



Neutral Citation Number: [2016] EWHC 2267 (Fam)

Case number omitted

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12 September 2016

Before:

SIR JAMES MUNBY PRESIDENT OF THE FAMILY DIVISION

In the matter of E (A Child) (Medical Treatment)

Mrs Fiona Walker (instructed by the local authority) for the applicant North Tyneside
Metropolitan Council

Mr Barry N Speker (of Sintons Law) for the second respondent The Newcastle Upon Tyne
Hospitals NHS Foundation Trust

Ms Elspeth Thomson (of David Gray Solicitors LLP) for the third respondent E
The first respondent (E's mother) was neither present nor represented

Hearing date: 8 July 2016

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.

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SIR JAMES MUNBY PRESIDENT OF THE FAMILY DIVISION

This judgment was handed down in open court

Sir James Munby, President of the Family Division:

1. I am concerned with a little boy E (that is not his true initial) who was born in Scotland in August 2014. His mother has many difficulties and has never been able to look after him. Initially E was placed with foster carers in Scotland. In December 2015 E was placed by the relevant Scottish authorities with a maternal aunt who lives in North East England.
2. On 14 April 2016 E was brought to the Royal Victoria Infirmary in Newcastle in what has been described as a near death condition. He was very seriously ill. A CT scan revealed a right subdural haematoma. His condition rapidly deteriorated and became life threatening. A further CT scan showed some extension of the subdural haematoma. An intracranial pressure measuring bolt was put through his skull and revealed high intracranial pressure. His condition was critical. Urgent neurosurgery was necessary to relieve the pressure. A consultant neurosurgeon, Mr Patrick Mitchell, performed a craniectomy, removing from the right side of E's head a piece of his skull approximately 10x12 cms. This allowed the brain to swell without raising the pressure. In his subsequent report (see below), Mr Mitchell explained that the craniectomy was deliberately fashioned behind the hairline to minimise the cosmetic impact.
3. Later the same day, 14 April 2016, and after he came out of theatre, E was examined by Dr Alison Steele, a Consultant Paediatrician and Designated Doctor for Safeguarding and Looked after Children for Newcastle. In a report dated 19 April 2016 Dr Steele listed no fewer than 75 marks, bruises and lesions on E's body. The local authority issued care proceedings in the Family Court on 15 April 2016; an interim care order was made the same day. E was discharged from hospital into specialist foster care on 6 May 2016. He has continued to make physical and emotional progress in the care of his foster carers and is thriving. Although these are early days, it seems likely that he will suffer no long-term neurological deficit. All in all, E has made a remarkable recovery. Photographs of him taken on 18 May 2016 show an alert, focused and active child.
4. The care proceedings continue in the Family Court. The final hearing is fixed for 26 September 2016. I understand that there is no realistic prospect of his mother resuming the care of E. His maternal aunt apart, no family carer has been put forward. Long-term fostering for a child of E's age is simply not appropriate. In all probability the judge hearing the care case will, if threshold is established (which on at least some basis seems likely), be faced with a stark choice: rehabilitation of E to his maternal aunt or adoption outside the family.
5. I am not concerned with the care proceedings and, beyond what I have already said, know little about them. Nothing I say can be allowed to have or will have any impact on the outcome of the care proceedings, which have to be determined by the judge exclusively on the basis of the evidence adduced at the final hearing of those proceedings. Nonetheless, for reasons which will become apparent in due course, I cannot avoid hazarding some view as to the likely outcome of the care proceedings. In the light of all I have read and heard I am satisfied that, for present purposes, I can properly and therefore ought to proceed on the footing (a) that the local authority will in all probability establish 'threshold' (though to what extent and in what terms is

more difficult to predict, and I do not venture a prediction) and (b) that there is a distinct possibility that the proceedings will end up with the court approving a plan for adoption and making a placement order in relation to E.

6. On 18 April 2016, the local authority issued an application seeking to invoke the inherent jurisdiction of the High Court in relation to various questions to do with E's medical treatment. I need not go through the subsequent proceedings in any detail. With the approval, appropriately given, of Cobb J, the Family Division Liaison Judge, the matter has been dealt with by Her Honour Judge Hudson, sitting as a Deputy High Court Judge. For present purposes all that I need note is (a) that on 15 April 2016 Judge Hudson gave the local authority permission in accordance with section 100(3) of the Children Act 1989 to invoke the inherent jurisdiction and (b) that the one matter with which I am concerned (see below) comes before me pursuant to an order made by Judge Hudson on 28 June 2016.
7. The issue before me was identified in Judge Hudson's order as being "determination of the preferred option to manage [E's] medical needs following the craniectomy." In short, should E have a cranioplasty, and if so when? Or should a decision be deferred?
8. The matter came on for hearing before me on 8 July 2016. I had a report from Mr Mitchell, in the form of a letter dated 1 June 2016 answering questions which had been put to him. In addition to her report dated 19 April 2016 to which I have already referred, I had further reports from Dr Steele dated 6 May 2016, 22 June 2016 (a short letter) and 6 July 2016. The local authority's evidence was in the form of a statement from E's social worker dated 4 July 2016. The report of E's guardian, Ms Maggie Singer, is dated 5 July 2016. In addition, I had position statements or skeleton arguments from Mrs Fiona Walker, who appeared on behalf of the local authority, from Mr Barry Speker, who appeared on behalf of The Newcastle Upon Tyne Hospitals NHS Foundation Trust (the Trust), and from Ms Elspeth Thomson, who appeared on behalf of E.
9. Before the hearing commenced there were, I was told, discussions outside court involving the two doctors, the social worker, the guardian and the various legal representatives, which helpfully clarified the issues and brought into sharp focus what turned out to be the key issue – should I decide now what was to be done or should that decision be deferred for others to take in due course.
10. I heard oral evidence from Mr Mitchell and Dr Steele. I did not hear oral evidence from either the social worker or the guardian, their reactions to the oral evidence being sufficiently communicated through Mrs Walker and Ms Thomson. At the end of the hearing I reserved judgment, which I now hand down. It had been sent to the parties in draft on 22 August 2016.
11. It is convenient to start with the medical evidence. It is clearly and succinctly expressed. There is much advantage to allowing these experts to speak for themselves. The nuance is important. The facts are unusual. I therefore set out the major part of the written evidence verbatim, rather than attempting paraphrase.
12. Mr Mitchell and Dr Steele met, together with E's guardian and solicitor, on 6 May 2016. Dr Steele set out her understanding of the matter in her report the same day. She identified Mr Mitchell as being "much more concerned about the effects on social

interaction if the plate is not in place” than on the medical risks of E being left without a plate.

13. In his report dated 1 June 2016, Mr Mitchell identified and evaluated the risks associated with the procedure for inserting a plate (a cranioplasty) as follows:

“General anaesthetic: minimal

Bleeding: low risk. Bleeding can be a problem but brisk dangerous bleeding is very rare.

Infection: This is a significant risk. I would estimate somewhere in the region of a 15% chance of a cranioplasty having to be removed because of infection.

Transient neurological impairment: I’d estimate this risk at around 10%

Permanent neurological impairment: I’d estimate this risk at around 5%

Death: Overall, I’d estimate this risk at 1-2% associated with the cranioplasty operation.”

14. In answer to the question *Approximately how large is the deficit in [E]’s skull and what is currently protecting his brain from damage and how strong is it?* Mr Mitchell said this:

“The defect is approximately 10 x 12 cm. The brain is being protected primarily by his scalp. His scalp is not especially strong, particularly against penetrating injuries but in a normal functional family environment the risk of an injury arising because of a craniectomy is extremely low.”

In answer to the question *What are the advantages of [E] having a plate inserted to cover the deficit? In particular can you comment on the need to do this to protect the brain,* Mr Mitchell said this:

“The principal advantages are cosmetic and psychological. As far as brain protection is concerned, the risks of the cranioplasty operation are larger than the risks associated with a craniectomy in a normal family environment.”

15. Mr Mitchell then answered a series of essentially technical questions:

“Why is the preferred option a titanium plate rather than a titanium mesh or other material being used?

There is no particular medical reason to prefer one method over another. Titanium sheet cranioplasties are thinner than mesh which makes it easier to fit at his age the difference is marginal.

What is the cosmetic result from a plate?

Generally pretty good. As a titanium cranioplasty will not grow with his head it can lead to an asymmetric head contour in later childhood. This is unlikely to be a major cosmetic issue as it is hidden behind the hairline and revision cranioplasty is always an option if desired.

Is there a time frame within which the plate should be inserted? What are the advantages and disadvantages of inserting a plate soon as opposed to at a later date? How long can plate insertion be delayed for it to be still a useful intervention?

There is no particular time limit. If the operation is delayed beyond about five years, its benefit becomes increasingly marginal as over that time frame the skull tends to reform naturally.

At what point and why might the plate need to be changed?

Unless the plate became infected it is unlikely that it would ever need to be changed. Reasons for changing it include cosmetic to make the head more symmetrical as growth occurs, and sometimes plates loosen and start to move which can be painful.

Would the risks be the same for revision of the plate as they were for the original insertion of the plate?

Yes

Please describe what is likely to happen to if no plate is inserted. How will the bone grow back? How long will it take? What will the functional and cosmetic implications be?

When we did the craniectomy the tissue layer that forms the bone was dissected off the bone flap and left in place. In time this layer generates new bone. I would expect him to have substantially complete bone coverage of the defect between 5 and 10 years after the operation to remove the bone. There are no particular functional implications of allowing this to happen unless he were to develop symptoms associated with alternate bulging out and sinking in of the scalp before bone formation occurred. This can be associated with a syndrome known as the syndrome of the trephined. In this syndrome postural changes, such as from lying to sitting to standing can provoke brain shifts that lead to headache, sickness or transient functional changes like vertigo or drowsiness. In reality though this syndrome is rare, particularly in children who are not tall enough to have large postural hydrostatic pressure shifts. There is a theory advanced by some rehabilitationists that a global

functional improvement is seen following a cranioplasty but this has yet to be demonstrated with hard evidence.”

16. Approaching the central issue, Mr Mitchell gave these answers:

“Does wearing a helmet reduce the risk of damage to the brain if a plate is not inserted?”

Helmets give significant psychological comfort to carers but their impact on injury rates is minimal because the kinds of injuries that people with a craniectomy are particularly prone to are so rare. They are largely restricted to penetrating head injury such as from arrows darts or airgun pellets. And these are rare in the UK.

Please can you describe your experience of the effect of plate vs no intervention on the perceptions of the child and carers and the social interaction of others with such children and the effect this might have on them with regard to development?

The plate is not likely to make much difference to the child’s own perception. The cosmetic defect will largely be covered by hair, which can be kept long, and by the time the child starts become self-conscious it is likely the natural bone formation will be well underway. The larger effect is likely to be on social interaction and the psychology of adult carers. If the condition is explained to other children, they are likely to react with cruelty and revulsion rather than understanding and adults are likely to react with overprotectiveness. These factors clearly can have an effect on the child’s development and are the usual reason for doing cranioplasties is in this age range.

In the previous discussion you mentioned the fact that the deficit was behind the hairline helped with cosmetic issues and that the fact that a dural matrix was placed over the incisions in the dura at the initial operation reduced the infection risk. Please could you enlarge upon these issues for the court and their relevance to [E]’s care.

The craniectomy was deliberately fashioned behind the hairline and above the temporalis muscle to minimise its impact on cosmetics and jaw muscle function. The dura was opened at the time of surgery to allow more room for brain swelling. The openings in the dura were covered with a synthetic dural material. The reason for this is not to reduce the infection risk but to make dissection of the plane in which to insert the cranioplasty easier and thus reduce the risk of brain injury during a subsequent cranioplasty operation. These measures are intended to minimise the impact of a cranioplasty if he were to have one, and to minimise the cosmetic impact of the

craniectomy while waiting for a cranioplasty, or alternatively, if it is decided that he should not have one.”

17. His concluding paragraphs get to the heart of the matter:

“The decision on whether to have a cranioplasty is not one that I make personally. My role in this is to advise parents and carers of the issues and risks involved, and to perform the operation if they decide to have it done. Craniectomy in this age range is relatively rare. Traditionally, the approach was to perform a cranioplasty by replacing the child’s own bone flap but since the aftermath of the Alder Hey scandal, we have not been able to retain human body parts for this purpose. Artificial bone cranioplasties are available and we believe that they do remodel a child’s head grows but unfortunately the material from which they made is relatively fragile and is not strong enough to be used until the skull is of a substantial thickness, usually around the age of seven. These are therefore not available for someone of [E]’s age. This leaves titanium as the only option, and that has the problem of not growing with the child.

There is no room for dogma about whether or not it should be done but on balance most people do end up having the operation and the reason has more to do with psychology and social interaction than it does with neurological function.”

18. In her final report dated 6 July 2016, and with the benefit of having read Mr Mitchell’s report dated 1 June 2016, Dr Steele said this:

“This 23 month old child now appears to be making good progress physically, behaviourally, emotionally and developmentally. He appears very settled in his current placement which is appropriately nurturing.

The major health issue to be resolved is whether [E] should have a titanium plate placed over the deficit in his skull. It is Mr Mitchell’s opinion that such a plate would offer more protection to the brain, particularly against penetrating injuries. However, it is his opinion that the risk of injury arising because of the craniectomy remains extremely low if he is in a normal functioning family environment. It is Mr Mitchell’s opinion that the principle advantages of such a procedure are cosmetic and psychological. Such a plate might need to be changed in the future as [E]’s head grows.

There are however significant risks associated with this procedure, which in Mr Mitchell’s opinion include a 1-2% risk of death, a 5% risk of permanent neurological impairment, a 10% risk of transient neurological impairment and a 15% risk of the plate having to be removed because of infection.

Although I fully acknowledge that it is the court's decision as to whether this procedure is in [E]'s best interests and I am not a neurosurgeon, at the current time in the current optimal home circumstances, it is my clinical opinion based on all the sources of information that have been available to me, that the risks of the procedure outweigh the benefits."

19. Mr Speker's skeleton argument appropriately adopted a dispassionate and essentially neutral stance on behalf of the Trust. He indicated that the Trust was in a position to perform the surgery and that it relied upon the evidence of its two clinicians, Mr Mitchell and Dr Steele,

"to assist the Court in reaching a decision as to whether consent should be given by the Court in the child's best interests to the carrying out of a titanium cranioplasty at this stage or whether the surgery or the decision to perform it should be deferred."

He went on to comment that "The observations, views and assessment of the [guardian] are particularly relevant." He submitted that:

"The decision is one to be made in the best interests of the patient in the widest sense including all relevant considerations – medical, emotional and sensory. This includes the impact upon [E] of the current appearance of the head, and how this can affect his life, his interaction with others, his prospective long term placement."

20. The stance of the local authority was, likewise, appropriately dispassionate and essentially neutral. The social worker, having carefully analysed and weighed the issues, concluded in her witness statement that the decision to be taken, although important, was not straightforward. She suggested that:

"Ultimately the final decision rests on whether there is a need medically for this procedure."

21. Mrs Walker, in her skeleton argument on behalf of the local authority, having analysed the medical and other evidence, concluded with this penetrating and compelling submission:

"The short answer to this is there is no reason why this has to be carried out now and therefore the decision ought to be left to whoever is determined to be the full time carer of [E]. That decision is likely to be in mid October 2016. There is no clinical reason it would appear why the surgery needs to be performed before that time. The following observations are made:

- a. [E] is currently thriving;
- b. There are no issues raised by his carers from his perspective to the continuation of him wearing his protective helmet;

c. The risks associated with the procedure may in fact materialise and if they do then it may become significantly more difficult to find the right carer for [E]. He deserves to have every chance to be claimed;

d. The decision is such a significant one it ought to be taken by the person who claims him and will be his parent – which is not likely to be either of his natural parents; and

e. [E] has suffered very significant harm and is continuing to make a good recovery from his trauma. One can only speculate at this stage prior to the court determination whether the ill-treatment, if that is what it was, began in December 2015. He ought to be spared what is likely to be traumatic surgery which carries risk until he has further recovered and settled in what will be his long term placement, if that is the decision which is then taken.”

22. The guardian’s report is perceptive, empathetic and compelling. Her description of E is illuminating:

“[E] wears a soft protective helmet through the day to ensure this comparatively fragile area of his head does not become damaged during his normal activities ... [His] foster carers are caring for [him] extremely well and he presents as being very confident and physical with them both ... [They] have commented that [he] now interacts well and in their opinion shows an encouraging level of resilience... [He] has made physical and emotional progress, he is dextrous and shows no unsteadiness or ‘clumsiness’, he walks and runs around confidently ... [He] does not appear to be troubled by his head in any way. However when he goes to play areas, other children are apparently inclined to stare at his head protection and adults regularly ask [his foster carers] why he has to wear the helmet. They simply say he has had an operation. [They] report that they treat [his] head gently and have a soft brush for his hair, but they do not report feeling anxious about touching his head and he regularly has his hair washed with no difficulty ... At my request [his] helmet was removed for a short time when I visited him within his foster placement. [He] rapidly tried to replace his helmet and is clearly now used to wearing this through the day. [He] apparently sleeps very well at night when his head protection is removed. When [he] was in hospital I observed him reaching up to where a patch covered the missing piece of skull, however he does not now seek to touch his head and does not appear to experience any discomfort during his normal play or other interactions.”

23. The guardian records that she requested the foster carers’ “views regarding potential options for [E]’s head as they both currently have the greatest insight into [his]

behaviour and their own interactions with him, both with and without his protective helmet in place.” Their differing responses intriguingly illustrate the difficulty in knowing what to do:

“[The male foster carer] would feel more comfortable if a plate was placed to seal [E]’s head. [The female foster carer] feels that she would not want to put [E] through any further pain or discomfort for a primarily cosmetic reason. She fears the emotional impact on [E] of further surgery and is aware that surgery is not without some risk as well as necessitating further surgery in the future when his head grows. [She] does not consider that potential advantages outweigh potential risk to [E].”

24. The guardian identified the following factors as being relevant to the decision whether E should have a cranioplasty:

- “• The risk associated with the operation
- The risk to [E]’s physical health of not having the operation
- The risk to [his] emotional and psychological health, both directly and as it impacts on his carers, of not having the operation
- The advice from Mr Mitchell that there is no immediate time imperative for the operation
- The impact on potential future family finding.”

25. Importantly, the guardian recommended that:

“those who are to be entrusted with the long term day to day care of [E] as he grows up should be able to have an input after interacting with him regarding their consideration of the various options for managing [his] health needs.”

26. The guardian’s position was helpfully elaborated by Ms Thomson in her skeleton argument:

“The Children’s Guardian has considered the risks and benefits associated with inserting a plate in [E]’s skull to cover the deficit, and has identified the following factors as being significant.

a) Mr Mitchell states the principal advantages of the procedure are cosmetic and psychological. As far as brain protection is concerned, the risks of the cranioplasty operation are larger than the risks associated with a craniectomy in a normal family environment.

- b) Mr Mitchell advises that there is no particular time limit for inserting a plate although if the operation is delayed beyond about five years, its benefit becomes increasingly marginal.
- c) The impact on [E]’s emotional and psychological health of not having the surgery at this stage
- i. he will continue to wear his helmet when out and about (this looks similar to a rugby skull cap) which is likely to attract comment and observations
 - ii. his carers may feel more protective and “treat him with kid gloves”
 - iii. his head will be uneven which could attract unwanted reactions in others
- d) The impact on potential future family finding; findings are yet to be made about the causation of [E]’s injury and it would be premature to reach conclusions about long term planning but one of the options which may be considered is adoption. Whether or not [E] undergoes surgery now could affect family finding in the following ways
- i. it may be easier to identify a family for [E] if his cosmetic appearance is improved through surgery
 - ii. some potential adopters may be deterred by having to assume the responsibility for making a decision about future surgery
 - iii. future adopters could be dismayed that a significant yet not urgent decision had been made about “their child” without taking into account their views.

The Children’s Guardian believes that the right family for [E] would not be deterred by i. or ii. His future carers will be caring for him in the full knowledge of his medical history and the right carers will be able to manage these issues.”

27. At the end of the day, Ms Thomson’s submission, reflecting the guardian’s view, was that:

“a decision about whether or not to insert a plate should be delayed until planning for [E] is clearer. If [he] is to be placed for adoption the decision on a cranioplasty operation should be taken by his adoptive parents. On the basis of the medical opinion there is no clear cut answer as to the right option at this stage. It is a personal decision for carers, and as the decision

can be left, it should be left to whoever is entrusted with [his] long term care.”

28. Thus the expert and other opinion and the various arguments as the hearing before me started. As I have said, I heard oral evidence, in each case quite brief, from Mr Mitchell and then from Dr Steele. There was no change in either witness’s opinion in relation to the medical issues. Dr Steele’s views remained unchanged. Mr Mitchell – I summarise the effect of his oral evidence – repeated that in the final analysis the decision was not a medical one but one which, he suggested, was precisely the kind of decision which most appropriately lent itself to determination by a judge. He questioned whether there was, taking everything into account, any benefit to be obtained by deferring that decision.

29. It is trite law that my decision has to be based on a judicial evaluation of E’s best interests. It is essential not to fall into the trap of assuming that, because the matter in issue here is a proposed surgical procedure, best interests are confined to the narrowly medical. As Mr Speker rightly submitted, I have to have regard to E’s best interests taken “in the widest sense.” As was said in *Re G (Education: Religious Upbringing)* [2012] EWCA Civ 1233, [2013] 1 FLR 677, para 27:

“Evaluating a child’s best interests involves a welfare appraisal in the widest sense, taking into account, where appropriate, a wide range of ethical, social, moral, religious, cultural, emotional and welfare considerations. Everything that conduces to a child’s welfare and happiness or relates to the child’s development and present and future life as a human being, including the child’s familial, educational and social environment, and the child’s social, cultural, ethnic and religious community, is potentially relevant and has, where appropriate, to be taken into account. The judge must adopt a holistic approach.”

Moreover (para 33), the child’s welfare is to be judged by the standards of reasonable men and women in 2016 and having regard to the ever changing nature of our world.

30. This case is unusual both because of the medical context in which it arises but more particularly because it raises in acute form a question which is rarely considered: when should a judge decline to decide and defer the decision for others to take in due course?

31. I am much indebted to the careful analyses which, from their differing professional perspectives, have been proffered by both the witnesses and the lawyers. They have made my task much easier, first in isolating what are in my judgment, at the end of the day, the key factors – the factors of magnetic importance – and, secondly, in pointing me to the proper outcome.

32. What are the key factors? They can, in my judgment, be summarised as follows:

i) The first is that, as Mr Mitchell expressed it, “As far as brain protection is concerned, the risks of the cranioplasty operation are larger than the risks associated with a craniectomy in a normal family environment.”

- ii) From this it follows, again as Mr Mitchell expressed it, that “The principal advantages are cosmetic and psychological.” The decision “has more to do with psychology and social interaction than it does with neurological function.”
 - iii) The corollary is that the decision is not one for doctors but for the child’s parents or carers.
 - iv) There is, as Mr Mitchell put it, “no room for dogma about whether or not it should be done.”
 - v) There is no clinical need for a cranioplasty to be carried out now. As Mr Mitchell put it, “There is no particular time limit”, though “If the operation is delayed beyond about five years, its benefit becomes increasingly marginal.”
 - vi) There is, I think, some force in Mrs Walker’s point that E should be spared what is likely to be traumatic surgery until he has further recovered and settled in what will be his long term placement, if that is indeed the decision which is then taken.
 - vii) Whatever the outcome of the forthcoming hearing of the care proceedings, E’s future carers will in all probability have been identified within a period of months at most, and well within the timescale referred to by Mr Mitchell.
 - viii) For the reasons given by Ms Thomson, with which I agree, potential future family finding for E is *not* going to be adversely impacted by deferring a decision. Conversely it *may* be (one cannot put it higher than this), that future adopters, if that is in fact where we end up, could, as Ms Thomson puts it, “be dismayed that a significant yet not urgent decision had been made about “their child” without taking into account their views.”
33. These factors, in my judgment, point to a very clear conclusion. It is, in substance, that for which both Mrs Walker and Ms Thomson contend. The decision is not one I need to take or should take. I agree with Ms Thomson when she submits that, on the basis of all the medical evidence, there is no clear cut answer as to the right option at this stage, that it is a personal decision for carers, and that, as the decision can be left, it should be left to whoever is entrusted with E’s long term care. As Mrs Walker puts it, and again I agree, the decision is such a significant one that it ought to be taken by whoever claims E and will be his parent. There is, as she says, no need for the court to decide at this stage and I ought therefore, she submits, to leave it to whoever will be E’s full time carer(s).
34. I agree with Ms Thomson and Mrs Walker.
35. Judges do not necessarily know best. Usually a child’s long-term carers, whether parents, adoptive parents or long-term foster carers are much better placed than a judge to decide what should happen to their child. In the realm of private law – and this issue, despite the public law context in which it happens to arise, is in truth one in the private law realm – the court, the State, usually becomes involved only because the child’s parents or carers have been unable to resolve the difficulty themselves, either because they cannot agree or, as sometimes happens in medical treatment cases,

because they prefer to leave a particularly agonising decision to a judge: see, on the latter point, *In re Jake (A Child)* [2015] EWHC 2442 (Fam), para 46. There being no particular urgency in this case it would, in my judgment, be inappropriate – indeed wrong as a matter of principle – for me to be arrogating to myself a decision which ought to be left to E’s long term carers. I therefore decline to make any order.

36. There is one final matter I should mention. I confess to having been somewhat surprised – in fact I expressed the point somewhat more forcefully in court – when I read Mr Mitchell’s reference to what had happened in the aftermath of the Alder Hey scandal. Mr Speker, with his great experience of such matters, and having enlisted the willing assistance of Mr Mitchell and his colleagues at the Trust, who in turn consulted clinical colleagues in other centres, was able to provide a detailed response shortly after the hearing had concluded. Mr Speker also referred me to the Human Tissue Act 2004, to various regulations including The Human Tissue Act (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) (Amendment) Regulations 2006 and The Human Tissue (Quality and Safety for Human Application) Regulations 2007, to *Failure of autologous bone-assisted cranioplasty following decompressive craniectomy in children and adolescents* by Grant et al, *J Neurosurg (Pediatrics 2)* 100:163–168, 2004, and to chapter 58, Cranioplasty, by James Tait Goodrich, in a leading neurosurgical textbook, *Principles and Practice of Paediatric Neurosurgery* by Albright et al, 3rd edition, 2015.
37. This material, and Mr Speker’s response, were of absorbing interest. Grateful though I am to Mr Speker and the others, I must resist the temptation to explore the matter in any detail. It suffices to summarise what Mr Speker told me: there is, he says, nothing in the 2004 Act which expressly precludes reusing a piece of skull removed from a patient, though the manner in which such piece of bone is stored and retained must be consistent with the detailed provisions of the Act and related regulations; there is no national system or protocol on the point; and there is no consistent message from the literature. He indicated that the Trust will further explore the issue, taking into account clinical assessment and patient need.