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IN THE HIGH COURT OF JUSTICE

FAMILY DIVISION

NEUTRAL CITATION NUMBER: [2019] EWHC 2255 (Fam)

Royal Courts of Justice
Strand, London WC2A 2LL

Friday, 9 August 2019

Before:

THE HONOURABLE MRS JUSTICE GWYNNETH KNOWLES

(In Private)

B E T W E E N :

Z

Applicant

- and -

Y

Respondent

MS J. JULYAN (instructed by Sills & Betteridge LLP) appeared on behalf of the Applicant.

THE RESPONDENT appeared by telephone as a Litigant-in-Person.

J U D G M E N T

MRS JUSTICE KNOWLES:

- 1 I give this judgment at the conclusion of the hearing which I held today. I am concerned today with a little girl called A, who was born in August 2012 and is, thus, almost seven years old.
- 2 This is an application made by her mother for a specific issue order that A undergo brain surgery to alleviate epileptic seizures. Her mother is called Z. A lives with her at an address (which is not known to the father) in England and Wales. Her father is Y. He is a Moroccan national living in Italy, which is where A and her mother used to live before they came to this country in about 2016.
- 3 The mother's application was issued on 29 July 2019 and it was issued because Y did not consent to A having brain surgery to relieve her epilepsy. He emailed the court to that effect on 23 July 2019.
- 4 On 31 July 2019, Her Honour Judge Clark, sitting as a Section 9 judge, considered the application on the papers and listed the matter before a judge of the Family Division on 6 August 2019 with a time estimate of two hours and directed that the mother was to serve a letter from the child's surgeon setting out in full the details of any risks of surgery; the father was to be served with the application and informed by telephone; an interpreter was to be booked and the matter would be dealt with by the court on that date.
- 5 It is unfortunate that, though the mother is represented, there is no-one here to represent the child. It is unclear to me why that is so, because I note that, in the ongoing private law proceedings to which I shall refer in a moment, CAFCASS made a recommendation to the court on 5 June 2019 that A should be made a party to the proceedings and have a Rule 16.4

children's guardian. Be that as it may, the shortness of time involved in this matter coming before me has meant it has simply been impossible and would have been impossible for me to direct effective participation in this hearing by a representative on A's behalf. That is because I was told, when I conducted the hearing on 6 August, that this matter was urgent and that the mother was anticipating a telephone call at any time in relation to the operation taking place.

- 6 That hearing, which I conducted on 6 August, was attended by the father on the telephone. He was assisted by an interpreter. The mother was represented by counsel through her instructing solicitors. The father has had the benefit of legal representation in private law proceedings, but that came to an end on 31 May 2019 and since then he has acted for himself in person. Efforts have been made by those who represent the mother to ascertain why he has not had the benefit of legal representation but so far, no information about that is forthcoming. It seems that he is entitled to public funding but has apparently chosen not to avail himself of the same.
- 7 At the hearing on 6 August 2019, it was apparent to me that there was a gap in the medical evidence, in that none of the medical reports addressed the risks posed, if any, to A if she did not have the surgery which the doctors recommended. Additional reports from Dr W, the consultant neurosurgeon, and Dr P, the consultant paediatric neurologist, who has been treating A for several years are now available. I directed that those reports were to be translated into Italian and emailed to the father. In the event that the translators were unable to do this in time, I suggested that the mother translated the reports as she speaks fluent Italian. Those reports were emailed to the father, and the Italian interpreter who has attended court today confirmed to me that, absent a few grammatical errors, the mother's translations of those documents were accurate.

8 It was also apparent to me on 6 August that the father had not received a translated copy of a report from Mr W dated 17 May 2019 so I directed that this material was translated and sent to him. He had, however, had a copy of the mother's application and, importantly, a translated copy of her statement dated 29 May 2019 in which she sets out in considerable detail A's health position and the care that A requires.

9 I turn, now, to the background to these proceedings. The father is a Moroccan citizen aged 44 years. The mother is a British citizen aged 48 years. They were living together and married in Turin in Italy and A was born in that city. They separated in 2014. The mother relocated to the United Kingdom with A and an order was made by the Italian Family Court providing for contact between A and her father. In June 2016, the mother obtained permission from the Turin Family Court to relocate with A to the United Kingdom, so she and A have been living here permanently since 2 August 2016. The father last saw A for contact in the sense of having direct contact with her, in July 2016. Further legal proceedings in Italy in relation to A came to a conclusion in February 2017, when the court ordered a degree of telephone contact each week and some staying contact at weekends on Saturdays and Sundays, taking place on a monthly arrangement alternating between the United Kingdom and Italy. There was also provision for A to spend time with her father during Christmas, Easter and summer holidays.

10 In May 2018, the father sought to bring proceedings against the mother to secure the effective rights of access or contact pursuant to Article 21 of the 1980 Hague Convention. I note that the litigation in relation to that matter continues in the Family Court. In July 2018, as is recorded on the face of the order made by the family court in April 2019, when the father was represented by counsel, the father had been convicted in Italy on 6 July 2018 of

(a) assault on Z on three occasions, (b) what is described as “battery” in relation A between summer 2013 and January 2015, (c) for failure to pay maintenance and (d) abandonment of the family household. The father, as he made clear to me today, does not accept the fact of that conviction and is seeking to appeal it and I understand from him that there is a hearing in that regard sometime in summer 2020. The proceedings in the United Kingdom have continued and the position as far as contact is concerned is that the mother is unwilling to permit any direct contact between the father and the child.

- 11 I turn, now, to set out a little bit of the background history in relation to A’s medical condition, which is what concerns this court today. It is set out in the mother’s statement dated 29 May 2019, of which the father has a translated copy. In summary, first of all, A was diagnosed with epilepsy at the age of 22 months when she was living in Turin. At that point, when seen at the Turin Children’s Hospital, she was having up to 15 seizures a day lasting some 5 to 40 seconds. She was placed on medication which initially led to a few seizure free months bar one or two seizures.
- 12 When the mother relocated to the United Kingdom in August 2016, A’s epilepsy was further investigated and she was referred to specialist epilepsy services under Dr P, a consultant paediatric neurologist. A has been treated with seven different anti-epileptic drugs with no success and her diagnosis is that of intractable epilepsy. That epilepsy manifests itself nocturnally and she suffers from what are described as “tonic clonic seizures”. Those cause her body to go rigid and to shake. Triggers for her epilepsy, which takes place irrespective of some of the triggers but can be enhanced by the triggers, include stress, lack of sleep and sudden loud noises. A was referred to the Children’s Epilepsy Surgery Service at a large regional hospital where there is a waiting list of one year. Prior to then, she was placed on ketogenic diet, which seemed initially to have a good effect, according to her mother, in that

she became more alert and coherent, her seizures were shorter and there were some seizure free periods.

- 13 In February 2019, A underwent a stereotactic EEG which is procedure in which 14 electrodes were implanted deep in her brain. As a result of that operation and the subsequent monitoring of these electrodes, she was deemed to be a suitable candidate for epilepsy surgery. I should note that the stereotactic EEG surgery and the fact of it taking place was noted on an order of the court dated 15 January 2019, where it is recorded that she would have a 5-hour S EEG operation (I think that means stereotactic electroencephalogram) at the children's hospital, this being a precursor to brain surgery. I note that the father, through his legal representatives, was aware of that and no objection was raised to that procedure or, indeed, to this being a precursor to brain surgery.
- 14 It is plain from the mother's statement that A experiences significant side effects from her medication, which include irritability, tiredness, a short attention span and that she also has a language disorder which appears to be associated with her epilepsy. She struggles with bladder control when she experiences a seizure at night and she also struggles with bowel control as a side effect of both her medication and her ketogenic diet.
- 15 Following a consultation in May 2019 with Dr W, the paediatric neurosurgeon charged with considering whether A was a candidate for surgery, it was proposed that she underwent brain surgery in August 2019. This surgery involves taking a section of the anterior right insular cortex deep in her brain and this being removed. This is the area in A's brain, the focal area where her epileptic seizures have been identified as emanating. The mother was told that the operation would last for some three hours, that A would need to spend a week

in hospital, would then need a month off school and would be required to have regular post-operative reviews with the medical/ surgical team.

16 I turn now to the medical reports which are before the court. Before I do so, I should briefly summarise the parties' positions. The mother wishes for A to have this operation. She believes it is the best chance for A to become seizure free and, despite the risks involved, which I will refer to shortly, she thinks that this is an operation which is worth those risks because of the potentially bright future which it offers to A. The father, on the other hand, is not willing for A to undergo the surgery. His opinion is that the surgery should have a success rate of 100 per cent or 90 per cent before he would consent to it, but a success rate of 50 per cent rate is simply not good enough. He is extremely concerned that A may succumb to the risk of paralysis in particular, that risk being associated with this particular surgical procedure.

17 There is firstly a report from Dr W, the paediatric neurosurgeon, dated April 2019. It confirms a history of epilepsy since A was two years old and that she has been tried on a number of medications and a ketogenic diet to control her epilepsy without success. I note that a ketogenic diet is a rigid, low carbohydrate, high fat diet. She has a number of epileptic attacks every night. Dr W noted that children with uncontrolled epilepsy, such as A, have a 1 in 250 risk to life each year. The only realistic chance of rendering her seizure free is if she could undergo epilepsy surgery. She was in April 2019 under investigation to see if surgery to remove the epileptic focus within the brain was possible. Dr W described the stereotactic EEG, which was undertaken in February 2019, as placing electrodes deep into her brain using a precise technique to identify the part of the brain causing the epilepsy. Dr W at that time was due to discuss the results of the stereotactic EEG with the mother. That is a summary of what he said about the treatment of A's epilepsy at that point in time.

Dr W provided an additional report dated 13 May 2019 in relation to A's travel overseas, and in that report he confirmed that any brain surgery was likely to take place in summer 2019.

- 18 Appended to the mother's application and dated 17 May 2019 but not signed until 4 June 2019, was a further letter from Dr W which confirmed that the surgery that A would undergo comprised an anterior insular resection involving the anterior and intermediate short gyri, resecting cortex at the X and K electrodes implanted into A's brain because this was where the focus of A's epileptic seizures was. He explained that the operation offered A a 50/50 chance of becoming entirely seizure free, that there was also a 20 to 30 per cent chance of an improvement in her seizures falling short of seizure freedom and that in 10 to 20 per cent of cases there was seen to be little or no benefit from surgery in respect of seizure control. He noted that if surgery were unsuccessful the team could consider reinvestigating to see if further brain resection could be undertaken in an effort to give A a seizure free life. He described that, after surgery, A's anti-epileptic medication would remain as it is for one year, but if she was seizure free after that time the medication would be gradually reduced. The ketogenic diet had helped her seizure control and it would be discussed whether this should be maintained during her in-patient admission. Once more, he confirmed that surgery would take place in August 2019.
- 19 On 2 August 2019, Dr W produced a further report in respect of the risks of surgery. I have already identified what those risks are. In that document, he indicated what the risks of undergoing surgery were. There was a 1 to 2 per cent chance of a risk of A developing weakness in her left arm or leg. That would be likely to improve but A may not completely recover. Again, there was a 1 to 2 per cent chance of the risk of a serious brain infection, such as meningitis, and a 1 to 2 per cent chance of a risk of a leak of brain fluid which might

require additional surgery. The risk to A's life of undergoing this procedure was 1 in 500 to 1 in 1,000. All of the risks identified of undergoing surgery should, in Dr W's view, be balanced against the disruption to A's life and schooling caused by her epilepsy and he noted once more, that there was an annual 1 in 250 risk to life with the uncontrolled epilepsy from which A suffers.

20 Dr W provided a further report dated 7 August 2019 which confirmed and stated in terms that resected epilepsy surgery was the only realistic treatment that might render A seizure free. If she did not have surgery, her epilepsy would continue; the frequency and severity of the seizures might vary and she would need to continue to take anti-epileptic medication as she was currently doing. His view was that the epilepsy would continue to disrupt her life and education, as it currently did, and he once more referred to the 1 in 250 risk of sudden unexplained death in epilepsy in someone with uncontrolled seizures, such as A.

21 Dr P also produced a helpful report dated 7 August 2019, which confirms the history given by A's mother in her statement, to which I have already referred. I am going to read into this judgment these paragraphs of Dr P's report.

“A is a known child with drug resistant epilepsy, that is she has failed to respond to two or more anti-epileptic medications. She continues to have daily night time seizures with a frequency of one to three seizures every night, each lasting for about a minute. The majority of her seizures are violent, tonic clonic seizures that involve shaking of both her arms and legs.

Over the last few years we have tried to control her epilepsy with various anti-epilepsy medications but with no success. Not only the anti-epileptic medications

have not been successful, there have been side effects associated with anti-epileptic medications as well and A's mother has informed us about her very challenging behaviour which is at times difficult to control and she is always on the go. In the most recent clinic of 27 March 2019, we witnessed this behaviour, when she was not able to sit even for 10 seconds and was always on the go and our epilepsy nurse had to be with her throughout the clinic as she had no sense of danger.

She has also been physically aggressive towards Mum, as well as other pupils in her school, and there have been reports about her hurting her one-to-one teaching assistant, who had to attend accident and emergency because of the bleeding. As per the national guidelines of patients with drug resistant epilepsy and as her epilepsy is likely focal in nature that is originating from one side of her brain, she has had extensive investigations as part of the epilepsy surgery pathway in our nearest dedicated centre, which is [redacted] Hospital.

The team in [redacted] Hospital, comprising of paediatric neurologists as well as paediatric neurosurgeons, have recently informed us, as well as Mum, that she is a candidate for epilepsy surgery. She is currently awaiting surgery in [redacted] Hospital. It is well known that any child or adult, if they have not responded to two or more anti-epileptic medications, that the chances of epilepsy control with adding on another anti-epileptic medication is very minimal. Nearly 30 per cent of children and adults with epilepsy fail to respond to two or more anti-epileptic medications and should go through the process of alternative management. The two alternative managements are either epilepsy surgery or ketogenic diet. It is to be noted that A has already been started on the ketogenic diet for more than a year now and unfortunately has not been able to give any control to her epilepsy. The outcome of

epilepsy surgery should be measured not only in terms of seizure freedom, but also in terms of development, neuropsychology, behaviour and quality of life. Overall, around 70 per cent of children will become free of seizures. Developmental outcome has been reported as improved following surgery in many studies. It is also now shown in studies that developmental and neuropsychological outcome is better if surgery is performed earlier rather than late.

It is my strong recommendation that A should have epilepsy surgery as that is the best hope for controlling her epilepsy. If epilepsy surgery is not conducted then she will continue to have multiple seizures at night on a daily basis. Nocturnal or night time seizures, as well as uncontrolled epilepsy, are independent risk factors associated with increased risk of sudden unexpected death in epilepsy. Both these increased risk factors are present in A, for which she requires a definitive epilepsy surgery.”

I note that because of the urgency of this hearing I did not hear oral evidence from either Dr W or from Dr P.

22 I turn now to the law which I must apply in these cases. The application before me is for a specific issue order made pursuant to s.8 of the Children Act 1989. When considering whether or not to make such an order, I must apply the criteria in s.1 of the Children Act 1989 and A’s welfare must be my paramount consideration. I must avoid delay and I should not make an order unless this is better for A than making no order at all. I must apply the Welfare Checklist set out in s.1(3) of the Act. Medical treatment cases require me to adopt an approach which is well set out in case law. Although the ultimate decision, when reached, may be extremely difficult, the intellectual milestones for a judge are simple. A judge must decide what is in the child’s best interests. The welfare of the child concerned is

paramount. The judge must look at the question from the assumed point of view of the patient. A child's best interests in this context encompasses medical, emotional and all other welfare issues and the court must conduct a balancing exercise in which all the relevant factors are weighed and a helpful role in undertaking that exercise is for the court to draw up a balance sheet. No two cases involving the medical treatment of children are the same. Each case is acutely fact-specific. That approach is derived from paragraph 87 in *Wyatt v Portsmouth NHS Trust & Anor* [2005] EWCA Civ 1181. Baroness Hale of Richmond, in para.19 of *Aintree University Hospital NHS Foundation Trust James and Others* [2013]UKSC 67, gave some guidance to decision makers in approaching the question of best interests. This requires them to look at welfare in a wider sense, not just medical but social and psychological.

“They must consider the nature of the medical treatment in question, what it involves and its possibilities of success. They must consider what the outcome of that treatment for the patient is likely to be. They must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be and they must consult others who are looking after him or interested in his welfare, in particular, for the view of what his attitude would be.”

23 I turn, now, to the hearing. I have already noted that the father had access to translated copies of all the medical reports to which I have referred and to the mother's statement dated 29 May 2019. He also had access to the application form and was well aware of the issue that was before the court. He was a litigant-in-person. Due to the shortness of time, he did not file and serve a statement. I allowed him the opportunity during the hearing today to ask relevant questions of the mother, though I stopped him from asking her questions which might have been more properly addressed to a doctor. I also gave him time

by rising for a short period of time to allow him to think about any additional questions he wished to ask the mother. He then gave evidence to me during which I asked him some questions and he was cross-examined briefly by the mother's counsel, Ms Julyan. In order to give the most assistance to the father as a litigant-in-person, I reversed the normal order of speeches and asked Ms Julyan to go first and gave him an opportunity to go last in reply.

24 During the course of the hearing, the mother gave oral evidence to me about the effect of A's epilepsy on their life together as a family. She told me about A's nightly fits which are intensely disruptive of her sleep; her concomitant loss of bladder control which requires her to be washed and her bedding changed, sometimes up to twice a night; and the faecal soiling in the day and night brought about by the side effects of her medication and the ketogenic diet. A was, to all intents and purposes, I formed the view, simply not toilet trained. A also plainly has difficulties in school and is about to go into year 2, when she should ordinarily be in year 3. She has difficulty concentrating and cannot read or write, and though there has been improvement on the ketogenic diet, her seizures are not controlled. Though there has been improvement in her progress in school, but this is slow and well behind that of her peers. The mother wished for A to have the operation recommended by Dr W and his team because she fears A's disability arising from her epilepsy will get worse and that A may never be independent. She is concerned about the risks of both the surgery and the risk of the procedure not being successful, but felt that the positive outweighed the negative. She told me, "If anything happens to A, I will feel that I have given her the best chance." The mother does not know whether, and told me honestly, a successful operation would bring about an improvement in A's learning and progress at school. A has, on the basis of what I understand from the mother, little understanding about the operation. She often forgets things. Though her mother has not prepared her in detail for it, she will do so as soon as she is told of the date of the operation.

- 25 The mother answered the questions put by the father carefully, but she rejected his suggestion that A's epilepsy had been caused by abuse from the maternal grandmother or had been made worse by A's separation from him. She explained the deterioration in A's epilepsy by saying that it had evolved as A's brain and body had grown so her epilepsy had developed to the point that it had become uncontrolled and intractable.
- 26 Turning to the father. I listened to his evidence very carefully. He is clearly struggling with the fact that he has little awareness of the effect of A's epilepsy on her daily life. He has also struggled with the contents of medical reports which he has had to digest at some speed. He clearly wants what he believes to be best for A and told me that he did not want the operation to go ahead until all was completely clear in his head, and I quote: "They have to send me all necessary things, including certificates." He wished to be present at the hospital. Fundamentally, he was unwilling to agree to the operation, as he was not sure it would have a successful outcome and was very concerned that A would be paralysed. He told me in his closing submissions that if an operation had a 100 or a 90 per cent chance of success he would, of course, agree to it. His evidence to me sought to suggest that the mother was uncooperative and a liar and that the paediatricians in the United Kingdom were similarly tainted, though I am afraid the explanation he gave me for that latter belief made no sense to me. His questions of the mother verged sometimes on seeking to blame her for A's problems.
- 27 I turn now to my analysis and I begin by looking at the Welfare Checklist. A's wishes and feelings are matters which I should consider first of all. She is almost seven. Her age means that her wishes cannot be determinative and it is apparent to me that she has relatively little understanding about the operation and what this entails.

28 Turning to her physical, emotional and educational needs, it is plain to me that her life is dominated by her epilepsy. Her seizures occur mainly at night. The majority are violent tonic clonic seizures, with shaking of arms and legs and sometimes she loses control of her bladder. Her epilepsy is intractable and various anti-epilepsy medications have been tried without success. Those medications have side effects, namely tiredness, irritability, a short attention span and difficult behaviour and, as the mother told me in her evidence today, diarrhoea. The ketogenic diet has also been tried and although this has brought about some improvement it has failed to give meaningful control of her epilepsy. I am also told that A has a language disorder associated with her epilepsy. Her behaviour, too, seems to be affected by that condition. Dr P has described challenging behaviour, with aggression to her mother, to fellow pupils and to her teaching assistant. Educationally, A is behind her peers, as I have already indicated, and though she is making progress, she requires intensive support in school with one-to-one support from a teaching assistant and with a specific education programme which is not that followed by the other children in her class. Finally, she has a degree of incontinence of bladder after epilepsy seizures and incontinence of bowels due to the side effect of her medication and the ketogenic diet. I do not know what effect emotionally all this will have on this little girl, but it seems to me that her epilepsy is a heavy burden for her to bear.

29 Looking at the likely effect on A of a change in her circumstances, that change being brought about in this particular instance by surgery, of course, there is a one in two chance of a successful operation and that success could be very dramatic, with A being seizure free and in due course being drug free. That has to be balanced against the possibility that there will be little or not change or very limited improvement in her seizures, again, balanced against the risks of the operation, risk of paralysis, of brain infection and the like (including

a risk of death). If circumstances do not change, A will continue to have her life disrupted by epilepsy with an annual risk of death of 1 in 250 each year whilst that remains the case.

30 A's age, sex and background. Her age is relevant - she is coming up to her seventh birthday - because Dr P says that her developmental and neuropsychological outcome is better if surgery is performed earlier rather than later.

31 Looking at the harm A has suffered or is at risk of suffering, there can be little doubt in one sense that she has suffered significant harm to her health and development by reason of her epilepsy. That harm is ongoing as she will continue to suffer multiple seizures at night on a daily basis and there is also an increased risk of sudden death in epilepsy.

32 Turning, finally, to the capability of her parents, her mother has cared for A throughout. There is no criticism of her care in any of the medical reports I have read. The mother deals with the daily reality of managing A's intractable epilepsy. It is clearly, from her evidence to me, a significant burden on her, but my decision, and I make this clear, has been taken from A's perspective and not from her mother's. Put bluntly, I would not approve this operation on the sole ground that it would ease the pressure on the mother if successful.

33 A's father is in a different position. He is not faced with the daily reality of A's epilepsy and the effect that this has on her. He also appears to blame the mother and believes that she has been untruthful, as have the doctors, about A's medical condition, though there is no basis for that assertion on the evidence before me. His suggestion that surgery should be risk free seems, to me at least, wholly unrealistic; no surgery is. Whilst I acknowledge his reservations about the chances of a positive outcome, these ignore the consensus of the

medical opinion that this operation is, as Dr W said in his letter dated 7 August 2019, the only realistic treatment that would render A seizure free.

34 I turn, now, to the factors identified by Baroness Hale. The nature of the treatment which A is due to undergo is brain surgery, namely resective epilepsy surgery, cutting into the anterior part of her brain at a precise location which has been identified by the EEG treatment in February 2019. The possibilities of success, as Dr W outlined in his reports, are that there is a 1 in 2 chance that A could become completely seizure free, a 20 to 30 per cent chance of improvement falling short of seizure freedom and a 10 to 20 per cent chance of little or no benefit from the surgery. There are clearly risks arising from the surgery itself, to which I have already referred, namely the risk of death, which is 1 in 500 to 1 in 1,000, and a 1 to 2 per cent chance of other complications, namely a weakness or paralysis in the left arm or leg, a serious brain infection or the leaking of brain fluid requiring further surgery. If there is no surgery, those risks must be balanced against the risk of death to A arising from some sudden unexplained death in epilepsy of 1 in 250 annually, which is the case for her, given her intractable and uncontrolled epilepsy.

35 I must try and put myself in A's place and ask what her attitude to treatment might be. A's attitude would be shaped by her experience of the profound problems caused to her by her epilepsy, to which I have already referred. Her quality of life is compromised by the effect of both her medical condition and the medication she needs to take. Her sleep, schooling and behaviour is disrupted and she experiences what I can only really describe as awful side effects. She is an older child now and the embarrassing side effects, such as loss of bladder and bowel control at school, will become more evident to her in future. Putting myself in A's shoes, she would take into account that there are better outcomes if surgery is performed while she is younger. She would also take into account that all the other ways of managing

her epilepsy, either drugs or a ketogenic diet, have failed to give control. I have come to the conclusion that A would be likely to support surgery. The prize of being epilepsy free, of being like the other children with whom she goes to school would be worth, for her, the risks the surgery failing to improve her condition.

36 I also consider the position from her parents point of view. Her mother supports the surgery. I have already described that she is confronted with the daily reality of A's condition. The father is opposed. The risk, in his view, is too great. He does not face the reality of the effect on A. He sees her for a snapshot of time on three occasions each week during indirect Facetime contact, when she appears to be happy, to be singing and dancing. That is not how A is for the majority of time.

37 With all of those matters in mind, I draw up a balance sheet. The negatives of surgery are that it potentially will not effect any improvement at all in A's epilepsy. The risk of that outcome is the same as the chance of being seizure free. The gains may be very small indeed after surgery, with at least a month's recovery and with time off school, and the risk of surgery itself is not to be underestimated. It is clearly not a risk free process and carries with it the risk of death and a relatively small risk of serious consequences. The positives in the balance sheet appear to me to be these. Surgery offers A a chance, the only realistic chance of being seizure free, being off medication and having a relatively normal life with a positive effect on her development. That would be a marked contrast to A's present circumstances. Even if she were not to be seizure free, there are potentially positive benefits of surgery in terms of a reduction in her seizure activity. The outcome of surgery would be better if it is performed earlier rather than later. The surgery proposed is well validated as treatment for a child with intractable epilepsy and is treatment proposed in line with national guidelines.

38 Standing back, and guided by the lodestar of the paramountcy of A's welfare, and looking at all of the matters to which I have had regard and which I am obliged to have regard, in statute and in case law, I am satisfied that A should have the surgery recommended by Doctors P and W and I make a specific issue order to that effect.

39 The father wished to be present when A has her operation. I was told by Miss Julyan that, by reason of his criminal conviction, he would be unable to enter the UK as a Moroccan citizen. I do not know whether this is correct but it is not unreasonable to think he may have problems obtaining entry clearance. However, I note that no order for direct contact has been made by the Family Court and that the mother challenges the enforcement in this jurisdiction of the contact order made by the Turin Family Court in 2017. I heard no evidence on this issue as the focus of this hearing was whether A should have brain surgery. It seems to me that it would be profoundly unwise to order that the father must be present at any surgery in circumstances where he may experience real problems in obtaining a visa to enter the UK. It would not be in A's best interest to delay her surgery. Given the other difficulties with contact referred to above, I have decided that it is in A's best interests for her surgery to take place as soon as possible, whether or not her father can be present.

40 That is my decision.

CERTIFICATE

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