Neutral Citation Number: [2025] EWCOP 21 (T3)

Case No: COP20016924

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10 June 2025

Before :

Miss Nageena Khalique KC

- -

Between :

OXFORD UNIVERSITY NHS FOUNDATION TRUST (1) OXFORD HEALTH NHS FOUNDATION TRUST (2)	**Applicants**
- and -	
AX	**Respondent**

- -
- -

Adam Fullwood (instructed by **Hill Dickinson LLP** for the **First and Second Applicants**)
Victoria Butler-Cole KC (instructed by the **Official Solicitor**) for the **Respondent**

Hearing dates: 10 June 2025

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 13 June 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

.....

MISS NAGEENA KHALIQUE KC, SITTING AS A DEPUTY HIGH COURT JUDGE (IN PUBLIC)

This judgment was delivered in public. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

MISS NAGEENA KHALIQUE KC:

Introduction

1. The application before me concerns AX, a 30-year old woman who is now 38 weeks pregnant with her second child. AX is currently detained under section 2 of the Mental Health Act 1983 ("the MHA") with a diagnosis of depression and psychosis.

2. The Applicants are (1) the NHS Trust which is responsible for providing ante-natal and obstetric care to AX and (2) the NHS Trust, which is providing mental health services to AX. The Applicants seek urgent declarations that AX lacks capacity to make decisions about the imminent birth of her second child and that it is her best interests to undergo an elective Caesarean section ("C-section") with associated care and treatment.

3. The urgency for this application is because of the risk of pre-eclampsia, the effect of AX's gestational diabetes and the concern that AX's mental health has significantly deteriorated. AX is electively mute and refusing to engage consistently with antenatal care.

4. AX's mother also attended the hearing remotely.

My decision

5. In summary, I am satisfied on the totality of the evidence that I should make the following declarations:

    A. Pursuant to section 15 of the Mental Capacity Act 2005 ("the MCA") AX lacks capacity to:

        a) conduct these proceedings;

        b) make decisions regarding her:

            i. ante-natal care;

            ii. mode of delivery; and

            iii. related care and treatment; and

    B. It is lawful and in AX's best interests pursuant to section 16 of the MCA to undergo a planned C-section on 11 June 2025 with all the ancillary care and treatment as set out in the Birth Care Plan filed with the court on 9 June 2025.

6. I handed down an ex-tempore judgment on 10 June 2025 as AX's C-section was planned to take place in the morning on 11 June 2025. This written judgment will be handed down electronically on 13 June 2025 at 10.00 a.m.

Background and procedural history

7. AX is described by her mother as a creative individual with a talent for acting and the performing arts. She is the mother of a 7 year old son, delivered by C-section in 2018,

who is currently living with his maternal grandmother. AX suffers with gestational diabetes for which she requires medication and monitoring. She has not been compliant with the latter.

8. The father of AX's unborn child is not a UK citizen or resident, and reportedly does not wish to be involved in the care of the child. He has not been consulted in relation to this application.

9. AX has been diagnosed with depression with psychotic features. Since 21 May 2025, she has been detained pursuant to section 2 of the MHA. Her current presentation mirrors that of a previous episode when AX was detained under the MHA in November/December 2023. The diagnosis made at that time was that AX was suffering with a psychotic disorder and depression/anxiety. Prior to that admission, AX went missing for 14 hours and was found wandering the streets of Oxford, expressing overly religious ideas. She was unkempt, had stopped eating and drinking and was electively mute. These features have been similarly evident during AX's current admission.

10. AX was successfully treated with anti-depressant and anti-psychotic medication and self-discharged from community services in November 2024, which was considered to be an insightful capacitous decision.

11. On 20 February 2025 and on 1 May 2025, during her appointments with the diabetes team, AX expressed her preference for an elective C-section. This request was repeated at an antenatal appointment on 14 April 2025 when the options of a vaginal birth versus a planned C-section were discussed. There was no suggestion of AX lacking capacity or signs of deteriorating mental health at any of these clinical appointments. As such, her preference around mode of delivery was considered to be made when her cognitive function was not impaired and she was presumed to have capacity to make the relevant decisions.

12. In late May 2025, AX was reported to be missing with her son. They were subsequently found by the police, sleeping rough in a local church. The police noted that AX was expressing paranoid thoughts including that her family was spying on her. On 20 May 2025, AX was taken by the police to the First Applicant's Accident and Emergency department and she was subsequently admitted to hospital.

13. On 21 May 2025, AX was detained pursuant to s2 of the MHA in light of her mental health presentation and was transferred to a mental health unit operated by the Second Applicant for an assessment. AX was declining blood tests (including monitoring of her diabetes), missed her 32-week scan and refused some clinical observations. In addition AX was refusing to communicate and presented as mute. She was prescribed an antipsychotic medication, Olanzapine but initially was not compliant with taking it. AX expressed a desire for a home birth, despite previously agreeing to an elective C-section.

14. A multi-disciplinary meeting was convened on 27 May 2025 with the obstetric, safeguarding and mental health teams in attendance. There was consensus that AX appeared to lack capacity to make decisions about the birth plan and related treatment and that a further assessment should be carried out. In addition, it was noted that AX's mental and physical health were deteriorating including:

i) Evidence of psychosis;

ii) Abnormal blood tests including raised liver enzymes indicating a risk of pre-eclampsia;

iii) Ongoing gestational diabetes.

15. On 3 June 2025 a mental health and mental capacity assessment was undertaken by Dr B, Consultant Psychiatrist, and Dr D, Speciality Registrar which concluded that AX lacked capacity to make the relevant decisions around her birth plan and care. AX was noted to have changed her mind about a home birth indicating she wanted a C-section. She also said that she did not want to be in hospital and was suffering with pregnancy related nausea.

16. On 4 June 2025, the Applicants issued this application for declarations and personal welfare orders under the MCA in relation to AX's capacity and obstetric care and treatment. The Vice President of the Court of Protection, Theis J, made administrative orders on 5 June 2025 including, inter alia:

i) A transparency order preventing publication of AX's name and address, the names and addresses of her treating clinicians and where she is being treated; the order was valid up until the hearing on 10 June 2025;

ii) Interim declarations pursuant to section 48 of the MCA in respect of AX's capacity to make decisions about her obstetric care and her litigation capacity;

iii) Directions to file further capacity evidence, a detailed birth care plan, an update on AX's presentation and response to treatment, and any safeguarding concerns;

iv) The matter was listed before me for final hearing.

The issues

17. There was some refinement of the position of the parties shortly before the hearing as to the issues for this court, as follows:

i) Does AX lack capacity to make decisions about her obstetric care and treatment, including whether to undergo a planned C-section tomorrow morning?

ii) In particular, is there a causal nexus between the impairment of the functioning of AX's mind or brain and the inability to make the specific decisions?

iii) Does the care plan give rise to any need for an authorisation to deprive AX of her liberty? This issue fell away at the start of the hearing as Mr Fullwood, on behalf of the Trusts explained that the care arrangements had been finalised to include:

a) The use of persuasion in the first instance;

b) Transient arm holds to administer anaesthesia safely;

c) No administration of general anaesthesia as a form of chemical restraint;

d) In the event of unmanageable emotional dysregulation and/or increased physical resistance by AX, no force or restraint would be used, the Applicants would review and return the matter to court;

18. The Official Solicitor was in agreement with the proposed care plan and therefore no deprivation of liberty within the meaning of Article 5 of the European Convention of Human Rights (ECHR) was proposed and no orders in this regard were sought.

19. In respect of AX's best interests, there was also agreement as between the Applicant Trusts, the Official Solicitor and AX's mother that it was in AX's best interests to undergo the proposed C-section and treatment and that this accorded with AX's previously expressed capacitous wishes and feelings. No party sought to adduce any oral evidence on the issue of best interests.

Capacity: the legal framework

20. There is no dispute as to the applicable law in this case which was helpfully summarised in a 'law sheet' provided by Mr Fullwood. The relevant law as to capacity was recently set out in the case of *Mid Yorkshire Teaching NHS Trust v SC* [2024] EWCOP 69 by Cusworth J :

"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].

21. The information relevant to the decision to consent to (or refuse) a Caesarean section was 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.'

Best interests: the legal framework

22. The relevant law relating to best interests is agreed as between the parties and can be summarised as follows:

Section 4 of the MCA 2005

"(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.

.....

(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).

.....

(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."

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

> 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."

24. In relation to wishes and feelings Henke J in *A Hospital Trust v P* [2024] EWCOP 7 said:

> "49. The weight to be attributed to CP's wishes and feelings will differ depend on such matters as how clearly the wishes and feelings are evidenced, how frequently they are (or were previously) expressed, how consistent CP's views are (or have been), the complexity of the decision and how close to the borderline of capacity the person is (or was when they expressed their relevant views)."

25. In *M v N* (by her litigation friend, the OS), Bury Clinical Commissioning Group [2015] EWCOP 76 Hayden J said:

> '[28] …where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interests'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them. Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment'."

The evidence and my analysis on capacity

26. I have considered the following evidence:

i) Joint written statement from Dr B, Consultant Psychiatrist and Dr D, Specialty Registrar, dated 4 June 2025;

ii) Oral evidence from Dr B;

iii) COP3 assessment from Dr C, Consultant Obstetrician dated 9 June 2025;

iv) Written statement from Dr A, Consultant Obstetrician dated 6 June 2025;

v) Oral evidence from Dr C;

vi) Email dated 10 June 2025 and brief oral evidence from AX's mother;

vii) Diabetes birth management plan dated 6 June 2025;

viii) Birth Care Plan dated 9 June 2025;

ix) Medical records;

x) Attendance note dated 9 June 2025 filed by the Official Solicitor's agent, Mrs Chapman.

27. The initial written statement from Dr B and Dr D summarises the clinical observations and assessment undertaken by them. AX presented as electively mute and only provided answers in short written notes or by gestures (i.e. 'thumbs up'). AX was noted to be dishevelled and unkempt and avoided eye contact. The medical notes record that at times, AX could be incongruent and indifferent to concerns and risks regarding her pregnancy and delivery. She was described as "lacking insight into the nature of her admission". Dr B concluded that AX did not retain details of the procedure or weigh up beyond providing superficial responses.

28. Dr B and Dr D concluded in their statement that AX was *"suffering from an impairment of mind, namely an acute psychotic disorder. This appears to have affected her ability to appropriately retain and weigh the information required for a decision to be made with capacity about her obstetric treatment....when asked to elaborate or demonstrate a weighing of the various considerations she is unable to do so beyond two reasons (to deliver at home so as to be with her child, or an elective C-section as her pregnancy sickness will resolve sooner)"*.

29. It was noted that AX did not appear to make use of any other salient information provided and could not demonstrate how she weighed the 'pros and cons' of the various options. Further, AX did not appear to have insight into her acute psychiatric illness, instead citing tiredness and nausea as the reasons for her current presentation.

30. In oral evidence, Dr B confirmed that AX's capacity was difficult to assess as she was 'guarded' and electively mute. The latter indicated psychopathology and it appeared to Dr B that AX was experiencing similar symptomatology to that of her previous presentation to mental health services in 2023. Dr B noted that AX was withdrawn and exhibiting poor self-care as well as delusional beliefs and preoccupation with religious issues. Her presentation included an affective component and low mood. These associated symptoms were causing cognitive impairment including low concentration, poor focus and impaired memory. AX was perplexed and easily distracted because of her acute psychosis and this in combination with her low mood was impacting on AX's ability to use and weigh relevant information. Although Olanzapine had been prescribed, AX was initially non-compliant which would inevitably delay improvement but after about 25 May, AX's compliance had improved. In short, Dr B's evidence was that AX was unable to retain or weigh up salient information (per s3 MCA) by reason of her mental disorder (s2 MCA).

31. In oral evidence, Dr C, Consultant Obstetrician, confirmed that she assessed AX's capacity on 9 June 2025 with a speciality midwife, using simplified language to discuss the options of spontaneous labour, induction and a planned C-section and associated risks.

32. The information relevant to the decision include details of such risks, as highlighted by MacDonald J in *North Bristol NHS Trust v R* [2023] EWCOP 5: Namely, 'why do you want 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' (see paragraph 62).

33. Dr C explained that AX appeared to understand some of the relevant information but she did not retain it. For example, Dr C discussed the need for foetal monitoring and risks associated with a C-section such as bleeding, bladder injury, and the risks of still-birth associated with waiting for spontaneous labour, but AX could only recount the risk of bleeding and did not retain information about any of the other discussed risks.

34. AX also stated she wanted to go home and did not want to wait in hospital and focussed on wanting a C-section to alleviate her pregnancy nausea, but did not refer to other significant risks which had been discussed only minutes before.

35. In addition, Dr C told the court that in her opinion, AX could not weigh salient factors into the balance. Dr C discussed the option of a C-section which AX had said was her preferred mode of delivery, explaining that it would necessitate the insertion of a cannula. AX stated she would not accept a cannula and in Dr C's view, this demonstrated AX's inability to weigh up the need for a cannula in order to have a C-section. AX was simply unable to reconcile the need for one to achieve the other.

36. Dr C concluded that AX was experiencing delusional thoughts about the insertion of a cannula or the use of 'wires' to undertake monitoring and when asked if her psychosis was rendering AX unable to make a decision about her obstetric care, Dr C agreed that it was having an 'overriding or overbearing effect' on AX's ability to make such decisions.

37. The combination of Dr B's and Dr C's evidence, points to a clear causal nexus between AX's inability to make decisions about her obstetric care (specifically not being able to retain or weigh up or use salient information) and her mental disorder. I find that AX's ability to make informed decisions about her obstetric care is impacted by this disordered thinking. Her mental disorder is such that she is unable to adequately weigh up the benefits and risks of each obstetric treatment option. Her decision making is short term and responsive to her concerns about pregnancy nausea and a desire to be at home rather than in hospital. Whilst AX is on anti-psychotic medication, there has been insufficient improvement in her mental health and it has not improved her decision-making capacity in the short period she has been taking it.

38. Accordingly, I find on the evidence before me and on the balance of probabilities that AX cannot retain or use or weigh the information that she has been given to make decisions about her obstetric care and ancillary care and treatment and this is because of an impairment or disturbance in the functioning of her mind or brain. Having regard to Lord Stephen's formulation as described in *A Local Authority v JB* [2021] UKSC 52 (paragraphs 67-78), I am satisfied that the presumption of capacity is rebutted and

pursuant to s.15 MCA, I declare that AX lacks the capacity to make decisions with regard to her obstetric care and ancillary care and treatment.

Best Interests

39. In addition to the evidence mentioned above, I have read the statement of Dr A, Consultant Obstetrician and a detailed Birth Plan. AX's wishes and feelings were expressed in February and early May 2025 when she was deemed to have capacity. Initially, AX had wanted a vaginal birth but later on in her pregnancy, she expressed a preference to have a C-section, which is entirely understandable.

40. Following her admission under s2 of the MHA, AX changed her mind and on 29 May 2025 stated she would prefer a vaginal delivery at home. Yet again, on 3 June 2025, AX changed her mind stating she wanted a C-section; on 5 June, she did not want to have a C-section and on 9 June she said she did want a C-section. Her changing preferences expressed from 29 May onwards must be viewed through the prism of her losing capacity in light of her deteriorating mental health.

41. Mr Fullwood, on behalf of both Trusts, submitted that the evidence that a C-section is in AX's best interests was both cogent and compelling. The Official Solicitor agrees. They invite me to make a declaration to that effect. Relevant factors pursuant to s4 of the MCA which I have taken into account include the following:

    i) Mental health factors: AX would be adversely affected by an adverse outcome to her unborn child and a planned C-section would likely result in the best outcome and reduce the chances that AX's acute psychiatric illness is prolonged;

    ii) Medical factors: due to gestational diabetes there is a risk of growth restriction and still-birth and a planned C-section at 38 weeks is recommended. In addition, AX's inconsistent compliance with blood glucose monitoring and failure to attend scans at 32 and 36 weeks mean that a planned C-section removes the risk of a still birth due to unmonitored or uncontrolled diabetes;

    iii) Risks associated with spontaneous or unrecognised labour, pre-eclampsia, uterine rupture and previous C-section scar rupture, are increased by AX being non communicative or non-verbal which may mean that signs and symptoms are not identified or reported;

    iv) Risk of an emergency C-section include increased risk of haemorrhage;

    v) A planned C-section at 38 weeks outweighs the reported risks of continuing a pregnancy in a woman with AX's risk factors (including gestational diabetes) as optimum maturity of the baby is obtained;

    vi) As outlined above, the care arrangements have been modified to obviate the need for physical or chemical restraint and no authorisation for deprivation of AX’s liberty within the meaning of Article 5 of the ECHR is being sought.

42. In determining what is in AX's best interests, I have given consideration to all the above relevant circumstances, to her past and present wishes and feelings, to the beliefs and

values that would be likely to influence her decision if she had capacity, and to the factors that she would be likely to consider if she were able to do so, including that she would want her unborn child to be born safely: s.4(6) MCA.

43. I take into account AX's wishes and feelings, albeit these have not been consistent. I attach more weight to the wish she expressed later in the pregnancy, whilst capacitous, to undergo a C-section.

44. I have also taken into account the views of Dr A and the clinical teams engaged in caring for AX and those interested in her welfare, in particular her mother: s.4(7) MCA. Their views align and the consensus is that a planned C-section for the reasons described above is in AX's best interests.

45. Thus, having surveyed the evidential canvas, and having weighed in the balance the advantages and disadvantages of the options, I consider that the elective C-section planned to take place on 11 June 2025 is in AX's best interests and accordingly I endorse the Birth Care plan.

46. That is my judgment.

Post script: Happily, I have been told that AX was successfully delivered of a healthy baby boy on 11 June 2025, as planned by C-section which was uneventful and that she was calm, speaking in full sentences and extremely co-operative for the whole procedure.