Neutral Citation Number: [2021] EWHC 1982 (Fam)

Case No: MA21C00512

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/07/2021

Before:

THE HONOURABLE MR JUSTICE MACDONALD

- -

Between :

Wigan Metropolitan Borough Council	**Applicant**
- and -	
W	**First Respondent**
-and-	
N	**Second Respondent**
-and-	
Y	**Third Respondent**
(By his Children's Guardian)	
-and-	
Wrightington Wigan & Leigh Teaching Hospitals NHS Foundation Trust	**Fourth Respondent**
-and-	
Greater Manchester Mental Health NHS Foundation Trust	**Fifth Respondent**

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Ms Cheetham QC and **Mr Philip Martin** (instructed by the **Borough Solicitor**) for the **Applicant**
The Second Respondent did not attend and was not represented
Mr Michael Jones (instructed by **Forbes Solicitors**) for the **Second Respondent**
Mr Callum Brook (instructed by **Temperley Taylor LLP**) for the **Third Respondent**
Mr Parishil Patel QC and **Ms Sian Davies** (instructed by **Browne Jacobson**) for the **Fourth Respondent**
Ms Katie Scott (instructed by **DAC Beachcroft LLP**) for the **Fifth Respondent**

Hearing dates: 13 July 2021

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Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

MR JUSTICE MACDONALD

This judgment was delivered in private. The Judge has given permission for this anonymised version of the judgment (and any of the facts and matters contained in it) to be published on condition always that the names and the addresses of the parties and the children must not be published. For the avoidance of doubt, the strict prohibition on publishing the names and addresses of the parties and the children will continue to apply where that information has been obtained by using the contents of this judgment to discover information already in the public domain. All persons, including representatives of the media, must ensure that these conditions are strictly complied with. Failure to do so will be a contempt of court.

Mr Justice MacDonald:

INTRODUCTION

1. In this matter I am concerned with the welfare of Y, born on 7 February 2009 and now aged 12. Y is represented by Mr Callum Brook of counsel through his Children's Guardian. Y has complex medical and behavioural issues. It is possible, although not definitively established, that Y suffers from ADHD and an autistic spectrum disorder. Y has a diagnosis of epilepsy. As will become apparent, Y has demonstrated, and continues to demonstrate challenging, violent and increasingly self-harming behaviour.

2. In what will be a scenario now depressingly familiar to those in the habit of reading on BAILII judgments given by High Court judges and Deputy High Court judges in cases of this nature, and within the context of acute emotional and behavioural difficulties consequent on past abuse, Y has been assessed as not meeting the relevant criteria for detention under ss.2 or 3 of the Mental Health Act 1983 as he is not considered to be suffering from a mental disorder. At the same time, the therapeutic treatment within a restrictive clinical environment for acute behavioural and emotional issues arising from past trauma that he does urgently require is simply unavailable.

3. In the circumstances, Y is currently and inappropriately placed on a clinical ward at the [named hospital], where he has had to be subject to chemical restraint, physical restraint and 5:1 staffing in order to attempt to control his behaviour. At times there have been up to thirteen police officers present on the ward in an effort to control Y' behaviour. That paediatric ward has now had to be shut to new admissions due to the risk presented by Y and parts of the ward have been closed entirely. Other gravely ill children have had to be moved to alternative hospitals across the North West of England and lists of elective surgeries for children in urgent need of such treatment have been cancelled. Nurses and other hospital staff have been injured. Other sick children and their parents have been alarmed and frightened. At present, Y has nowhere else to go.

4. Within this context, Wigan Metropolitan Borough Council applies for an order authorising the continued deprivation of Y' liberty on the hospital ward, that application having been issued on 6 July 2021. Y is also the subject of care proceedings under Part IV of the Children Act 1989 issued on 1 July 2021. On 8 July 2021, the Designated Family Judge for Greater Manchester, Her Honour Judge Singleton QC, made Y the subject of an interim care order and an interim order authorising the deprivation of his liberty and re-allocated this matter to me for hearing.

5. The first respondent is Y' mother, W. She has not attended this hearing and is not represented. The second respondent is Y' father, N, represented by Mr Michael Jones of counsel. On 8 July 2021 HHJ Singleton QC joined Wrightington Wigan & Leigh Teaching Hospitals NHS Foundation Trust as a party to the proceedings. The Trust is represented by Ms Sian Davies of counsel at the hearing and now by Ms Davies and Mr Parishil Patel of Queen's Counsel. Helpfully, the Greater Manchester Mental Health NHS Foundation Trust has also attended this hearing represented by Mr McGough at the hearing and now Ms Katie Scott of counsel. During the hearing I indicated that it was my intention to join the Greater Manchester Mental Health NHS Foundation Trust as a party to the proceedings and I have done so.

6. In determining whether to extend the order authorising the deprivation of Y' liberty on the paediatric ward I have been assisted by reading the court bundle and by the comprehensive written and oral submissions of counsel. In light of the issues raised by this case I reserved judgment overnight and now set out my decision and the reasons for it.

BACKGROUND

7. Y first became known to the Local Authority in April 2011, following an allegation that the father was misusing drugs and alcohol, leading him to make threats to the mother of the children. It was alleged that those threats comprised statements that the father was going to "gas them, blow the house up and slit the children's throats whilst they are sleeping". On 13 April 2011 a strategy discussion was held by the local authority and an enquiry under s.47 of the Children Act 1989 initiated. Thereafter, following a Child Protection Case Conference, Y and his siblings were made the subject of Child Protection Plans under the category of emotional abuse.

8. Between 2011 and 2015 Y spent periods as the subject of a Child Protection Plan and as a Child in Need. On the 21 July 2015, Y became Looked After for the purposes of the Children Act 1989 and was placed into the care of the local authority following the mother giving her agreement to his accommodation pursuant to s.20 of the Children Act 1989. This was as the result of the father's continued alleged substance misuse and the presence of unexplained injuries to the children. Y was found to have grazes and friction burns on his hand. These were thought to be accidental and due to lack of supervision. Whilst Y was in the care of the local authority the father was the subject of a positive PAMS assessment. Within this context, Y was returned to his father's care on the 29 of March 2016.

9. Earlier this year Y was placed on a further Child Protection Plan under the category of neglect following an allegation that the father had inappropriately physically chastised Y. The issues that lead to this step included:

    i) On 25 September 2020, the father was alleged to have said during a conversation at Y' school that "you have to be cruel to be kind".

    ii) On 7 October 2020, Y informed school staff that he had not eaten for three days and was hungry. The father stated that he had run out of money.

    iii) On 15 December 2020, the school made a referral to children's services after Y had not been at school for two days. During a home visit, the father stated he had hit Y and thereafter had not had sight of him.

10. Following further concerns that Y's medical and basic needs were not being met at home, that the father was displaying a lack of engagement with professionals, that the home conditions were poor and concerns with respect to the father's mental health, the local authority held a Legal Planning Meeting. In particular, that meeting considered the following issues:

    i) The father was said to have a diagnosis of ADHD (the father disputes this) but does not take medication for this condition as he asserted that he did not believe in medicating his illness.

ii) The father was alleged to have regularly used alcohol and cannabis. The father was reported by the mother to go missing for hours when he had consumed alcohol.

iii) The father was alleged to talk openly about his own childhood trauma in front of Y and to re-direct conversations from Y to his own childhood trauma and choices.

iv) Y was noted to have a number of unexplained injuries, including broken fingers, a bruise to the right temple, burnt hair and a cut to his face. On 2 July 2021 Y attended school with a mark to his forehead, approximately 2cm in diameter and a mark to the left side of his mouth.

v) The father was alleged to have failed to administer to Y the medication required to manage Y' ADHD and epilepsy, the latter resulting in Y's seizures re-emerging at school and an ambulance being called. The father was further alleged to have failed to co-operate with appointments designed to remedy the effects of the disruption to Y's medication regime. The father had allegedly refused to sign a safety plan with respect to Y' epilepsy.

vi) Y' school noted that he would attend school in a heightened state (during which he is almost non-verbal), necessitating staff having to physically restrain Y at times to manage his behaviour and the need to allocate staff to him on a 3:1 ratio and to make provision for segregated learning.

vii) Y presented with dangerous behaviours on transport to and from school, putting staff, himself and members of the public at risk. The most recent incident involved Y attempting to pull the handbrake on whilst the school vehicle was in motion.

viii) On 22 February 2021, Y stated to a school therapist that he wanted to "hang himself one day" and that he may seek to do so when travelling home from school one day. On that date, Y proceeded to place a seatbelt around his neck. Y has taken that action on another four occasions on school transport. The father was alleged to have declined to take Y to see a medical professional. When the GP attended the family home she witnessed Y waiving two knives and called the police.

ix) On 4 May 2021, Y was discovered to have been searching the Internet using the search terms "suicide", "death" and "being in prison" on a school computer.

x) On 14 May 2021, Y displayed self-harming behaviour in school by scratching his arms with his finger nails.

xi) Y' school attendance stood at 39.4%.

11. Following the Legal Planning Meeting, the father is said to have failed to engage with the local authority following the letters sent to him by the local authority as a result of the Legal Planning Meeting. Indeed, it is alleged that the father ripped up the second copy of the letter in front of the social worker. An application for an emergency protection order was made on 1 July 2021 and an EPO was granted on that day. As I

have noted, care proceedings were also issued on 1 July 2021. Y was placed in a residential care placement.

12. On 3 July 2021, Y attempted to strangle himself at the residential placement using a phone charger cable. Y was conveyed to the Emergency Department at the [named hospital] where he presented as agitated and combative on arrival. The history given at the Emergency Department was that care home staff had found Y distressed and threatening to kill himself. He had a screwdriver which he had used as a tool to self-harm and was blue in the face with a cord around his neck which they removed. Y was said to have had fought out against them and assaulted them by spitting and hitting them.

13. On arrival of the CAMHs practitioner at the emergency department Y was in full restraint with several police officers and staff. His legs were strapped together and his face covered with a guard to prevent him from spitting and biting. On the advice from the CAMHS practitioner, Y was given IV lorazepam following a discussion with the psychiatric consultant, Dr Amdan. Y was admitted to a paediatric ward.

14. The [named hospital] is not CQC registered to provide mental health care and does not have staff trained to provide physical restraint. During the course of the hearing Ms Davies on behalf of the hospital Trust reiterated that staff on the ward do not have the training or expertise or manage the challenging behaviour that is exhibited by Y and no training in the deployment of physical restraint techniques. Within this context, the local authority agreed to provide trained staff to undertake these tasks. Ms Davies contends however, that there have been difficulties with both the attendance of and the qualifications of the staff provided by the local authority. This has resulted in the Trust having to make frequent calls to the duty social worker in relation to the care provision for Y.

15. On 4 July 2021 at 3pm Y absconded from the ward following a further incident in which he had become aggressive and combative with staff. Y was recovered to the ward by police, social workers and security staff. He was returned to the ward in handcuffs. Upon removal of the handcuffs, Y crawled under the hospital bed and attempted to bring the bed mechanism down on himself. He was pulled out from under the bed by police and restrained on a mattress situated on the floor. The handcuffs were re-applied by the police at this point. Following this, Y had several incidents of holding his breath.

16. On 5 July 2021, Y was the subject of a mental health risk assessment conducted by DA, Clinical Lead for CAMHS. DA concluded that:

> "On assessment and in context Y seems to present as an extremely vulnerable young man who clearly has a complex set of difficulties as outlined above, there seems to be issues in terms of communication and trust with others including professionals, this could be symptomatic of an unhappy child who has been distressed. Y will most likely have extreme difficulty being able to communicate his distress and this will no doubt manifest in dangerous and impulsive acts. Y is not considered and demonstrates extremely poor consequential thinking. The only point clearly articulated by Y was that he did not like his Father. Y is unknown to mental health services and on this occasion has presented due to the risk he has demonstrated in the community. Given his complex presentation his stress levels are likely due to distress,

> change and adjustment. Whilst Y is feeling uncontained and distressed it is likely that his self-risk and injurious behaviour will continue.
>
> Y would benefit from [a] care setting where he has regular and experienced care staffing who are experienced in working with young people with complex needs and who can build up trust and relationships with him, the situation that Y finds himself in will be new, unknown and very frightening and exacerbating the difficult traits we may associated (*sic*) with ADHD and ASC.
>
> I do not feel that Y is presenting with mental illness however his risk taking behaviours would question if Y is competent to make decisions in respect of his own welfare and wellbeing at this point and he would benefit from professionals acting in his best interests."

17. In his statement, Dr H comments as follows regarding the situation with respect to Y on the ward position on 5 July 2021:

> "[22] During these episodes, since his admission, police were called in several times to assist with restraint and at some point 15 police officers were present according to nursing staff. Y was kicking and punching walls, hitting out at staff, spitting at carers and harming himself. Two doses of promethazine and haloperidol (as well as a previous dose of lorazepam) were required within a 24 hour period. This goes beyond the protocol. Following these medications, he crawled onto the floor of the cubicle and placed himself in the corner where he fell asleep. During this period there 3-4 carers, multiple nursing staff, senior medical staff and numerous police officers and security guards present to restrain him and prevent him from harming himself and others."

18. Following this, section 5(2) of the Mental Health Act 1983 (detention of a person who is already an in-patient for a period of 72 hours) was implemented. On the night of 5 to 6 July 2021 it was reported that Y had to be restrained on a number of occasions, including for the first time the use of rapid effect tranquilisers administered by intra-muscular injection to calm him down. Y had banged his head against a metal rod covered in plastic and had attempted to self-harm. The police had been called to the ward on a number of occasions during the night to assist with restraining Y. Thirteen police officers had to attend the ward over a 3 hour period in order to support in the restraint of Y and to attempt to assist in managing the situation. Y had to be once again staffed at a ratio of 5:1 on the ward and, as I have noted, the ward was shut to new admissions due to the risk presented by Y. The invocation of s.5(2) of the Mental Health Act 1983 allowed a formal mental health assessment to be undertaken in respect of Y and a mental health assessment of Y was requested. Whilst professionals were informed that such an assessment would be completed, none materialised on 6 July 2021. The mental health Trust asserts that it took the steps it could to support co-ordination of the Mental Health Act assessment of Y.

19. An application for permission to invoke the inherent jurisdiction and for an order authorising the deprivation of Y's liberty on the hospital ward was finally issued on 6 July 2021. On 6 July 2021 HHJ Singleton QC made a short order authorising the deprivation of Y' liberty on the hospital ward, including the use of physical restraint by

professionally trained staff from the local authority to prevent Y from leaving the hospital. On 6 July 2021 HHJ Singleton QC also indicated in terms that, given his needs, she would not countenance an unregulated placement for Y. HHJ Singleton QC listed the matter before herself again on 8 July 2021 to deal with the application for an interim care order and to review the position with respect to the order authorising the deprivation of Y' liberty.

20. At 9.50pm on the evening of 6 July 2021, Y' behaviour again escalated on the ward and he attempted to assault staff. The police were called and four officers attended. With the help of four carers Y was restrained, including the use by police of handcuffs, one of the carers being punched to the face by Y and sustaining injuries to his eye and nose. Intra-muscular Lorazepam was again administered to Y. He continued to spit and hit out at staff until he passed out. At this point Y exhibited slightly low oxygen saturations and was given a face mask.

21. On 7 July 2021 Y was seen by an Approved Mental Health Professional (hereafter AMPH) for a formal mental health assessment. The AMPH sought to engage Y as a means of conducting her assessment, which commenced at 1pm on 7 July 2021. During the course of their exchange Y stated that he wanted to sleep on the streets and did not want to go home as he wished to kill his father and himself. Y informed the AMPH that when he self-harms it is with the intention of killing himself. When asked if he wanted to see or speak to his father Y became agitated and began to place objects in his mouth. Thereafter, Y became highly agitated, managed to kick the door of the ward open and attempted to abscond. Y became aggressive to staff and attempted to damage property. He was restrained by security staff. Once back on the ward Y became highly aggressive again and the police were called. The police officers were required to restrain Y and he was given a dose of rapid tranquiliser. Y made further attempt to harm himself at a later point by putting a carrier bag over his head and wrapping it tight. He was restrained for his own safety and passed out. When he came round he started banging his head against a wall and again attempted to kick down the ward to the door. Y attempted to punch the security staff and spat at them.

22. The outcome of the mental health assessment by the AMPH was that Y was *not* detainable under s.2 of the Mental Health Act 1983 and did *not* require a Tier 4 bed. This conclusion was reached based on the view of the AMPH that Y' behaviour was "trauma based". Ms Davies makes clear that the hospital Trust were surprised by this outcome having regard to Y' presentation on the ward. Within this context, the s.5(2) detention was discharged and it became impermissible to use rapid effect tranquilisers on Y, with restraint being thereafter limited to that authorised by the deprivation of liberty order made on 6 July 2021. A recommendation was made that Y be placed in a therapeutic placement. The hospital indicated that it wished to discharge Y on the basis he was no longer in the correct setting.

23. By a statement dated 7 July 2021, Dr H, Consultant Paediatrician at the hospital confirmed that Y was medically fit for discharge. Dr H states that Y required medication in the form of Lorazepam daily in order to keep himself and other's safe when he entered a period of escalated and violent behaviour. Within this context, Dr H recorded that:

> "The Trust have today administered to Y the maximum amount of Lorazepam that would be safe, in his best interests. Even with the further

> hands on restraint support set out above, it is felt that chemical restraint will still be required. Risperidone is an oral medication suggested by Dr Rowsell as a stabilizer, usually used to treat psychosis but this would take time to work and would require Y to accept an oral medication which has been impossible."

24. Within the foregoing context, Dr H articulated the concerns of the NHS Trust underpinning its application for party status in these proceedings that was issued on 8 July 2021 (with respect to the absence of Mental Health nurses dealt with at paragraph [33] of Dr H's statement, the mental health Trust asserts it was not in fact commissioned to provide such staff to the hospital Trust but attempted to do so as "a matter of good will"):

> "[32] The Trust is concerned that there is a clear pattern of escalation of behaviour and aggression which is worsening the longer Y remains on the ward. Y is a risk to himself, staff and other children on the ward. The Trust has a duty to safeguard the medical, physical and mental health of all its patients. Having attempted and further considered the less restrictive options, at the current time Y is on a side room on the ward, with bedding etc taken out of his room for his own safety. The area of his side ward is separated from the other children on the ward. Due to risk of ligature form the draw string in the shorts he was wearing, Y is wearing scrub pants.
>
> [33] A multi-agency meeting took place on 7 July 2021. At this meeting the Trust raised serious concerns of the failings of the support package that is in place for Y. Two Mental Health Care Nurses did not arrive. The four staff from Innovate agency arrived but there were discrepancies in their restraint policies. Unfortunately, this meant the staff on the [ward] had to put themselves into very dangerous positions to ensure Y and the rest of the patients on the ward were kept safe.
>
> [34] Some children have heard loud bangs and have felt the frenzy on the ward and expressed anxiety."

25. When the matter came back before HHJ Singleton QC on 8 July 2021 the learned judge made the NHS Trust a party to these proceedings. On that date, and in circumstances where the local authority had not identified a therapeutic placement for Y, HHJ Singleton QC extended the order authorising the deprivation of Y' liberty on the hospital ward, the restrictions authorised comprising 5:1 supervision on the ward, the use of physical restraint and the use a fast acting tranquiliser administered intramuscularly if efforts to gain his co-operation proved impossible. HHJ Singleton QC expressly deprecated the use of handcuffs on Y as a method of restraint.

26. Y currently remains contained on the ward in a sectioned off area. The doors to the paediatric ward have been securely shut and the area cleared of all movable objects. The door to the shower in which he washes himself has been removed, and therefore Y has no privacy at all when showering or dealing with other aspects of his hygiene. He is at present sleeping on a mat on the floor and he is unable to have a pillow, or a sheet due to the risk of self-harm and suicide. Y is still being prescribed daily intra-muscular Olanzapine, which is an anti-psychotic, the hospital taking the view that without this chemical sedation Y' behaviour would be simply unmanageable. Y does not socialise.

In stark contrast to every other case of this nature that has recently come before this court (none of which involved placement on a hospital paediatric ward rather than in a residential setting), neither the evidence contained in the bundle nor the submissions made by the advocates identifies *any* positives with respect to Y current parlous situation, whether with respect to improvements in his behaviour, his relationships with staff or otherwise. His assaults on staff are frequent, violent and cause injuries to both Y and the staff.

27. At this hearing, I have the benefit of a further statement from the hospital Trust, provided by the Deputy Chief Executive of the Trust, Mary Fleming and dated 12 July 2021. Ms Fleming is responsible for the delivery of safe patient services at the Trust. She details the following incidents that have taken place on the ward since 8 July 2021:

    i) On Saturday 10 July 2021 Y grabbed a plastic chair on the ward and tried to attack a mental health nurse provided by the local authority. This caused Y to suffer a nosebleed, and the nurse to sustain an eye injury.

    ii) Y filled a sink with water and tried to drown himself. As a result, the water to the sink has now been turned off. Y has also tried to suffocate himself with a pillow.

    iii) Y has engaged in self-harm and now has an arm injury that is believed to be infected. He will not however, allow medical staff to provide him with medical attention.

    iv) Y has broken the computer in the nursing bay on the paediatric ward.

28. Within this context, Ms Fleming describes the current position for Y on the ward as follows:

> "The situation on [the ward] is described by staff as harrowing, Y feels like he is being 'caged' and is frightened when Police are called by the ward who require assistance when his behaviour becomes a safety risk to himself and others. At all times Y still requires an incredibly high level of supervision, he is restrained often and is controlled by chemical sedation."

29. Ms Fleming further highlights the fact that, whilst Y is still being prescribed daily intra-muscular Olanzapine administered in accordance with the Alder Hey protocol and that without this chemical sedation Y' behaviour would be simply unmanageable (it in any event making little difference to the incidents of Y attempting to self-harm, harm to others or damage to property), this places the Trust's medical staff in a very precarious position notwithstanding the terms of the authorisation granted by HHJ Singleton QC on 8 July 2021:

> "At the MDT meeting on 12 July 2021, Dr SH, Consultant Paediatrician, made it extremely clear to all attendees that a medication plan was not in place nor set out for the Trust to follow. As the Court is aware, the Trust is not CQC registered to provide mental health services. The Paediatricians on [the ward] are not experienced at prescribing anti-psychotics and other psychiatric medication to patients. At the current time, the clinicians rely on the Alder Hey medication protocol for guidance, along with assistance from

> on-call clinicians at Hollins Park Hospital (operated by Mersey Care NHS Foundation Trust). The clinicians feel that the care they are providing, whilst is the very best they can provide in Y's best interests, is reactive and without the appropriate level of support. They are unaware of what the long-term plan is for Y's medication, and this is causing understandable serious concern and frustration."

30. Finally, with respect to the situation at the hospital, Ms Fleming relates to the court that staff on the ward are approaching "burn out" with an increasing risk that levels of staff absence due to sickness will begin to rise. Further, with respect to the wider impact on the provision of paediatric care in the North West of England, Ms Fleming describes the effect of the absence of an appropriate placement for Y on paediatric services across North West England as follows:

> "Last week (week commencing 5 July 2021) three Paediatric operating lists were cancelled as a result of the severe impact that managing Y is having. Due to Y's complex social needs, a large portion of the ward is cordoned off for his care. This means that there are empty Paediatric beds that cannot be used for sick children. This was relayed to all by Dr SH at the MDT meeting on 12 July 2021. In addition to Y, Dr SH is also currently looking after the remaining patients on the unit, ten very sick children requiring oxygen ventilation and an intense level of care. As a result of the time and resources that are being utilised for Y, in his best interests, Paediatric patients are now being transferred to other North West hospital Trusts. Quite simply [the ward], despite all the staff working tirelessly (including at times coming in on their days off to provide support), are not able to manage. [the ward] was never intended and is not designed to safely look after a child with such complex social care needs… Due to large parts of the ward being cordoned off, the relatives rest room, play area and sensory room can no longer be accessed."

31. Within the foregoing context, despite extensive efforts that have ranged across a search of regulated residential placements, unregulated residential placements and the secure accommodate estate, the local authority has been unable to find an alternative placement for Y, let alone one that is appropriate to his extensive and highly complex needs. That position subsisted at this hearing. In the circumstances, at this hearing the local authority articulated two further options, both of which face grave hurdles to their successful implementation and which, in any event, I am satisfied could not be implemented effectively before Y requires to be moved from the paediatric ward.

32. The first option posited by the local authority is based on a two bedroom property that has been identified as the basis for a bespoke placement for Y. However, no provision has yet been made with respect to the staffing of such a placement. Previous experience suggests that that will not be a simple task and will require time to accomplish, if it can be accomplished at all. The second option advanced by the local authority is for Y to return to the care of his father, on the basis that the risk to his welfare of that step is currently *less* than the risk to his welfare constituted by the continuance of the deprivation of his liberty on the hospital ward. However, this option again faces considerable obstacles, not least that Y has on a number of occasions refused to see his father and has on occasion expressed the wish to kill his father. As noted by DA, the *only* point that Y was capable of articulating clearly was that he did not like his father.

33. Little is understood about the underlying causes for Y' presentation. Initially in this case, the AMHP service refused to undertake a further Mental Health Act assessment of Y notwithstanding the lacuna identified by Children's Guardian in the first AMPH assessment and a request by the hospital Trust for a further assessment based on that Trust's observation of Y' behaviour and their belief that the first assessment was incomplete. The AMHP service has now however, agreed to review the original Mental Health Act assessment.

THE LAW

34. I have set out the law that governs the application before me in a number of recent decisions. The salient points can be summarised as follows.

    i) It is a fundamental principle of a democratic society that the State must adhere to the rule of law when interfering with a person's right to liberty and security of person (*Brogan v United Kingdom* (1988) 11 EHRR 117 at [58]).

    ii) Within this context, Art 5(1) of the ECHR stipulates that everyone has the right to liberty and security of person and that no one shall be deprived of his liberty save in the circumstances described by Art 5 and in accordance with a procedure prescribed by law.

    iii) The purpose of Art 5 is to ensure that people are not deprived of their liberty without the safeguards that secure that the legal justifications for the constraints which they are under are made out (*P (acting by his Litigation Friend the Official Solicitor) v Cheshire West and Chester Council* [2014] A.C. 896).

    iv) Whilst Art 5(1)(d) of the ECHR provides a specific example of the detention of children, namely for the purposes of educational supervision, that example is not meant to denote that educational supervision is the only purpose for which a child may be detained (see *Mubilanzila Mayeka and Kaniki Mitunga v Belgium* (2008) 46 EHRR 449).

    v) The rights enshrined in the ECHR are to be read and given effect in domestic law having regard to the provisions of the UN Convention on the Rights of the Child. Art 37 of the UNCRC provides that no child shall be deprived of his or her liberty unlawfully or arbitrarily.

    vi) The court may grant an order under its inherent jurisdiction authorising the deprivation of a child's liberty if it is satisfied that the circumstances of the placement constitute a deprivation of liberty for the purposes of Art 5 of the ECHR *and* it considers such an order to be in the child's best interests.

    vii) With respect to the first question of whether the arrangements in the placement amount to a deprivation of liberty for the purposes of Art 5, three broad elements comprise a deprivation of liberty for the purposes of Art 5(1) of the ECHR, namely (a) an objective element of confinement to a certain limited place for a not negligible period of time, (b) a subjective element of absence of consent to that confinement and (c) the confinement imputable to the State (see *Storck v Germany* (2006) 43 EHRR 6). Only where all three components are present is there a deprivation of liberty which engages Art 5 of the ECHR.

viii) Within this context, in *Cheshire West and Chester v P* [2014] AC 896 the Supreme Court articulated an 'acid test' of whether a person who lacks capacity is deprived of their liberty, namely (a) the person is unable to consent to the deprivation of their liberty, (b) the person is subject to continuous supervision and control and (c) the person is not free to leave.

ix) With respect to the application of the second and third limbs of the acid test, in *Re RD (Deprivation or Restriction of Liberty)* [2018] EWFC 47 Cobb J summarised the position as follows:

a) 'Free to leave' does not mean leaving for the purpose of some trip or outing approved by those managing the institution; it means leaving in the sense of removing herself permanently in order to live where and with whom she chooses.

b) It is accepted wisdom that a typical fourteen or fifteen-year old is not free to leave her home.

c) The terms 'complete' or 'constant' define 'supervision' and 'control' as indicating something like 'total', 'unremitting', 'thorough', and/or 'unqualified'.

d) It does not matter whether the object is to protect, treat or care in some way for the person taken into confinement.

e) The comparative benevolence of living arrangements should not blind the court to their essential character if indeed those arrangements constitute a deprivation of liberty.

f) What it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities.

g) The person's compliance or lack of objection, the relative normality of the placement (whatever the comparison made) and the reason or purpose behind a particular placement are not relevant factors.

h) The distinction between deprivation and restriction is a matter of "degree or intensity" and "in the end, it is the constraints that matter".

i) The question whether a child is restricted as a matter of fact is to be determined by comparing the extent of the child's actual freedom with someone of the child's age and station whose freedom is not limited.

j) The sensible and humane comparison to be drawn is that between the situation of the child with the ordinary lives which young people of their ages might live at home with their families.

k) The 'acid test' has to be directly applied on each case to the circumstances of the individual under review. Where that individual is a child or young person, particular considerations apply.

x) To determine whether someone has been "deprived of his liberty" within the meaning of Art 5, the starting point must be his or her concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question (see *Guzzardi v Italy* [1980] 3 EHRR 333).

xi) The courts have utilised comparators against which to measure the elements of that test in respect of the subject child. Within this context, it is important to note that all children are (or should be) subject to some level of restraint, which adjusts with their maturation and change in circumstances". Childhood is not a single, fixed and universal experience between birth and the age of majority, but rather one in which, at different stages, in their lives, children require differing degrees of protection, provision, prevention and participation.

xii) With respect to the second question, namely whether it is in the child's best interests to authorise the circumstances that amount to a deprivation of liberty for the purposes of Art 5, that deprivation will only be lawful if the court is satisfied that it is in the child's best interests having regard to the child's welfare as the court's paramount consideration.

xiii) When the court is considering the welfare of the subject child as its paramount consideration in the evaluative exercise with respect to welfare required on an application made pursuant to the inherent jurisdiction of the High Court, the court surveys and takes into account a wide range of matters.

35. This is another case in which it has proved impossible to identify a suitable placement capable of meeting the subject child's needs. With respect to the relevance of the absence of such a placement to the best interests evaluation to the court, in *Tameside MBC v L* [2021] EWHC 1814 (Fam) I held as follows:

> "[71] In circumstances where it is rarely, if ever, the case that a particular welfare option will meet *perfectly* all of a given child's welfare needs, safeguarding and promoting a child's best interests will almost invariably involve a degree of compromise. The extent to which a given welfare compromise is or is not acceptable will in turn depend, in part, on whether or not another welfare option that does not require such a compromise is or is not available. A course of action that can meet some of the child's needs may well not be acceptable where a course of action that meets all of the child's needs is available. But where a course of action that meets all of the child's needs is not available, a course that meets only some of the child's needs *may* become acceptable, particularly where the alternative is that none of the child's welfare needs will be met. Thus, for example, a placement that keeps a child physically safe from sexual exploitation but lacks appropriate therapeutic provision to address sexual trauma may not be in a child's best interests where a safe placement with therapeutic provision is available. However, a placement that keeps a child safe from sexual exploitation but lacks appropriate therapeutic provision may, depending on the facts of the case, be capable of being held to be in a child's best interests where a safe placement with therapeutic provision is not available, particularly in the shorter term whilst further searches are made and where otherwise the safety of the child would be threatened.

> [72] In these circumstances, whilst not determinative, I am satisfied that the lack of availability of any alternative course of action with respect to welfare *is* one factor to be taken into account in evaluating properly the extent to which in it is in L's best interests for the court to authorise the current restrictions that I am satisfied constitute a deprivation of his liberty. I accept that, where the merit of the sole placement available is limited to keeping the child safe in the broadest sense, taking into account the unavailability of alternatives risks the welfare outcome arrived at being one that is based on an undesirably narrow welfare formulation that can come closer to a test of necessity than a test of best interests. As this court recognised in *Lancashire County Council v G (Continuing Unavailability of Regulated Placement)(No.4)* at [30]:
>
> > "The judgment of the Supreme Court in the appeal against the decision of the Court of Appeal in *T (A Child)* [2018] EWCA Civ 2136 is awaited. However, as in previous judgments, in the foregoing circumstances I am again left asking myself whether, where there remains, six months after the commencement of proceedings, only one sub-optimal, unregulated placement option open to the court, the court is really exercising its welfare jurisdiction by reference to G's best interests if it chooses that one option, or if the court simply being forced by necessity to make an order irrespective of welfare considerations. If the latter, then it is difficult to see how the decision I have made can be lawful by reference to the current law governing the use of the inherent jurisdiction to authorise the deprivation of a child's liberty."
>
> [73] However, and with a degree of weary resignation, I further accept Mr Carey's submission that the welfare analysis of the court has to be realistic and not idealistic in its approach and, accordingly, pending any revision to the current law the court simply has no choice but to grapple as best it can, within the best interests paradigm, with the reality of the ongoing paucity of appropriate resources for children who do not meet the criteria for detention and treatment under the Mental Health Act 1983, but nonetheless require urgent assessment and therapeutic treatment for acute behavioural and emotional issues within a restrictive clinical environment by reason of their past traumas.
>
> [74] Accordingly, the question of whether it is in L's best interests for the court to authorise the current restrictions that I am satisfied constitute a deprivation of his liberty falls to be answered in the clear eyed knowledge that his current arrangement is the only one presently available. The child's welfare needs must be considered both holistically and realistically, which approach demands that the court consider the likely consequences of any order it does or does not make. Within that context, to leave out of the best interests equation the lack of availability of an alternative course of action with respect to L's welfare would be to artificially constrain the court from evaluating fully the extent to which it is in L's best interests for the court to authorise the current restrictions that constitute a deprivation of his liberty."

36. As I noted in *Tameside MBC v L* at [75], and for the reasons set out in that judgment, in the foregoing context, where there is no alternative placement the court should

approach the case by asking is it in Y' best interests for an order authorising the deprivation of his liberty at his current placement, noting that, although Y is deprived of his liberty, there is no alternative available which offers a lesser degree of restriction. As made clear in *North Yorkshire County Council & A CCG v MAG & GC* [2016] EWCOP 5, following the decision of the Court of Appeal in *R (Idira) v Secretary of State for the Home Department* [2015] EWCA Civ 1187, this approach will involve consideration of whether the placement is *so* unsuitable as to breach Y's rights under Art 5 of the ECHR, in which case the court would be unable to authorise it as being lawful.

37. In this case, Mr Jones submits that the position of Y is of a wholly different magnitude to the young person with whom the court was concerned in *Tameside MBC v L*, such that in this case the court must be concerned not only with the question of whether the only placement available is *so* unsuitable as to breach Y's rights under Art 5 of the ECHR, but also with whether the treatment or the conditions resulting from that deprivation of liberty breach Y' rights under Art 3.

38. Article 3 of the ECHR provides as follows with respect to the right not to be subjected to torture or inhuman or degrading treatment or punishment:

> "**Art 3**
>
> No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

39. The prohibition contained in Art 3 on torture or inhuman or degrading treatment or punishment is absolute and does not admit of any exceptions. This means that there is an absolute prohibition on the State, whether by itself or through its agents, subjecting a person to torture or to inhuman or degrading treatment or punishment.

40. Further, as made clear by Sir James Munby in a similar context in *Re X (No 3) (A child)* [2017] EWHC 2036 at [36], Art 3 of the ECHR embodies a positive obligation on the State to take steps to prevent treatment that falls within the ambit of the protections provided by Art 3 (see *Pretty v United Kingdom* (2002) 35 EHRR 1 at [51]). Within this context, the House of Lords has recognised that the particular vulnerability of children will be relevant to the scope of the positive obligation under Art 3, Baroness Hale observing *in Re E (A Child)(A)(Northern Ireland)* [2008] 3WLR 1208 at [9] that:

> "The special vulnerability of children is also relevant to the scope of the obligations of the state to protect them from such treatment. Again, in *Mayeka v Belgium*, at para 53, the court reiterated, citing *Z, A and Osman*, that:
>
> > 'the obligation on high contracting parties under article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken in conjunction with article 3, requires states to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment, including such ill-treatment administered by private individuals. Steps should be taken to enable effective protection to be provided, *particularly to children and other*

> *vulnerable members of society*, and should include reasonable measures to prevent ill-treatment of which the authorities have or ought to have knowledge.' (Emphasis supplied.)

Despite the fact that the state had detained the little girl, the court treated the case, not as a breach of its negative obligation, but as a breach of its positive obligation to look after her properly. She:

> 'indisputably came within the class of highly vulnerable members of society to whom the Belgian State owed a duty to take adequate measures to provide care and protection as part of its positive obligations under article 3 of the Convention': para 55.

This they had failed to do: para 58. The court also found a breach of the state's obligations towards the child's mother, because of the distress she must have suffered at her daughter's treatment, even though it could be said that she had to some extent brought it on herself by arranging for the child to travel through Belgium without a visa: para 62."

41. As to what constitutes inhuman or degrading treatment or punishment for the purposes of Art 3 of the ECHR, in *R (Limbuela) and others v Secretary of State for the Home Department* [2006] 1 AC 396 at [7] Lord Bingham held as follows:

> "Treatment is inhuman or degrading if, to a seriously detrimental extent, it denies the most basic needs of any human being. As in all Art 3 cases, the treatment, to be proscribed, must achieve a minimum standard of severity, and I would accept that in a context such as this, not involving the deliberate infliction of pain or suffering, the threshold is a high one…It is not necessary that treatment, to engage Art 3, should merit the description used, in an immigration context, by Shakespeare and others in *Sir Thomas More* when they referred to 'your mountainish inhumanity'".

42. Finally, in this case, as in many cases, there is an apparent tension between Y' needs as they appear to the professionals responsible for his care and the requirements of the mental health legislation; in particular the requirement that the child have a mental disorder for the purposes of s.1 of the Mental Health Act 1983 before the gateway to the powers available under the statute opens. Within this context, it is important to note the following.

43. Section 1 of the Mental Health Act 1983 provides as follows with respect to the application of that piece of legislation:

> "**1 Application of Act: "mental disorder".**
>
> (1) The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.
>
> (2) In this Act—
>
> "mental disorder" means any disorder or disability of the mind; and "mentally disordered" shall be construed accordingly;

> and other expressions shall have the meanings assigned to them in section 145 below.
>
> (2A) But a person with learning disability shall not be considered by reason of that disability to be—
>
> (a) suffering from mental disorder for the purposes of the provisions mentioned in subsection (2B) below; or
>
> (b) requiring treatment in hospital for mental disorder for the purposes of sections 17E and 50 to 53 below,
>
> unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.
>
> (2B) The provisions are—
> (a) sections 3, 7, 17A, 20 and 20A below;
>
> (b) sections 35 to 38, 45A, 47, 48 and 51 below; and
>
> (c) section 72(1)(b) and (c) and (4) below.
>
> (3) Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection (2) above.
>
> (4) In subsection (2A) above, "learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning."

44. The Code of Practice published pursuant to s.118(4) of the Mental Health Act 1983 provides the following assistance with respect to the definition of "mental disorder" in s.1(2) of the Act. Paragraph 2.4 of the Code of Practice states:

> "[2.4] Mental disorder is defined for the purposes of the Act as 'any disorder or disability of the mind'. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability."

Paragraph 2.5 goes on to state that examples of clinically recognised conditions which could fall within this definition include autistic spectrum disorders (including Asperger's syndrome) and behavioural and emotional disorders of children and young people. Paragraph 2.5 of the Code of Practice makes clear that the list of clinically recognised conditions that could fall within the definition contained within s.1 of the 1983 Act is not exhaustive.

45. With respect to autistic spectrum disorders, Paragraph 2.17 of the Code of Practice provides as follows:

> "[2.17] The learning disability qualification does not apply to autistic spectrum disorders (including Asperger's syndrome). It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if it is not associated with abnormally aggressive or seriously irresponsible behaviour. While experience suggests that this is likely to be

> necessary only very rarely, the possibility should never automatically be discounted."

46. With respect to the assessment of a mental disorder in a child, paragraph 19.5 of the Code of Practice cautions as follows:

> "[19.5] …the developmental process from childhood to adulthood, particularly during adolescence, involves significant changes in a wide range of areas, such as physical, emotional and cognitive development – these factors need to be taken into account, in addition to the child and young person's personal circumstances, when assessing whether a child or young person has a mental disorder…"

47. With respect to the question of autistic spectrum conditions, Chapter 20 of the Code of Practice stipulates as follows:

> "[20.18] Autistic spectrum conditions (autism) have been defined as a lifelong developmental disability that affects the way a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition meaning each individual will have different needs.
>
> [20.19] The Act's definition of mental disorder includes the full range of autistic spectrum conditions, including those existing alongside a learning disability or any other kind of mental condition. It is possible for someone on the autistic spectrum to meet the criteria in the Act for detention without having any other form of mental disorder, even if the autism is not associated with abnormally aggressive or seriously irresponsible behaviour, but this will be very rare.
>
> [20.20] Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism, who may be very distressed by even minor changes in routine and is likely to find detention in hospital anxiety provoking. Sensitive, person-centred support in a familiar setting will usually be more helpful. Wherever possible, less restrictive alternative ways of providing the treatment or supporting a person should be found. The specialist expertise and skills of staff should be regularly audited, particularly the ability to recognise social and health needs, and specialist communication skills.
>
> …/
>
> [20.28] People with autism should be detained for as short a period as possible. Many people with autism who have been detained will require, and be entitled to, after care (chapter 33). Discharge planning for people with autism should begin when the person is admitted and involve health and local authorities to work together in the interests of an individual to ensure appropriate community-based support is in place before discharge. This will require assessment by a practitioner with expertise in autism, as set out by the statutory adult autism guidance."

48. Within the foregoing context, the case law arising from the Mental Health Act 1983 highlights the difficulty that can arise in seeking to distinguish between psychiatric illness and the psychological impact of trauma. The difficulty in making the distinction between psychological distress consequent upon trauma and symptoms amounting to a diagnosable psychiatric illness were noted by the Court of Appeal in *R v D* [2006] EWCA Crim 1139 at [30]:

> "As the Law Commission reports [in Liability for Psychiatric Illness, No.249 (1998) HC 525], the distinction 'is not clear', quoting one medical consultee who suggested that the 'overlap between mental health and illness is so large a grey area that it is not suitable for the legal purpose to which the diagnosis is being put'. The classification in DSM-IV and ICD-10 were not themselves always sufficient 'to distinguish those with the greatest impairment of functioning', and several of the consultees commented that it would be unjust to relay on the criteria in these classifications to distinguish psychiatric illness from 'mere mental distress'. It was suggested that some did not 'reflect the complexities of the psychological impact of trauma', and current categorisation might exclude some diagnoses which were generally acceptable. Observations like these confirm that current understanding of the workings of the mind is less than complete".

49. In *R v Chan-Fook* [1994] 2 All E.R. 552 at 559 Hobhouse LJ observed as follows with respect to the approach to this issue by the Court of Appeal in *Attia v British Gas* [1988] Q.B. 304:

> "[T]he Court of Appeal discussed whether the borderline should be drawn between on the one hand the emotions and distress and grief, and on the other hand some actual psychiatric illness such as anxiety neurosis or a reactive depression. The authorities recognise that there is a line to be drawn and whether any given case falls on one side or the other is a matter for expert evidence."

50. Finally, and within the foregoing context, it is important to note the current acceptance criteria for Tier 4 CAMHS provision. The current Service Specification for Tier 4 CAMHS services as set out on the Gov.uk website is as follows with respect to acceptance criteria:

> "**2.4 Acceptance Criteria**
>
> 2.4.1 The service accepts referrals meeting the following criteria:
>
> - Primary diagnosis of mental illness including young people with neurodevelopmental disorders including mild learning disability and autism, drug and alcohol problems, physical disabilities, or those with social care problems as secondary needs
>
> - Severe and complex needs that cannot be safely managed within Tier 3 CAMHS

- Aged 13 years until 18th birthday (there may be rare cases of 12 year olds being more appropriately admitted than to a Tier 4 CAMHS Children's Unit)

- May require detention under the Mental Health Act although not a pre-requisite."

DISCUSSION

51. Having considered carefully, and anxiously, the evidence and submissions in this case, I am satisfied that it is *not* appropriate to make an order further authorising as lawful the deprivation of Y' liberty on the paediatric ward at [the named hospital], notwithstanding that there is currently no alternative placement that can meet his needs. My reasons for so deciding are as follows.

52. There is no dispute that, and I am satisfied on the evidence that, the current restrictions imposed on Y on the hospital ward constitute a deprivation of his liberty for the purposes of Art 5 of the ECHR. Within this context, the remaining question for the court is whether it is in Y' best interests to make an order authorising the restrictions that constitute the deprivation of his liberty, having regard to Y' welfare as my paramount consideration. In circumstances where the hospital ward is the only "placement" available for Y, in resolving that question the court must have regard to the fact that, although Y is deprived of his liberty, there is no alternative available which offers a lesser degree of restriction. Within the context of the concerns raised before the court, that approach will necessarily involve consideration of whether the placement is so unsuitable as to breach Y's rights under Art 5 of the ECHR.

53. The genesis of my decision that it is not in Y' best interests to grant the authorisation sought by the local authority lies in the description of Y' current situation that I set out earlier in this judgment. Having regard to that description the only possible conclusion regarding Y' current situation on the hospital ward is that it is an inappropriate, demeaning and, quite frankly, brutal one for a 12 year old child.

54. The primary purpose of a paediatric hospital ward is to treat children, not to deprive them of their liberty by means of locked doors, sparse belongings and chemical restraint. There is now no clinical basis for Y to be on the hospital ward and he is medically ready for discharge. There is therefore also now no connection *at all* between purpose of the hospital ward on which Y is held and the deprivation of Y' liberty. Within this context, Y currently remains contained on the ward in a sectioned off area that is not designed to restrict the liberty of a child but rather to provide medical treatment to children. The doors to the paediatric ward have been securely shut and the area cleared of all movable objects. Accordingly, not only is there no connection at all between purpose of the hospital ward on which Y is held and the deprivation of Y' liberty, but the arrangements that are in place to restrict his liberty in that setting are, accordingly and necessarily, an entirely *ad hoc* arrangement that is not, and indeed can never be, designed to meet his needs.

55. The door to the shower in which Y washes himself has been removed, and therefore Y has no privacy at all when showering or dealing with other aspects of his hygiene. It must be beyond reasonable dispute that, whilst aimed at preventing him from harming himself, this is a grossly humiliating situation for a 12 year old child to be in and one

that presents him with an invidious choice between embarrassment and the maintenance of personal hygiene. It would likewise appear that Y has no means of ensuring privacy on the ward when getting dressed and undressed. Added to this indignity, Y must at present sleep on a mat on the floor and he is unable to have a pillow, or a sheet due to the risk of self-harm and suicide. Y does not socialise. It is unclear on the evidence before the court how Y takes his meals or how he maintains any form of daily routine more generally. Once again, these ignominies have their roots in the fact that a paediatric hospital ward is simply not equipped to undertake the task that circumstance, and an acute lack of appropriate resources, has assigned to it.

56. I accept the submission of the Children's Guardian that a further consequence of the paediatric hospital ward being a wholly inappropriate venue for the deprivation of Y' liberty is that there is an increased risk that the restrictions authorised by the court as lawful risk being regularly exceeded in an attempt to manage Y in an inappropriate setting. There is indeed evidence that this has taken place in circumstances where, for example, Y has been deprived of a bed, pillow and blankets, where on occasion physical restraint is taking place by staff who are not properly trained and, whilst HHJ Singleton QC authorised the use of "fast acting tranquilisation" as a means of chemical restraint when efforts to gain Y' consent fail, where the current regime of chemical restraint cleaves closer to that of constant sedation. This is *not* the result of malice or negligence but simply of an increasingly desperate attempt to contain Y in a situation that is not designed, in any way, for that purpose.

57. Further, and within this context, the fact that the hospital ward is a wholly inappropriate venue for the deprivation of Y' liberty forces medical staff to step outside the normal safeguards that are put in place in that environment. As I have noted, Y is still being prescribed daily intra-muscular Olanzapine, which is an anti-psychotic, the hospital taking the view that without this chemical sedation Y' behaviour would be simply unmanageable. However, as Dr SH has made clear, a medication plan is *not* in place nor set out for the Trust to follow, the Trust is *not* CQC registered to provide mental health services, paediatricians on the ward are *not* experienced at prescribing anti-psychotics and other psychiatric medication to patients and, in that context, the only guidance available is that provided by the Alder Hey medication protocol. All these factors in my judgment increase the risk to Y of being harmed by the restrictions that are in place.

58. In stark contrast to every other case of this nature that has come before this court, neither the evidence contained in the bundle nor the submissions made by the advocate identifies *any* positives with respect to Y current parlous situation, whether with respect to improvements in his behaviour, his relationships with staff or otherwise. His assaults on staff are frequent, violent and cause injuries to both Y and to the staff who are doing their utmost to care effectively for him. In this context, I accept the submission of Mr Jones that whilst the arrangements in cases such *as Lancashire v G (Unavailability of Secure Accommodation)* [2020] EWHC 2828 (Fam) or *Tameside MBC v L (Unavailability of Regulated Therapeutic Placement)* [2021] EWHC 1814 (Fam) were sub-optimal, and in certain respects inappropriate, Y' current situation is orders of magnitude more severe having regard to the matters that I have set out above.

59. Having regard to the matters set out above, I cannot in good conscience conclude that the restrictions in respect of which the local authority seeks authorisation from the court are in Y' best interests, having regard to Y' welfare as my paramount consideration.

Indeed, I consider that it would border on the obscene to use the protective *parens patriae* jurisdiction of the High Court to authorise Y' current situation. I am further satisfied that this conclusion is not altered by the fact that, as at 12 noon yesterday, there was no alternative placement available capable of meeting Y' needs. In this case, I consider that the current arrangements for Y are *so* inappropriate that they constitute a clear and continuing breach of his Art 5 rights. Within this context, the fact there is no alternative cannot by itself justify the continuation of those arrangements. All the evidence in this case points to the current placement being manifestly harmful to Y. Within that context, the absence of an alternative cannot render what is the single option available in Y' best interests and hence lawful.

60. In circumstances where I am satisfied that the current arrangements for Y constitute a breach of his Art 5 rights, it is not necessary for me to go on to address the submission that Y' Art 3 right not to be subjected to torture or to inhuman or degrading treatment or punishment has also been breached in this case. A given situation will cease to be in a child's best interests long before that situation meets the criteria for a breach of Art 3 of the ECHR. However, I would observe that, whilst the threshold is a high one, there is considerable force in the argument that Y's current situation as described above breaches Art 3 in circumstances where treatment is inhuman or degrading for the purposes of Art 3 if, to a seriously detrimental extent, it denies the most basic needs of any human being, particularly were Y' current parlous situation allowed to persist for any longer.

61. The foregoing conclusions of course lead inexorably to a stark question. What will now happen to Y? The answer is that local authority simply *must* find him an alternative placement. Y is the subject of an interim care order and therefore a looked after child. Within this context, the local authority has a statutory duty to under Part III of the Children Act 1989 to provide accommodation for Y and to safeguard and promote his welfare whilst he is in its care. More widely, and again as made clear by Sir James Munby in in *Re X (No 3) (A Child)* [2017] EWHC 2036 at [36], Arts 2, 3 and 8 of the ECHR impose positive obligations on the State, in the form of both the local authority and the State itself. Art 2 contains a positive obligation on the State to take appropriate steps to safeguard the lives of those within its jurisdiction where the authorities know or ought to know of the existence of a real and immediate risk to life. Art 3 enshrines a positive obligation on the State to take steps to prevent treatment that is inhuman or degrading. Art 8 embodies a positive obligation on the State to adopt measures designed to secure respect for private and family life. Pursuant to s.6 of the Human Rights Act 1998, and within the foregoing context, it is unlawful for a public authority to act in a way which is incompatible with a Convention right.

62. Within this context, the court has discharged its duty, applying the principles the law requires of it, to give its considered answer on the two questions that fall for determination on the local authority application. That answer is that it is not in Y' best interests to authorise his continued deprivation of liberty on a paediatric ward. The court having discharged its duty, the obligation now falls on other arms of the State to take the steps required consequent upon the courts' decision, having regard to mandatory duties imposed on the State by statute and by the international treaties to which the State is a contracting party.

CONCLUSION

63. For the reasons set out in my judgment, I decline to authorise the continued deprivation of liberty of Y on the paediatric ward at [the named hospital]. Given the conditions in which Y is currently deprived of his liberty, which I am satisfied breach Art 5 of the ECHR, it is simply not possible to conclude that the restrictions that are the subject of the local authority's application are in his best interests, even where there is no alternative currently available for Y.

64. Judgments given by a court should be sober and measured. Superlatives should be avoided. It is likewise prudent that a judge carefully police a judgment for the presence of adjectives. However, and as the hearing proved, in this case it is simply not possible to convey the appropriate sense of alarm without recourse to such language. In this case, having observed that in his thirty years at the Bar he had never been in a position of having to ask a court to authorise a regime for a child "as shameful as this one is", Mr Martin conceded on behalf of the local authority that, boiled down to its essence, his submission was simply that the court must today prefer the lesser of two acknowledged evils, the hospital ward or the street, in circumstances where there is currently no alternative placement. But that is not a solution that can be countenanced in a civilised society. The test laid down by the law is not which is the lesser of two evils but what is in the child's best interests having regard to the child's welfare as the paramount consideration. The *parens patriae* inherent jurisdiction of the court is *protective* in nature. As I have observed above, it would border on the obscene to use a protective jurisdiction to continue Y' current bleak and dangerous situation simply because those with responsibility for making proper provision for vulnerable children in this jurisdiction have failed to discharge that responsibility.

65. Once again, the difficulty in this case is that a child requires urgent assessment and therapeutic treatment for acute behavioural and emotional issues arising from past abuse within a restrictive clinical environment but no such placement is available. Once again, these difficulties are further exacerbated by the problems that arise when seeking to distinguish between psychiatric illness and the psychological impact of trauma for the purposes of the application of the domestic mental health legislation.

66. In *Bensaid v United Kingdom* (2001) 33 EHRR 205, in comments endorsed in the House of Lords by Lord Bingham in *R(Razgar) v Secretary of State for the Home Department* [2004] 2 AC 368, the ECtHR observed as follows:

> "Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world…The preservation of mental stability is in that context an indispensable precondition to the enjoyment of the right to respect for private life."

67. Art 39 of the United Nations Convention on the Rights of the Child provides as follows:

> "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflict. Such recovery and

> reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child"

68. Within this context, Art 25 of the UNCRC requires States Parties to recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health to a periodic review of treatment provided, Art 17 of the UNCRC requires States Parties to ensure the child has access to information aimed at the promotion of his or her physical and mental health and Art 27(1) articulates the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. Also of note in this context, Art 12 (1) of the Covenant of Economic, Social and Cultural Rights (to which the United Kingdom is also a party) enshrines a right of everyone (including children) to the enjoyment of the highest attainable standard of physical and mental health.

69. The United Kingdom is a signatory to the UNCRC and the House of Lords and the Supreme Court have repeatedly stated that our domestic law must be interpreted and applied in a manner consistent with our international obligations as articulated by the UNCRC (see *Al Adsani v United Kingdom* (2001) 12 BHRC 88 at 103, *Dyer (Procurator Fiscal, Linlithgow) v Watson; JK v HM Advocate* [2004] 1 AC 379 and *Smith v Secretary of State for Work and Pensions* [2006] 1 WLR 2024 at [78]).

70. It must be acknowledged within the foregoing context that, as made clear in *Botta v Italy* (1998) 26 EHRR 241, in considering the application of Art 8 a fair balance must struck between the general interest and the interests of the individual and the State has, in any event, a margin of appreciation. Within this context, and historically, the courts have stopped short of holding that there is an *obligation* under Art 8 to provide treatment at any specific level (see for example *Tysiac v Poland* (2007) 45 EHRR 947 and *R (A) v West Middlesex University Hospital NHS Trust* [2008] EWHC 855 (Admin)). The domestic courts have likewise been reluctant to interfere with the decision by a health authority in respect of the allocation of a limited budget, even where a child's life expectancy is in issue (see *R v Cambridgeshire District Health Authority ex p B* [1995] 2 All ER 129).

71. However, the foregoing provisions of the ECHR and the UNCRC, and the case law arising out of those provisions, once again highlight the obligations on the State to make proper provision for the physical and psychological recovery and social reintegration of children who have suffered neglect, exploitation, or abuse.

72. Two further matters call for comment. Whilst the focus of this court is, and has to be, on the welfare of Y, it cannot be ignored that the situation that has arisen in this case by reason of an acute lack of appropriate resources for vulnerable children in Y' situation has impacted severely on many other children and families. In this case the absence of appropriate resources has resulted in many other children being denied planned surgery, being diverted to hospitals further from home at a time of illness and anxiety and in disruption to the paediatric care arrangements for an entire *region* of the United Kingdom. Within this context, the adverse impact of the lack of appropriate provision that the courts have to wrestle with week in and week out in cases of this nature is now also impacting on the health and welfare of children and families who have no involvement with the court system.

73. Finally, I wish to make clear that nothing that I have said in this judgment constitutes a criticism of the doctors, nurses, social workers, police and other professionals who have been required to engage with Y. They have, I am satisfied on the evidence before the court, tried to do their best in a situation in which they should never have been placed. All those involved have done their level best in a situation that has bordered on the unmanageable. In so far as fault falls to be apportioned, it must settle on those who have not made the provision required to address the needs of highly vulnerable children such as Y.

74. It is, once again, my intention to direct that a copy of this judgment is provided to the Children's Commissioner for England; to Lord Wolfson of Tredegar QC, Parliamentary Under Secretary of State for Justice; to the Rt Hon Gavin Williamson CBE MP, Secretary of State for Education; to Josh MacAllister, Chair of the Review of Children's Social Care; to Vicky Ford MP, Minister for Children; to Isabelle Trowler, the Chief Social Worker; and to Ofsted.

75. That is my judgment.