusworth :

1. This application is concerned with the best interests of SC, a 37 year old woman (she was born on 20 October 1987), who is currently pregnant, with a due date of 22 November 2024. She has given birth twice before, and has had two previous emergency Caesarean sections, in 2007 and 2012. She has previously been detained under the Mental Health Act in 2019 and 2021. Sadly, in January of this year she suffered an early miscarriage. She fell pregnant again in the following months, and by a scan on 28 June 2024, it was confirmed that she was 19 weeks pregnant, and that she was carrying one child.

2. On 26 September 2024, SC was again detained under s.2 of the MHA. On 22 October, she was detained under s.3 MHA, diagnosed as suffering from mania with psychotic symptoms. On the following day, 23 October, an ultrasound scan showed evidence of static foetal growth in respect of her unborn child, such that the medical consensus was that delivery should take place no later than 4 November. That was 11 days earlier than had been planned. This was the primary reason for the urgency for the determination of this application. On 25 October 2024 the applicant NHS Trust filed these proceedings in the Court of Protection, under the Mental Capacity Act 2005. This case has then been urgently listed for hearing before me, with a time estimate of 1 day on 1 November 2024, the date for the planned Caesarean section having to be brought forward from 15 November to 4 November.

3. The urgency is explained by Mr Sachdeva KC for the applicant, as shown in the medical evidence, as being due to:

a. Tightening and abdominal pain shown by SC, raising the risk of spontaneous labour.

b. As explained, evidence of static foetal growth on ultrasound on 23 October.

c. Absent or reduced foetal movements.

d. A concern that SC's mental health has been deteriorating.

4. Mr Sachdeva expresses the applicant's concern that each of these risk factors are sufficient alone to consider delivery from 37 weeks. When taken together, the applicant says that it would be running a very high risk to both mother and baby to postpone the Caesarean section past 4 November 2024. The risks are set out in detail in the medical evidence which I have read from Miss A (consultant obstetrician). I have also considered evidence from Dr B (consultant psychiatrist), Dr C (consultant anaesthetist) and Dr D (consultant perinatal psychiatrist). As none of their evidence is challenged by the Official Solicitor, I have not heard any oral evidence from the medical team.

5. The Official Solicitor has been instructed to act as SC's litigation friend, and she is represented today by Ms Bazley KC. She has noted the following in particular that:-
    - It was clear by June 2024 that there were serious concerns about SC's mental state and willingness to engage with obstetric care;
    - On 2 September 2024, the local authority had decided at a Core Group meeting to go to a Legal Gateway for PLO to remove the baby from SC at birth;

- SC's obstetric history was well known, and the treating clinicians were aware of the likelihood that she would need to give birth by C-section;
- SC was sectioned under s.2 MHA on 26 September 2024;

6. After the proceedings were filed on 25 October 2024, the decision-makers sought to inform SC about the application that was being made and to seek her views about it only on 30 October 2024, just two days ago. SC's presentation at the consultation the previous day was such that the clinicians did not feel able to discuss the proposed care plan before the Court. Because SC had not yet been told about the application, a visit by the Official Solicitor's agent had to be delayed until 31 October 2024, the day before this hearing. In fact, however, that visit has taken place and the Official Solicitor is satisfied that she has been able to properly consider SC's position and to elicit her views. I received this morning a record of the meeting between SC and Natalie Coates ('NC') of the Official Solicitor's office, from which I can extract the following expressions of her position:

> '*NC noted that she understood the doctors were proposing a c-section because she has had two previous c-sections. SC interrupted NC and stated, "that was because of neglect, it's different this time, I'm not agreeing to it when I know I can give birth". NC asked whether a second opinion from any doctor would change SC's mind. SC confirmed, "no not to a c-section. They are trying to make me believe I am only having one baby. I know there is more. There were 3 babies on the scan pictures". …*
> *NC noted that SC had scan pictures and asked whether she could see them. SC did not agree to show the pictures. SC continued, "when I had a scan there were 2 heart beats so there are at least 2 babies, I know there are 4 in me, I can feel them I know this because they are in me. If I have the c-section, I'll get 1 and they will take the other 3 away and sell them. That is what they want to do. I need more power more rights". …*

NC asked SC whether she could clarify what her wishes and feelings are. [She accepted this formulation of them]. "I believe there is more than one baby, and I think they will take the others if there is more than one". SC …stated, "it is the way you phrase it, they think I am mentally unstable, I have a high mental IQ. I am not lying. I have the right to refuse a c-section. 6 weeks of pain, sown up and they take my babies".

NC asked SC, "you don't want the c-section, but what if something went wrong". SC was becoming agitated and stated, "I am sick of talking about it now, I have told you what I want. If I came into difficulty, I would have it"…

SC stated, "Tell them I want a natural birth, it is not their life and not their kids. I am not going to change my mind. I have human rights, I am a human we are all human, I understand the staff say I am abusive to them, but they are abusive to me, I know two wrongs do not make a right". …

"If you could find me a number for a mother baby unit that would be helpful, if I give birth here they're going to be taken away. Imagine what it will do to my mental health".'

7. The Law. The MCA 2005 states as follows:

"1 The principles

(1) The following principles apply for the purposes of this Act.

(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(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.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(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.

2 People who lack capacity

(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.

(2) It does not matter whether the impairment or disturbance is permanent or temporary.

(3) A lack of capacity cannot be established merely by reference to–

(a) a person's age or appearance, or

(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

(4) 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…

3 Inability to make decisions

(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable–

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).

(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of–

(a) deciding one way or another, or

(b) failing to make the decision."

8. Lord Stephens, in *A Local Authority v JB* [2021] UKSC 52 explained that Section 2(1) requires the court to address two questions, the first being whether P is unable to make a decision for himself in relation to the matter [67], and the second being whether that inability to make a decision is "because of" an impairment of, or a disturbance in the functioning of, P's mind or brain [78]. Since the assessment of capacity is decision-specific, the court is required to identify the correct formulation

of "the matter" [68]. The correct formulation of "the matter" leads to a requirement to identify "the information relevant to the decision" under s3(1)(a) which includes information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision: [69]. The court must identify the "information relevant to the decision" "within the specific factual context of the case": [70]. Capacity may fluctuate over time, so that a person may have capacity at one time but not at another time. The "material time" within s2(1) is decision-specific; the question is whether P has capacity to make a specific decision at the time when it needs to be made: [64].

9. Lord Stephens went on to make clear that the information relevant to the decision includes information about the reasonably foreseeable consequences of a decision, or of failing to make a decision. These consequences are not limited to the "reasonably foreseeable consequences" for P, but can extend to consequences for others: [73]. There should be a practical limit on what needs to be envisaged as the "reasonably foreseeable consequences" of a decision or of failing to make a decision so that "the notional decision-making process attributed to the protected person… should not become divorced form the actual decision-making process carried out in that regards on a daily basis by persons of full capacity": [75]. P's ability to use or weigh information relevant to the decision as part of the decision-making process "should not involve a refined analysis of the sort which does not typically inform the decision… made by a person of full capacity": [77].

10. Section 4 of the MCA 2005 defines the process of determining best interests as follows:

"(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and

(b) if it appears likely that he will, when that is likely to be.

(4) He 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.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),

(b) the beliefs and values that would be likely to influence his decision if he had capacity, and

(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,

(b) anyone engaged in caring for the person or interested in his welfare,

(c) any donee of a lasting power of attorney granted by the person, and

(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—. . . (b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) "Relevant circumstances" are those—(a) of which the person making the determination is aware, and (b) which it would be reasonable to regard as relevant."

11. Best interests are not just medical best interests, but are widely defined. In *Aintree v James* [2014] AC 591 Baroness Hale said:

> 24. ...The advantage of a best interests test was that it focused upon the patient as an individual, rather than the conduct of the doctor, and took all the circumstances, both medical and non-medical, into account (paras 3.26, 3.27). But the best interests test should also contain "a strong element of 'substituted judgment'" (para 3.25), taking into account both the past and present wishes and feelings of patient as an individual, and also the factors which he would consider if able to do so (para 3.28). This might include "altruistic sentiments and concern for others" (para 3.31). The Act has helpfully added a reference to the beliefs and values which would be likely to influence his decision if he had capacity....
> 45. ...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... 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."

12. The information relevant to the decision to consent to (or refuse) a Caesarean Section as considered to consist of the following by MacDonald J in *North Bristol NHS Trust v R* [2023] EWCOP 5:

> '62. ...in my judgment the information relevant to the decision on the matter in this case can usefully be derived from the questions that might reasonably be anticipated upon a member of the population at large being told that their doctor is recommending an elective Caesarean section and being asked whether or not they consent to that course. Namely, why do you want to do a Caesarean section, what are the alternatives, what will happen when it is done, is it safe for me, is it safe for my unborn child, how long will I take to recover and what will happen if I decide not to do it. Within this context, I am

satisfied information relevant to the matter requiring decision by R in this case can be articulated as follows:

i) The reason why an elective Caesarean section is being proposed, including that it is the clinically recommended option in R's circumstances.

ii) What the procedure for an elective Caesarean involves, including where it will be performed and by whom; its duration, the extent of the incision; the levels of discomfort during and after the procedure; the availability of, effectiveness of and risks of anaesthesia and pain relief; and the length and completeness of recovery.

iii) The benefits and risks (including the risk of complications arising out of the procedure) to R of an elective Caesarean section.

iv) The benefits and risks to R's unborn child of an elective Caesarean section.

v) The benefits and risks to R of choosing instead to carry the baby to term followed by natural or induced labour.

vi) The benefits and risks to R's unborn baby of carrying the baby to term followed by natural or induced labour.

63. …I consider that that relevant information will include some information concerning the impact on her unborn child of R taking or not taking a decision on the matter. R's unborn child has no separate legal identity until he or she is born. That position was confirmed in *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276, in which Sir George Baker held that a foetus cannot, in English law have a right of its own at least until it is born and has a separate existence from its mother, an approached affirmed by the ECtHR in *Paton v United Kingdom* (1981) 3 EHRR 408 in the context of Art 2 of the ECHR. But that legal position does not prevent the impact on the unborn child of taking or not taking a decision being information relevant to the matter requiring decision. Indeed, I consider it a safe assumption that one of the foremost pieces of information a pregnant woman would consider relevant in deciding whether to undergo any medical procedure during pregnancy is that of the potential impact on her unborn child.'

13. So, I must first determine whether SC has capacity in this case to make the required decision. That in itself requires the answering of a number of separate questions, expressed by MacDonald J in *R*'s case (above) as follows, at [57].

> 'There are four questions for the court to answer when deciding if R has capacity. First, what is the "matter", i.e. what is the decision that R has to make. Second, what is the information relevant to that decision. Third, is R unable to make a decision on the matter. Fourth, if R is unable to make a decision on the matter, is that inability caused by a disturbance in the functioning of her mind or brain.'

14. As to the matter to be determined, I am satisfied that MacDonald J's general formulation in that case - '*whether or not her baby should be delivered pre-term by means of an elective Caesarean section*' is applicable here. The alternative option of carrying the baby to term, SC's preferred option, remains relevant as the alternative in that formulation, but is not clinically indicated, and need not be part of the formulation. I must then determine the relevant information, which again I will consider through the prism of MacDonald J's formulation.

15. As to the reasons why a Caesarean is proposed, it is clear that the three possibilities available are these: to continue to term and attempt to deliver vaginally; to continue to term and run the risk of a third emergency Caesarean Section; or to a planned early Caesarean section. It is evident from the medical evidence that there are strong reasons to favour the last of those: it brings a lower risk of uterine rupture than vaginal delivery; the baby is in a breech position and it is not generally advisable to rely on moving the baby manually in cases where there have been two previous Caesarean Sections; and planned Caesareans are (self-evidently) safer than emergency Caesareans. The procedure for an elective Caesarean is fully set out in the updated care-plan, which I have carefully considered.

16. As to the benefits and risks to both SC and her unborn child inherent in either course, have in mind the important medical considerations already alluded to at paragraph 3 above, and set out in detail at paragraph 23 below. I also have to remember that, in the event that a Caesarean is anyway required on an emergency basis during any attempt at natural birth, that will almost certainly not be possible under general anaesthetic. If SC becomes distressed during the process, both her own health and that of her unborn child may be affected.

17. However, I am also concerned about the prospect that SC's psychiatric conditions will worsen if she has to undergo a Caesarean section against her will. As set out above, she has expressed a very clear view, albeit tempered by her remark that '*If I came into difficulty, I would have it (the C-section)*'. However, she currently believes that she is carrying 4 children, to all of whom she is determined if she can to give birth to naturally. The must be a real risk that her currently exhibited psychiatric symptoms would worsen, and her ability to cooperate with those who are caring for her would only reduce further if she was subject to the procedure now planned, without her consent. This will only be exacerbated by the local authority's plans as set out in the care plan once the child has been born. Dr B states that:

'*SC is at increased risk of further deterioration of her mental health during the postpartum period; her current mental state is so far poorly responded to antipsychotic treatment, and her delusional beliefs may worsen when she realises, she only delivered a single baby and if there is a social services involvement due to child safeguarding concerns*.'

18. Turning to whether SC is unable to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section,

s.3(1) of the 2005 Act requires consideration of whether she is able to understand, retain and use or weigh that the relevant information I have identified above, and to communicate her decision. The Applicant Trust and the Official Solicitor both submit clearly that she is not. Dr B describes her current position in these terms:

SC is currently presenting with mania with psychotic symptoms. SC has a fluctuating mental state including elated mood, irritability, being argumentative, poor sleep, verbal hostility, physical aggression, paranoid persecutory delusional beliefs regarding nursing staff, including a belief that nursing staff are sedating her at night and sexually assaulting her by sucking her nipples and removing the colostrum, poisoning her with food, raping her whilst she was administered IM Olanzapine under restraint.
SC also reports bizarre beliefs including that she is currently pregnant with quadruplets. Scans undertaken by MYTT have confirmed a single pregnancy, but SC does not accept those findings. SC reports that she is a midwife or a doctor and that she can deliver her babies herself in her own home.
Upon admission to the mental hospital, SC engaged in disruptive and challenging behaviours on an open ward she was loud, rude in her speech towards staff, making several false accusations in consequent to her persecutory beliefs such as staff are sexually assaulting her whilst she is asleep. She was interfering with the care of other service users on the ward, on occasions she was verbally aggressive towards other service users which was putting her at increasing risk of retaliation from other service users. SC attempted to physically assault staff by lunging at them.

19. In his second statement he opines: *In my opinion SCs delusional ideas of having four babies and them being removed from her care are interfering with her decision making and acceptance of factual information provided by professional of the need for a caesarean section in the context of a high risk pregnancy.*

20. It has recently been confirmed in the Court of Appeal that where there is objectively verifiable medical consensus as to the consequences of not having medical treatment, if a person does not believe or accept that information to be true, it *may* be that they are unable to understand it

and/or unable to weigh it for the purposes of the MCA: *Hemachandran v Thirumalesh* [2024] EWCA Civ 896, where King LJ said at [123]:

'an absence of belief may but not inevitably will, on the facts of a particular case, lead to a clinician or a court to conclude that the functional test in section 3(1) is not satisfied and that the person in question does not have the ability to make the decision in question'.

21. In light of that evidence I am satisfied that SC is not currently able to make the decision that is now urgently required of her. She has been diagnosed with Bipolar Affective Disorder, which currently is manifesting as Mania with Psychotic Symptoms. She is suffering from delusional beliefs. Whilst the evidence of a psychiatrist is likely to be determinative of that issue for the purposes of section 2(1) MCA, it remains the case that the decision as to capacity is a judgment for the court to make. The medical evidence here is clear that there is an impairment in the functioning of her mind or brain. It is equally clear to me that it is that impairment which is, for SC, the reason why she is unable to make that decision. I am therefore satisfied that she lacks capacity to decide whether or not her baby should be delivered pre-term by elective Caesarean section in circumstances where she is unable to make that decision, and that inability is by reason of an impairment in the functioning of her mind or brain.

22. Accordingly, this court has jurisdiction under the 2005 Act to determine what course is in SC's best interests and to make declarations accordingly. I will have to determine, amongst other matters, whether the risk to her of a serious deterioration in her mental health by reason of her undergoing the Caesarean against her expressed wishes is outweighed by the very significantly advantages to her physical safety, and that of her

unborn child, with a planned Caesarean. It is also the case that a significant deterioration in her mental health is at real risk of occurring after the birth of her child, whatever decision I make, given her current delusional beliefs about the nature of her pregnancy, and the local authority's current plans. I remind myself too that it is SC's best interests alone that I am considering.

23. To consider those best interests properly, I will return first to the evidence of Miss A (the consultant obstetrician), where she says in her statement of 30 October 2024:

12. The first risk factor is that SC has presented with tightening and abdominal pain which raises the risk of spontaneous labour. If SC were to go into spontaneous labour before the date of her Caesarean Section then this would pose the risk of uterine scar rupture potentially causing major haemorrhage and foetal death. This would put the life of mother and baby at risk and so if a patient is at risk of spontaneous labour then this would be a reason to consider delivery from 37 weeks in order to minimise the risk to mum and baby. Additionally at the last USS SC's baby was breech. There is no evidence to support offering ECV to women with 2 previous caesarean sections in order to turn the baby to the head down position. Nor is there any RCOG guidance or evidence to support vaginal breech delivery after 2 previous caesarean sections. Any woman wanting to embark on a vaginal breech birth after 2 previous caesarean sections would need an informed personalised care plan with a senior Obstetrician where the woman understands the risk of not only uterine rupture but also the risk of complications of a vaginal breech delivery.

13 The second factor is that, on the last USS there was static growth of the foetus. This can be an indication of placental insufficiency. The third factor is that SC has noted on a number of occasions that she has absent or reduced foetal movements. Recurrent reduced foetal movements can also be an indication of placental insufficiency.

14 These second and third risk factors are independent risk factors for stillbirth and so when taken together would certainly be a reason to consider delivery from 37 weeks rather than waiting until 39 weeks with the risk of placental failure in the interim. Were SC to suffer a stillbirth and decline medical intervention this would pose a risk of major haemorrhage, disseminated intravascular coagulation ("DIC" – a

condition where blood does not clot) and possibly death, as well as having a significant impact on her mental health.
15 In summary, each of these three risk factors is sufficient reason alone to consider delivery from 37 weeks. When taken together I am of the view (and it is agreed by the obstetric MDT) that it would be running a very high risk to both mother and baby to postpone or delay the c-section post 4 November 2024.

24. So the medical position is clear, but the best interests test as set out above is wider than that, as Baroness Hale in *Aintree v James* (above) at [45] made clear – '*...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."*

25. So, I do take fully into account what SC has said to Ms Coates, her unhappiness and suspicions about the way that she has been treated by the staff who have seeking to care for her. I also remind myself, importantly, of the significance of the decision that the court is here being asked to make. As MacDonald J properly said in *North Bristol NHS Trust v R* (above) at [84]

'...for the court to authorise a planned Caesarean section is a very serious interference in a woman's personal autonomy and Art 8 rights. As the Vice President noted in Guys and St Thomas NHS Foundation Trust & Anor v R, Caesarean sections present particular challenges in circumstances where both the inviolability of a woman's body and her right to take decisions relating to her unborn child are facets of her fundamental freedoms.'

26. Notwithstanding that very important consideration, I am nevertheless satisfied that in these circumstances, it is very clearly in SC's best interests for the planned Caesarean to go ahead on Monday as the Applicant Trust and the Official Solicitor both agree. The views that she has expressed are I am clear very much influenced by her mental illness, and her delusional

belief that she is carrying four small babies that can be delivered by her vaginally with no difficulty or risk. The increased risk of uterine rupture after having had two previous Caesarean sections is very real, which could cause real danger both to her life and that of her unborn child. The medical evidence in favour of a planned Caesarean is overwhelming.

27. Further, and whatever course is taken, the reality that SC is carrying only one child, and that the local authority plan to make an application for its removal from her, will no doubt have a devastating but unavoidable impact on her health and well-being. In those circumstances, any attempt at vaginal delivery, aside from being fraught with medical risk, may also be the cause of further trauma for SC if, even after coming through that procedure successfully for the first time, she is nevertheless unable ultimately to care for her child. Consequently, I am satisfied that the birth should take place in the safest and least traumatic circumstances for SC, so that her ability to recover in future is not further impaired by additional traumatic memories.

28. I consequently grant the application as being in SC's best interests, and will make the order as sought.