Neutral Citation Number: [2023] EWFC 12

Case No: FD23P00038

IN THE FAMILY COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31/01/2023

Before:

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between:

Kettering General Hospital NHS Foundation Trust

Applicant

- and –

C

1st Respondent

-and-

North Northamptonshire Council

2nd Respondent

- -
- -

(**Mr Parishil Patel KC** instructed by **Capsticks LLP**) for the **Applicant**
(**Miss Katie Gollop KC** instructed by the **Official Solicitor**) as amicus to the court
The **First Respondent did not attend**
(Ms Mary Anne Beedle, solicitor for the Second Respondent

Hearing dates: 23rd January 2023

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered in private. 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.

MR JUSTICE HAYDEN:

1. This is an application, made on behalf of the Trust, for anticipatory declarations relating to an unborn child. Such orders are rare and are founded in the Inherent Jurisdictional powers of the High Court.

2. The first respondent, C, is currently 37 weeks pregnant. She is HIV positive and has declined anti-retroviral treatment during the course of her pregnancy. The views of those responsible for her care and that of her baby, consider that the child may well be born HIV positive. C is due to give birth by planned caesarean section, tomorrow, 24th January 2023. This application is intended to secure the administration of anti-retroviral medication to the baby, commencing immediately upon birth and to continue for a period of 28 days. Critical to the prospects of success for this treatment is that it should commence within 4 hours of the birth.

3. Dr Alina-Maria Guna, Registrar in Obstetrics and Gynaecology and Dr Sophie Herbert, Consultant Physician in Genitourinary and HIV medicine, have held primary responsibility for C's treatment. It is clear that they have given their patient's needs very considerable care and attention. Both doctors have had multiple face-to-face appointments and telephone discussions with C and her partner since November 2022 outlining the risks of transmission to her unborn child. The tone of these meetings is captured in a statement in support of this application prepared by Dr Guna, dated 23rd January 2023. It is necessary to set them out:

> *i. In December 2022, C disclosed to me that while in Romania she only took antiretroviral treatment once in 1999, but has since declined it (please see the reasons for this below).*
>
> *ii. In December 2022, C mentioned that in an attempt to convince her to have treatment for HIV that could prolong her life, when C was 14 years old, a HIV Consultant in Romania took her to a Paediatric Ward with 'end of life' patients infected with the HIV virus, and explained that she could soon be in that situation if she continued to decline the medication. C told me that she declined the medication, as she had felt that she would be ok with a good nutritional diet and taking vitamins;*

> *iii. In January 2023, C further told me, that although she has had friends who have passed away due to complications from the HIV virus, she has led a "normal life" so far and is therefore convinced that her baby will not be infected with the virus. She has also mentioned that she has had friends in Romania with HIV whose new-born babies were healthy (HIV-free) despite not having been administered the medication.*

4. C manifestly wants the best for her baby and her objections to medication should not be construed otherwise. C believes that the anti-retroviral regime is not *'good for her baby'*. Her own refusal to take the medication, other than on one occasion, is that it makes her feel unwell and she experiences vomiting and dizziness. These are recognised as side effects of the medication but can be remedied by accompanying anti-sickness medication. C has agreed to attend the hospital and to take the medication on multiple occasions over the last few months of her pregnancy. However, having screwed her courage to attend the hospital, she has, on each and every occasion, changed her mind and refused.

5. Dr Guna emphasises that C's own immune system is very weak and that this, in turn, in the absence of anti-retroviral medication presents a *"high possibility"* that her baby will be infected. Tragically, the risk of C developing a life-threatening infection is also described as *"very high"*. Both doctors have emphasised that there is a real risk, indeed a likelihood, that this baby will grow up without a mother. C's partner (F) has never been tested for HIV and has refused to do so. The couple have disclosed that they have been having unprotected sexual intercourse for more than 12 years. I incorporate this very private fact into this judgment because it is important to understand that the medical consensus establishes that it is very likely that F will, most likely, be HIV positive himself. Inevitably, he has not been receiving any treatment and is accordingly exposed to medical complications which are avoidable.

6. It is important to understand the mechanism of transmission of HIV infection from mother to child. As Dr Herbert has explained to me, HIV is a viral infection which can be transmitted from a mother to a child during pregnancy. It passes from the mother to the child through the blood flow via the umbilical cord and through the mixing of blood and genital fluids during birth. The overall risk from older studies estimates the risk during (i) pregnancy (ii) delivery and (iii) post-natal period to be between 15-45%. In 2023, these risks are mitigated by a number of interventions which have been repeatedly shown to reduce the risk of transmission. If treatment is administered during these stages, the estimated rate of mother to child transmission of HIV is reduced to 1-2/1000 or 0.1-0.2%.

7. As Dr Herbert has properly identified, the available data varies but there is some evidence that the greatest risk of transmission is thought to occur late in pregnancy in those who have a detectable virus level in the blood. She cites a paper, by Kouris and Butlery (2010) which states:

> *"the authors have argued that approximately one half of MTCT of HIV occurs late in pregnancy, possibly in the days before delivery, as the placenta begins to separate from the uterine wall. Only a small proportion of MTCT (<4%) seems to occur in the first trimester and less than 20% by 36 weeks of gestation"*

8. In her evidence, Dr Herbert states:

> *"There are a number of factors which can affect transmission risk to the baby. HIV is monitored by blood tests looking at the immune system as measured by a CD4 count, and the amount of virus in the blood (the HIV viral load). When people are not on treatment for a long time, or have never been on treatment, the virus level can be anywhere from 20,000 to over 1 million, and usually will increase over time without treatment as the immune system becomes weakened and is unable to manage the infection to keep the virus under control.*
>
> *Children can manage the infection differently to in adults. I am not a paediatrician but AMC was diagnosed aged 11 and that she has had very little treatment over the years. Notwithstanding her viral load level has remained low (9000-13200) during her time with us. She has therefore remained well but this level of virus poses a significant risk of transmission to the baby. Any viral load greater than 400 poses a risk to the baby. For that reason, ordinarily treatment is provided to get the viral load in the mother to an undetectable (or at least <400 copies/ml) level as soon as possible before delivery."*

9. As the opportunity to prevent transmission has now passed, the focus must be on the available treatment, geared to reducing the risk of infection in the child. Dr Herbert has explained that the viral load level in the mother, at 36 weeks, determines the management of the delivery of the baby. If the level is undetectable, a normal vaginal delivery can take place. If the level is detectable but between 50-399 copies/ml, a c-section is recommended. Above 400 copies/ml, a c-section delivery

is strongly recommended and advised. This mode of delivery provides the lowest risk of HIV transmission.

10. Dr Herbert has further explained that the HIV virus level at 36 weeks also determines the medication to be provided to the mother during delivery and the type and number of medications, and length of treatment of the baby after birth. The greater the level of viral load in the mother, the greater the number of medications required for the child and the longer the period they are required for in order to decrease the risk of transmission to the child and to decrease the risk of the virus establishing itself in the child if it has been transmitted. If C had taken her medication through pregnancy and had an undetectable virus level at 36 weeks the child would have only needed to be given two weeks of a single antiretroviral drug. But because her virus level is high and she has not taken the antiretroviral treatment, the child will have to undergo a course of three separate drugs for four weeks. This will provide the child with the best chance of preventing the virus taking hold.

11. In order for the risk of HIV transmission to the baby to be reduced at delivery, a combination of a number of different HIV medicines will be given to the mother immediately before and during delivery. This is set out in the treatment plan. C has said that she will consent to this treatment. However, given her history of non-compliance, there is of course a substantial risk that she will not agree at the time. I am inclined to be pessimistic about the prospects of C taking medication herself. Her resistance is longstanding and her expressed compliance has not been carried through. I emphasise that I am not making criticism. C's anxiety about medication is deeply embedded. Dr Herbert has had some necessarily frank conversations with C. C speaks good English but, as it happens, Dr Guna also shares C's language as her own first language. The exchange in clinic in November 2022 requires to be highlighted:

> *"C was very cross with us - I asked why she thinks it is ok for her baby to have HIV - she said 'I have been ok and I would rather he had HIV than Downs and the test for Downs was wrong so this may be wrong".*

12. At the same appointment, C told Dr Herbert that she was very angry that she is being *'forced'* to take antiviral medication for the child's sake. She repeated that she has several friends who are also positive HIV like her and are not taking medications and when they got pregnant their doctors did not force them to take medication and their children are HIV negative. C told Dr Herbert that she regretted telling her that she was pregnant. She stated that she wished that she had held back from attending the clinic until much later in her pregnancy *"then all this would not be a problem".* She also stated that she is a trained nurse/pharmacist in her home country so understood everything and did not understand why she was *"being punished"*, as she perceived it.

13. It is also clear that C has been presenting to other hospitals with, what would appear to be, the objective of achieving a birth plan for her and the baby which accorded with her own perspective on what is necessary and appropriate. Dr Herbert's statement records the following:

> *"On 13th January 2023 she presented to Norfolk and Norwich Hospital. She told the clinicians there that she had moved there, and that her husband had a new job, (he does not). She had told the clinicians in Kettering that she went to Norfolk for a wedding. She told me she cannot drive, but when asked how she travelled to Norfolk this week, she said she could drive and was back in Norwich giving a present to her partner's cousin. (She had told the team in Norwich she had returned to go to the bank).*
>
> *All of the matters above give rise to a serious concern that even if though she consents now to provide her child with the necessary anti-retroviral medication, there is a significant risk that she will change her mind and not consent to or administer it after delivery. In those circumstances, and in light of the considerable risks (set out below) to the child if the medication is not given, I support the application for an order that, if the event that C does not consent, he court does so for the child to be given the necessary medication."*

14. As the medical evidence makes clear, there is a very small clinical window for the administration of medication to the new-born child. The strong preference is that it should be immediate or, at very least, within the first four hours of life. It is clear that during pregnancy and delivery, the foetus will be exposed to the HIV virus. Given the high viral load in the mother, there is a significant risk that some virus will be present in her baby. The level of infection may not be so great as to generate a lifelong infection. There is therefore a window of opportunity to prevent this happening. Dr Herbert analyses that research evidence shows that large scale activation *'awakening'* of the new-born child's immune system, allowing the HIV virus to recognise and target cells in the child to infect takes place in the short window immediately after birth (Kourtis et al 2006, Lancet Infectious Diseases). She identifies the British, European and US guidelines which all recommend that the treatment should be administered within the first four hours and that after 72 hours the time window

has closed and the treatment is no longer thought to be effective. The relevant part of the BHIVA guidelines provides:

> *"9.1.6 Timing of neonatal PEP All infant PEP should be started within 4 hours of delivery. There are no clear data on how late infant PEP can be initiated and still have an effect, but all effective studies of infant PEP have started treatment early and animal data show a clear relationship between time of initiation and effectiveness, with no benefit demonstrated if commenced after >72 hours [48-50].* ***Immediate administration of PEP is especially important where the woman has not received any ART****."*

15. The plan is therefore that once born, the child needs to undergo three tests to look for HIV infection: an HIV antibody test, a viral load test (by looking at the amount of HIV in the baby's blood), and a test looking for pro-viral DNA, an early marker of infection. These tests need to be taken immediately at delivery, two weeks, six weeks, and 12 weeks as well as later at six months and 18-24 months. I understand that it can take up to 2 years for the HIV antibody test to become negative in a truly HIV negative infant. For completeness, it is important to record what it is envisaged will happen. Dr Herbert sets this out in her report, thus:

> *"It is usual that the child will have HIV antibodies showing at birth as these cross the placenta from the mother. The other tests are likely to give a more accurate indication as to whether the infection has been transmitted. But it takes time for the results to be known. In respect of the viral load blood test, results can be available within hours as they are processed on the hospital site. The samples for the pro-viral DNA have to be sent to a specialist laboratory and are not usually available for up to 2 weeks. The tests are repeated because research has shown that it is possible to have a negative HIV virus test at birth but for it to become positive at two weeks or later."*

16. It is important that I consider the jurisdictional basis of this application, which strikes me as a paradigmatic example of both the parameters and reach of the Inherent Jurisdiction. The Local Authority, which is present and represented at this application, has no power to intervene without Court order. If this proposition requires authority, see: *R (G) v Nottingham City Council* [2008] EWHC 152 (Admin), [2008] 1 FLR 1660, and *R (G) v Nottingham City Council and Nottingham University Hospital* [2008] EWHC 400 (Admin), [2008] 2 FLR 1668. Further, as Munby J, as he

then was, properly emphasised in *Bury Metropolitan Borough Council v D [2009] EWHC 446 (Fam)*, the Court is not concerned with any jurisdiction relating to the welfare of a child. The child remains en ventre sa mere and accordingly, the Court has no jurisdiction to make any order either pursuant to the Children Act 1989 or under its wardship jurisdiction (see: *Re F (In Utero) [1988] Fam 122)* It is also important to state that no jurisdiction arises under the Mental Capacity Act 2005, in the Court of Protection. The fact that C's views in relation to the proposed treatment may be entirely out of step with received medical opinion, does not challenge and certainly does not rebut, the presumption that she is capacitious to take the decision herself. Very recently in *NHS Surrey Heartlands Integrated Care Board v JH [2023] EWCOP 2*, I made the following observation which strikes me as having resonance here:

> *"[22] JH has long been of the belief that his stomach pains are in some way related to his Asperger's Syndrome. He has held this view for most of his adult life. It is misconceived. But many people hold irrational, inaccurate or even superstitious views in relation to their own health. In the context of Covid-19 vaccinations, a significant cohort of people do not accept or trust the accuracy of orthodox, peer-reviewed medical opinion and guidance. None of this is to be equated with lack of capacity. It is simply a facet of human nature."*

17. Here, as occurred in *Bury Metropolitan Borough Council v D* (supra), the Court is required to consider an application made in the absence of C. It is elementary that C has rights, pursuant to Articles 6 and 8 of the European Convention of Human Rights (ECHR), to be fully involved in the planning both for the birth of her baby and the baby's postnatal care. These principles are reflected in the ECHR case law e.g., *W v United Kingdom* (1988) 10 EHRR 29 at paras [63]–[64], *McMichael v United Kingdom* (1995) 20 EHRR 205 at para [87] and *Re G (Care: Challenge to Local Authority's Decision)* [2003] EWHC 551 (Fam), [2003] 2 FLR 42, at paras [30]-[31], [35]-[36]. However, the Article 8 and 6 rights engaged are not absolute rights and require to be balanced against other competing rights and interests. The ECHR has recognised that there will be, circumstances where parental involvement must yield to alternative rights, particularly where the interests of children are engaged. Without notice applications, in this sphere, have been endorsed as compatible with the Convention in a number of cases, see: *Haase v Germany [2004] 2 FLR 39; Venema v The Netherlands [2003] 1 FLR 552*. Many of the cases arise in the context of emergency protection orders where the ECHR has emphasised that it is for the state to establish that a careful assessment of the impact of the proposed measure on the parents and child was carried out, prior to

the implementation of the plan, as well as careful consideration of the possible alternatives. These principles of proportionality resonate throughout the whole of the European jurisprudence.

18. This application was made on 23rd January 2023. I was informed of it at 11:30am. Fortunately, I was able to accommodate it quickly. I signalled that I could hear it by 12pm. In the event, due to difficulties in instructing Counsel, the case was heard at 2pm. Cafcass, understandably, were unable to assist, given the child is not yet born. Nonetheless, I was concerned about the proportionality of proceeding in circumstances where C had purposely not been informed of the hearing. For this reason, I asked counsel for the applicant Trust, Mr Patel KC, to ask his team to make enquiries as to whether the Official Solicitor might be prepared to act as amicus. Ms Castle, the Official Solicitor, readily agreed and I am extremely grateful to her for doing so. Counsel, Miss Gollop KC was instructed.

19. As I have recorded above, the planned caesarean is scheduled for tomorrow. It is deeply regrettable that this application is made so late in the day. Whilst I understand entirely that everybody has been doing their best, it is important to emphasise, once again, that these applications require to be brought in a timely way, where that is possible, in order that the important issues they present can be ventilated without added time pressure. The hearing did not conclude until 7:30pm. This is simply not fair on anybody involved. One of the advantages of declaratory relief is that it is anticipatory i.e., it can be considered in advance of the contemplated situation. This application should have been made days ago. I have heard no satisfactory explanation as to why it was not.

20. In *Bury Metropolitan Borough Council v D,* Munby J, drew an analogy between the facts of that case and the drastic measure of removal of a child, without involvement of the parents, in the context of care proceedings (either under the aegis of an EPO or an interim care order). As is clear from my analysis above, I consider the analogy to be apposite. The domestic courts have followed and to some degree, developed the Strasbourg jurisprudence. The emphasis has been on proportionality, clear justification for interference with family life, identifying *"an overriding necessity"* to do so, see: *Re B (Care: Interference with Family Life)* [2003] EWCA Civ 786, [2003] 2 FLR 813, at [34]; *Re H (A Child) (Interim Care Order)* [2002] EWCA Civ 1932, [2003] 1 FCR 350, at para [39]. By parity of analysis, the criteria which circumscribe the circumstances in which a child can be removed must apply and with equal rigour to the wholly exceptional circumstances in which a public authority may make an application which directly engages parental rights, without them being notified of or involved in the decision-making process. Thus, when considering whether this case can proceed in the absence of C, it must be justified as both necessary and proportionate. There must be compelling reasons for justifying what must be regarded as an exceptional procedure. Munby J described it as *"at the extremity of what is permissible under the Convention"* and *"a*

highly exceptional course of conduct", echoing the language of the ECHR in *P, C and S v United Kingdom (2002) 35 ERR 31, [2002] 2 FLR 631.*

21. Inevitably, the application of the principles is fact specific. Put in another way, and at its simplest, can the Trust justify the procedure they contend is appropriate as 'exceptional' in the context of the above case law?

22. In answering that question, it is crucial to highlight the fact that C is acquiescing to the birth plan. In particular, she had agreed to take retroviral medication at the latter stage of her pregnancy. Dr Herbert told me, in oral evidence, that the prescribed dosage of the retroviral has been increased for C, in effect, using her as a conduit to medicate her baby prophylactically. HIV passes from the mother to the child through the blood flow, via the umbilical cord and particularly, in consequence of the mixing of blood and genital fluids during birth. Thus, as I understand it, the birth process becomes a high point of risk of infection for the baby. There is very considerable doubt as to whether C has been taking the retroviral medication in the run up to the birth. The preponderant evidence indicates that is unlikely, but it is sufficient for me simply to conclude that the position is, as yet, unknown.

23. M has also agreed that her baby should receive retroviral medication immediately after birth and **without delay** (my emphasis). The objective is effectively to provide a strong defence for the baby from infection by the HIV virus and to prevent it, if it is present, from becoming an established infection. The longer the virus is in the baby's body and permitted to circulate, the greater the risk of the infection becoming established. Where a mother has not taken retroviral medication in pregnancy, there is a greater risk that the foetus might already have become infected. Thus, the immediacy of intervention is key. The baby will be given an antibody test at birth followed by a viral load test and a proviral DNA test (to see whether the baby was infected earlier in pregnancy). I am told that there is a real possibility that the baby might achieve HIV negativity, albeit, that it can take up to two years for the HIV antibody test to become negative in a truly HIV negative infant.

24. The difficulty arises in the history of this case. Though the mother has repeatedly attended hospital during the course of her pregnancy, seemingly prepared to comply with medication, ultimately, she has declined to do so and has left the hospital. Her anxiety surrounding her treatment may lie in the circumstances of her infection. I was told that C knew a number of women with HIV, some of whom she believes have given birth to healthy children, without any retroviral medication for mother or baby. I enquired how she came to know such a seemingly wide group of HIV positive individuals. I was told by Dr Herbert that she was part of a cohort of children who had been infected

during a programme of routine childhood vaccinations with needles that must have been contaminated with HIV. This information was not included in the case papers. To my mind, it is not difficult to see how such an experience, which I should record did not occur in the United Kingdom, might generate a pervasive distrust of medical advice. C reports having felt very sick when she took the retroviral medication in the past. Dr Herbert agreed that nausea was a recognised side effect but told me that it could be corrected by anti-sickness medicine. C has steadfastly refused that medicine. She has also indicated recently that if her baby were to be sick under this medical regime then she might withdraw her consent to the treatment. As Dr Herbert noted, young babies are often sick or posseting and there is a real risk that C might misinterpret this risk. Dr Guna, who is able to communicate with C in her first language, was particularly concerned about this risk. Indeed, she considered it to be one of her biggest concerns. C told her expressly and in a conversation which is very recent, that if her baby vomited, she would most likely stop the baby from receiving further medication as she *"knows how bad it was for her"*.

25. It is important to record that my impression of M's behaviour, as it emerges from the papers, is that of a mother who is entirely committed to her pregnancy and resolved to the best, as she sees it, for her baby. Her anxieties are deep rooted and pervasive. Though she has been offered psychological support, tailored specifically for those infected by HIV, she has not felt able to avail herself of it.

26. Finally, it is also important to record that C and her partner have travelled some distance recently to make enquiries about giving birth at a different hospital. This was picked up very quickly but Dr Herbert was surprised and unsettled by the distances involved. C has also talked about returning to her home country. This would have to be a lengthy journey by car, as she is now too advanced in her pregnancy to fly.

27. Thus, the identifiable risks here are stark and, to some degree, complex:

    i. Based on the history, it is possible that C may simply not co-operate with the birth plan at all;
    ii. It seems unlikely that C has been taking the retroviral medication in the period leading up to her birth, thus increasing the risk of infection in labour;
    iii. C has a heavy viral load, a poor immune system and has not really ever taken anti-retroviral medication, at any stage since her initial infection. Accordingly, there is risk that her baby will already have been infected i.e., during the course of the pregnancy. This, in conjunction with (ii) above, renders it necessary for the baby to have retroviral medicine almost immediately on birth in order to have the best chance of becoming HIV negative. Thus, time is of the essence!

iv. There is a later risk that C's initial co-operation with the baby's medication may be withdrawn if she considers the baby to be sick.

28. C is presently at the hospital being prepared for her caesarean. It is obvious, given the nature of the treatment involved and the importance of timing, that it can only be achieved by prospective declaration. This is not an application that has been made lightly and a great deal of work has been done with the mother, in what I find to be a constructive and sensitive way, to achieve her co-operation. That co-operation may ultimately be forthcoming but it is certainly not possible to be confident that it will. On the baby's birth, it is, to my mind, redundant of contrary argument that it will be the baby's best interest to receive the medication offering the best chance of avoiding infection.

29. Miss Gollop KC, on behalf of the Official Solicitor, has robustly tested the ambit of the applicable law and the wider medical picture. She initially submitted that the 'exceptional' circumstances required to justify a declaration of this kind being made, in the absence of C, were not met in this case. Recognising that were the declaration not to be made, there would be inevitable delay in the medication of the baby at the most crucial time, Miss Gollop contended that the countervailing harm might not be as significant as the Court was contemplating. Many people, she said, now live full and active lives whilst HIV positive and achieve a long-life span. In fact, for children who have contracted and are living with HIV, that data is inevitably not yet available. However, the general point is broadly valid. HIV is, happily, not the death sentence it once was. But, the fact that people confront an HIV diagnosis with courage and phlegmatism does not, to my mind, detract from its life altering impact. It continues, as I was reminded, to carry very great stigma in all areas of the world. It requires lifelong medication. It has a real and enduring impact on the most intimate aspects of people's lives. It carries a psychological burden, which is not easy to bear. An infected child will come gradually to know of their infection but in early adolescence they will confront the stark realities of the virus at a time of their life when they will be ill-equipped. C herself, I have been told, jealously guards the privacy of her HIV status. Moreover, whilst her attitude to medication is, objectively, misconceived, I am not left in any doubt that her most profound wish would be for her baby to be HIV negative. I have a strong sense that this is a very much wanted baby, by both prospective parents.

30. Towards the end of her submissions, Miss Gollop received instructions from the Official Solicitor that if I considered that the *"exceptional"* criteria identified in the case law were met, they would not press against it. I am entirely satisfied that the circumstances in this case, do meet those criteria. The fact that the baby may be able to live with HIV does not mean that he should. It is wholly

contrary to his best interests. The doctors and medical team are entirely right to identify the immediate medical treatment as an imperative which establishes a secure basis for what remains an exceptional declaration.

Postscript

31. In the paragraph above, I have referred to the baby by the male pronoun. As I was concluding this judgment, I was notified that the birth went well. C complied with the anti-retroviral medication immediately prior to the caesarean. Her baby boy is doing well. I have been told that both parents are expressing clear consent to the 28-day treatment regime. I hope that when they read this judgment, they will understand why the Court has taken the course it has. I should also like to extend my congratulations to them on the birth of their son.