Refusals of deprivations of liberty authorisations for children

1. In many reported judgments considering the deprivation of liberty of children, courts have been at pains to set out the extreme scarcity of placements for children with high levels of need, and in many cases, the court's own considerable reluctance to authorise detentions in settings which fall far below what would be optimal for the child's care.[1]

2. However, only in relatively few reported cases has the Family Division actually refused to grant the authorisations sought. We consider four cases (one of which included two judgments):

[1] See, e.g., MacDonald J in *Lancashire CC v G (Unavailability of Secure Accommodation)* [2020] EWHC 2828 at [61]:

> *In particular, the shortage of appropriate resources increases the risk that the decisions regarding the welfare of children will be driven primarily by expediency, with the welfare principle relegated to a poor second place. Within the context of secure accommodation, the local authority and the court must each consider whether the proposed placement would safeguard and promote the child's welfare (see Re B (Secure Accommodation Order) [2019] EWCA Civ 2025). When considering whether to grant an order authorising the deprivation of a child's liberty the court must treat the child's best interests as its paramount consideration. Where a local authority or a court is placed in a position of having to approve a placement because it is the only option available it is obvious that these cardinal principles will be at risk of being undermined. Yet this is the situation that local authorities and courts are forced to grapple with everyday up and down the country by the continuing shortage of appropriate resources and as highlighted repeatedly in the authorities that I have referred to above and more widely by the Children's Commissioner for England.*

See also *Tameside MBC v L (Unavailability of Regulated Therapeutic Placement)* [2021] EWHC 1814 (Fam*)* at [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.*

a. *Wigan BC v Y (Refusal to Authorise Deprivation of Liberty)* [2021] EWHC 1982 (Fam) (MacDonald J); (*'Wigan')*
b. *A County Council v A Mother & Others* [2021] EWHC 3303 (Fam) (Holman J); *('A County Council'*)
c. *Nottinghamshire County Council v LH, PT and LT* [2021] EWHC 2584 (Fam); *Nottinghamshire v LH, PT and LT (No. 2)* [2021] EWHC 2593 (Fam) (Poole J); ('*Nottinghamshire'*)
d. *An NHS Trust v ST (Refusal of Deprivation of Liberty Order)* [2022] EWHC 719 (Fam) (MacDonald J) (*'ST'*)

3. This paper considers recent reported cases in which courts have refused to authorise deprivations of liberty for children and young people. The annex includes details of the cases above including:
    a. The age of the child;
    b. The detention setting;
    c. The child's background;
    d. Consideration of the use of the Mental Health Act;
    e. Conditions of detention:
    f. Alternative options; and
    g. The court's reasons for refusing the deprivation of liberty authorisation.

4. From these cases, we would note several common themes:
    a. Age: In the four reported cases we consider, the children have been quite young (two aged 12, two aged 14). The young ages of the children have been emphasised in the judgments, and we would consider that the courts may apply a higher level of scrutiny for very young children in highly restrictive settings.
    b. Detention setting: All the cases we consider have involved children who have been detained in hospitals, which the child entered in a crisis after a breakdown of the child's situation in the community. We are not aware of any reported cases in which a deprivation of liberty authorisation was refused for a child in a community placement (though many judgments have granted only short periods of authorisation for sub-optimal community arrangements, ordering further evidence ahead of consideration of any renewal). In each of

the above cases, the children were medically fit for discharge, and the detaining hospital was clear that the child should be discharged as soon as possible as the hospital were unable to care for the child. Three out of four cases we considered involved acute hospitals, and one was a psychiatric hospital. In refusing the authorisation, the courts considered both the institutional nature of the hospital setting and the lack of connection between the hospital and the purpose of the child's detention were relevant to the inappropriateness of the child's detention.

c. Child background: The children had a range of mental health diagnoses, but three of the four had experienced trauma for which they appear to have received little or no formal therapy or input from mental health services in the community. In the fourth case, the child had moderate learning disability and autism, associated with severely challenging behaviours and did have some prior involvement with CAMHS in the community. In three of the four cases, the children had been living with their parents prior to detention in hospital. In each case, there had been a lead-up of at least several months to the crisis in which the child's behaviour had been the cause of considerable concern. In each case, immediately prior to admission to hospital, the children had been engaging in very severe self-harming behaviour and aggression towards others, leading to very high levels of restraint being used. These severe self-harming behaviours continued after their admissions to hospital, again with high levels of physical and chemical restraint being deployed.

d. Mental Health Act: In all the cases, consideration had been given to the use of the Mental Health Act 1983, and the children were found not to meet the criteria for admission. In all cases, CAMHS had recommended that the children needed stable 24-hour care in the community. However, it also appears that there was limited involvement with the children in the community (with only one child appearing to have an ongoing relationship with CAMHS arising out of her moderate learning disability and autism).It is also not suggested on the face of the judgments that community mental health services

were predicted to play an major role with the children following their discharge.[2]

e. Conditions of detention: Even by the standards of cases of this nature, the facts in these cases were very extreme and often shocking. In all cases, the situations had arisen as a result of a crisis in which the child had been brought to hospital. In three out of the four cases, this was because the child had come to harm and a medical review was sought, and the child was considered unable to return to where they had been living. In all cases, the child had needed no more than limited medical treatment, and the purpose of their stay in hospital

[2] The interaction between cases of this nature and the Mental Health Act was explored in some length in the case of *Blackpool Borough Council v Ht (A Minor by her Children's Guardian), CT, LT, Lancashire and South Cumbria NHS Foundation Trust* [2022] EWHC 1480 (Fam). In the matter, the process for assessment for admission to a Tier 4 CAMHS inpatient bed and the role of the High Court is summarised at paragraphs [43-44]:

> *43. It is plain on a proper analysis of the mental health legislation and guidance that, even where an application for admission for assessment is certified by two qualified medical professionals as meeting the criteria under s.2 of the Mental Health Act 1983, the provision of the Tier 4 CAMHS bed remains subject to the outcome of a referral that complies with the National Referral and Access Process, which includes the completion of an Access Assessment undertaken by reference to the criteria contained in the service specification for the Tier 4 CAMHS Service.*
>
> *44. With respect to the role of the court where the Access Assessment has concluded that an admission to a Tier 4 CAMHS Service is not appropriate notwithstanding the certification of an assessment application by two qualified medical professionals, that role is necessarily limited. The court will not ordinarily entertain a claim for judicial review in respect of a decision not to allocate medical resources to a particular case, here the relevant decision being not to admit a child or young person to a Tier 4 CAMHS bed following an Access Assessment (see R v Central Birmingham Health Authority ex parte Collier, Unreported, 6 January 1988 and R v Cambridge Health Authority ex parte B [1995] 1 WLR 898). The court may, and in cases such as this one often does, join NHS England (and sometimes the relevant Clinical Commissioning Group) where the circumstances are such that the court may wish to invite reconsideration by the NHS Trust of the decision not to make Tier 4 inpatient provision for the subject child. By way of example, this step was taken by Sir James Munby in Re X [2017] EWHC 2036 (Fam). Alternatively, the court may consider directing a direct a single joint expert qualified in Tier 4 CAMHS to provide a second opinion, albeit that the efficacy of this approach is likely to be limited by the fact that upon receipt of the report the court's powers to give effect to an expert recommendation contrary to the position taken by NHS England are limited for the reasons I have already described.*

had quickly come to an end. In all cases, the hospitals were extremely clear that they were unable to care for or offer any therapeutic support for the child and staff involvement was directed at containing the child and stopping harm in the immediate present. It was considered across the cases that the child's stay in hospital was actively harmful to the child and resulting in a worsening of their presentations. The children were all in very distressed conditions, with all frequently attempting serious self-harm or attempts to harm others. All were subject to very high levels of physical restraint, with chemical restraint being very common. In most of the cases, it is also described that their presence on the ward had caused other children in need of medical attention to have to be moved elsewhere or turned away prior to admission.

f. Alternative options: Notably, in two of the four cases, at least one immediately alternative option was identified for the child in a return to the child's family home. However, they were dismissed by the courts as being flatly unacceptable even in the context in which the child's situation in hospital was quite dire.

g. Reasons for refusing the deprivation of liberty authorisation: In each case, the central reason for refusing the deprivation of liberty was that the courts considered that despite the lack of viable alternatives, they could not conclude that the detention was in the child's 'best interests' as the conditions of the child's detention were so poor:

    i. In some cases, the detentions were described as 'brutal' and 'abusive,' and there is a strong implication that the court would have found Article 3 to be violated if it had reached the question.

    ii. The courts emphasised the lack of connection between the services provided by the hospital and the nature of the child's detention. It was strongly emphasised that the hospitals were not designed or prepared to provide care for these children, and arrangements were fundamentally ad hoc.

    iii. As a result, there were very few or no safeguards which would be available in settings which were equipped to offer containment and restraint (such as secure psychiatric hospitals, which would have detailed frameworks for physical and chemical restraint and seclusion).

iv. In the two judgments by MacDonald J, he also expressed concerns that if the risk of restraint going further than terms of the deprivation of liberty if authorisation were granted.

5. Despite the refusals to authorise the deprivations of liberty, in no case did the courts actually order that the child be discharged from hospital or that the arrangements for the child's care should change. In one case, Holman J emphasised that his decision did not oblige the hospital to discharge the child, and considered that the law of necessity might offer a defence:

> *I do not have a solution to this case. Clearly, it is the duty of the local authority to whose care this child was entrusted over seven years ago to keep her safe. Provided they act in good faith and do the very best they can, the lawfulness of what they do may be justifiable by a doctrine of necessity. I make crystal clear, as I have done many times during the course of this hearing, that I am not in any way whatsoever indicating to the hospital trust that it MUST now discharge this child, still less ordering it to do so. It must make its own decisions. If it does decide to keep her longer, then it also may be able to justify such a decision by a doctrine of necessity. But I am sorry to say that, at the end of this long day, I am simply not willing myself to apply a rubber stamp and to give a bogus veneer of lawfulness to a situation which everybody in the court room knows perfectly well is not justifiable and is not lawful.*[3]

6. We would consider that arising of these cases are some key questions which have yet to be fully resolved by courts:
    a. Does some option always have to be in a person's 'best interests'?
    b. Can detention in the sole available option breach Article 5 without breaching Article 3 or Article 8?
    c. What should hospitals do when asked to admit a child in crisis who they consider will be harmed in their care, and/or where they know there is no discharge option?

7. We would consider that several cases are instructive here:
    a. *North Yorkshire v MAG* [2016] EWCOP 5: In this case, Cobb J considered an appeal of a decision to refuse to authorise a community deprivation of liberty

[3] *A County Council v A Mother & Others* [2021] EWHC 3303 (Fam) at [37].

in relation to an adult. Concerns had been raised that MAG's home was profoundly unsuitable for his physical needs. The placement was so small that he could not use his wheelchair indoors, leading to his only be able to mobilise by crawling on the floor. This was causing him to have painful bursitis in his knees, and his registered learning disability nurse considered that living there was causing him physical and emotional harm. His care regime had only become less restrictive following the receipt of independent expert evidence in the COP proceedings, and the court expressed profound frustration that the statutory bodies had done little or nothing to rectify a plainly inappropriate situation which had persisted for years. District Judge Glentworth refused to make an order authorising MAG's deprivation of liberty, stating *'Refusing the authorisation sought means that NYCC must take the steps necessary to ensure that there is no breach.'* This decision was reversed on appeal to Cobb J, who considered that the court ought to have broken its decision-making down as follows [24]:

> *i) Whether it is in MAG's best interests to live at the property, noting that although he is deprived of his liberty, there is no alternative available which offers a lesser degree of restriction;*
> *ii) Whether the accommodation provided to MAG was so unsuitable as to be unlawfully so provided, breaching MAG's rights under the ECHR (notably Article 5).*

The court found that in the absence of alternatives, it was in MAG's best interests to live in the property, despite its obvious shortcomings. In refusing to authorise the deprivation of liberty, the court had looked beyond the available options, and *'placed wholly unjustified pressure on NYCC as a public authority.'* [47] The court found that the evidence did not 'come close to proving' a breach of Article 5 under these circumstances, noting that the court had recognised some positive aspects of the placement. [25] However, it is notable that the court based this decision on a finding that *'Article 5 is concerned with the reason for the detention, not the conditions of it,'* [43(i)], a conclusion which has been called into question by *Rooman*.

b. *Rooman v Belgium* [2019] ECHR 105: The ECtHR made explicit that the conditions of detention are relevant to the lawfulness of detention:

> *208. Analysis of the Court's case-law, particularly as developed over the past fifteen years, shows clearly that it should now be considered that there exists a close link between the "lawfulness" of the detention of persons suffering from mental disorders and the appropriateness of the treatment provided for their mental condition. While this requirement was not yet set out in the first judgments delivered in this area (see Winterwerp , § 51, and Ashingdane , §§ 47 and 48, cited above), from which it appeared that the therapeutic function of compulsory confinement was not as such guaranteed under Article 5, the current case-law clearly indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release (see paragraphs 199 and 201 above).*

Does some option always have to be in a person's 'best interest'?

8. In all of the cases, the courts made statements to the effect that they could not describe the arrangements as being in the child's 'best interests'. However, we would consider that on a close reading, the courts were actually making a finding which was more in line with the conceptual framework proposed by Cobb J in the *MAG* case: in any circumstance, there must be some scenario that is the best of those available, but that 'best' scenario may be so unsuitable as to breach Article 5.

9. This is demonstrated in the reported cases in which the child could have returned to the family home, but no orders were made to return the children there because it was apparent that the consequences would have resulted in even more harm the child was experiencing in hospital. In cases where no alternative option was available, the courts similarly made no orders directing the child's removal from hospital or stressed that the hospital might be protected under the doctrine of necessity for housing the child in the absence of any other option, even in the absence of a deprivation of liberty authorisation.

10. To this end, we consider Cobb J's framework in *MAG* is instructive, and describes what happened in these cases: the courts have found that the best available option for the child was to remain in situ, but concluded that the detention was so unsuitable as to breach Article 5.

Can detention in the sole available option breach Article 5 without breaching Article 3 or Article 8?

11. While this question has not yet been reached by the courts, we would consider that the threshold applied in these Article 5 cases appears to be very close to an Article 3 standard. We would note that in each case considered, the courts were clear in concluding that the detentions were actively harmful to the children. The descriptions of the conditions of detention found that they were:
    a. *'an inappropriate, demeaning and, quite frankly, brutal one for a 12 year old child'* (*Wigan)*;
    b. *'a placement that is entirely unsuited to that task, has resulted in a situation that is a brutal and abusive one for ST.' (ST)*
    c. *'her continuing detention in this hospital and the restrictions that they are having to impose upon her are not only "not in her best interests" but are positively "damaging for her and her future".'* (*A County Council)*
    d. *' "harmful to her wellbeing" for LT to remain on the unit. He says that he is "very concerned that prolonged admission in an acute mental health setting will have a detrimental effect on LT and every hour she spends on the unit is harmful to her."'* (*LT)*

12. The court touched on, but did not reach, the question of whether the detention in the *Wigan* case breached Article 3:

> *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.*

13. While there have been no authorities specifically on point in the context of deprivations of liberty of children, we would consider that in practice, when determining whether placements are so unsuitable as to breach Article 5, the courts are applying a standard which is very much akin to an Article 3 standard.

14. In respect of Article 8, standalone breaches of unconnected with breaches of statutory duties are uncommon[4] and in cases where courts have considered duties owed to people whose sole recourse to state support was on a human rights basis, courts have typically found that Article 8 does not add to the analysis under Article 3. Unlike Article 3, Article 8 is a qualified right, and the court is more likely to take a holistic approach which considers the efforts which have been made to secure provision. However, we would note that the Court of Appeal in *Anufrijeva* [2004] QB 1124, para 43 found that this consideration may vary as to whether a child or adult was involved (particularly if failure of provision prevents a child from engaging in family life), and this area may require further consideration:

> *"We find it hard to conceive, however, of a situation in which the predicament of an individual will be such that article 8 requires him to be provided with welfare support, where his predicament is not sufficiently severe to engage article 3. Article 8 may more readily be engaged where a family unit is involved. Where the welfare of children is at stake, article 8 may require the provision of welfare support in a manner which enables family life to continue ..."*

Should hospitals agree to admit in a crisis?

15. Finally, we would sound a note of caution for Trusts from the case of *An NHS Trust v ST (Refusal of Deprivation of Liberty Order)* [2022] EWHC 719 (Fam). In this matter,

[4] This proposition was tested in the matter of *R(Idolo) v London Borough of Bromley* [2020] EWHC 860 (Admin). In that matter, the claimant argued that his Article 8 rights had been breached despite the lack of a breach of a statutory duty to him, and sought damages. Mr Idolo had been essentially confined to his bedroom for nearly two years as a result of his housing situation, as he was a wheelchair user and the doorways and corridors of his home were too narrow to allow him to leave a single room. Despite finding his situation 'indisputably grim' and 'his well-being was in a thoroughly poor state,' the court found that his Article 8 rights had not been breached. The court went on to find that absent a breach of a statutory duty, there would need to be a demonstration of at least a lack of respect for the person's rights, or culpability by the public body for an Article 8 breach to be shown.

the child, ST, had been involved with CAMHS in the community. ST's parents were having very serious problems caring for her, and on at least one occasion, had presented at the hospital with her in a crisis. Her community CAMHS consultant psychiatrist had given clear advice that she should not be admitted to hospital as a place of safety (in the absence of medical need), because it was an inappropriate setting for her and would be detrimental to her. However, ST's parents subsequently presented again in crisis and refused to take her home, and the hospital did admit her to provide a place of safety.

16. MacDonald J offered pointed criticism of the NHS Trust for agreeing to admit her in the first place, seeking a detailed explanation of why it had chosen to do so against the advice of CAMHS:

> *35. The Trust itself rightly concedes that ST's needs are not being met on the ward. Within the context of ST's particular and acute needs arising out of her Autistic Spectrum Disorder and her learning disability they were never going to be. Her current placement is a general paediatric ward. It is not equipped to manage the behaviours exhibited by ST and was never designed to do so. It is not equipped to provide ST with the support she requires nor with the privacy she is entitled to whilst being cared for.*
> *36. Within this context, in due course I will require a detailed explanation from the Trust and the local authority as to why the advice of CAMHS given on 21 January 2022, that that ST should not be admitted to hospital unless there was a medical need as 'there is clear risk of harm to her and others if she is admitted and this is not an appropriate place of safety in a crisis', was not followed. In light of ST's diagnosed Autistic Spectrum Disorder and learning disability, that advice was self-evidently correct and redundant of argument. It does not take expert evidence for the court to understand the adverse impact of the current regime, with its uncertainty, its concentration on physical contact and its location in a loud and unfamiliar environment, on a child who is autistic and learning disabled. What this must be like for ST is hard to contemplate. Within this context, the failure of Trust and / or the local authority to follow the advice of CAMHS requires an explanation with a greater level of detail than Ms Leeming has been in a position to provide the court with today.*

17. Statutory bodies must consider whether they are appropriately situated to offer a place of safety, even where a crisis has emerged. This will be a fact-specific determination in every case, and the hospital will need to consider its duties broadly, including its Article 2 and 3 ECHR duties if the child is at serious risk. Trusts may even seek to seek declarations of the lawfulness of non-admission in the future.

18. In determining what to do in the case of a child who has already been admitted, we would consider that the case of *University College London Hospitals NHS Foundation Trust v MB (Rev 1)* [2020] EWHC 882 (QB) (09 April 2020) is of interest. This case, decided at the start of the first wave of the pandemic, considered an application by the hospital for possession of the room of a patient, MB, who had refused to leave after having been medically fit for discharge for approximately eight months. MB was residing at the National Hospital for Neurology and Neurosurgery, on a ward with only 12 beds. The court made findings of fact that MB's needs could be met with a community care package which was available to her in the community. MB opposed the order for possession on Article 3, 8 and 14 ECHR grounds, arguing that she would suffer 'extreme distress' if she were discharged from hospital. The court accepted that she would suffer this distress, and further concluded on the evidence that the risk of her attempting suicide or self-harm were moderate to low. On the Article 3 issue, the court concluded that while MB was likely to suffer 'extreme distress' if she were forced to leave the hospital, *'if the Hospital were precluded from doing anything which might precipitate such distress, it would soon end up in a situation where it was legally precluded from taking any step other than in accordance with MB's wishes.'* [54] MB's wishes were not determinative of the hospital's obligations under Article 3. The court further concluded that Article 3 would not be breached where a hospital refused to treat a patient on the basis that it could not provide care to all who required it and other patients would 'derive greater clinical benefit' from that care. [55] The court found this principle held even if the refusal to provide treatment resulted in suffering for the patient who was refused treatment:

> *This is because in-patient care is a scarce resource and, as Auld LJ put it in R v North West Lancashire Health Authority ex p. A [2000] 1 WLR 977, at 996, '[i]t is plain… that article 3 was not designed for circumstances… where the challenge is as to a health authority's allocation of finite funds between competing demands'. Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and, in making it, it is necessary to consider the needs of more than one person.*

19. In this case, there was no direct comparison between MB's needs and those of another identified person. However, *'the decision to withdraw permission for MB to remain in*

the Hospital is still a decision about the allocation of scarce public resources…The absence of evidence identifying a specific patient or patients who will be disadvantaged if MB remains where she is does not mean that such patients do not exist.' [56] The court emphasised that a decision had already been taken that MB would not be provided with further in-patient care. Mr Justice Chamberlain noted that the *'where the decision to discontinue in-patient care involves the allocation of scarce public resources, the positive duty can only be to take reasonable steps to avoid such suffering: cf R (Pretty) v Director of Public Prosecutions [2002] 1 AC 800, [13]-[15] (Lord Bingham). It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by deciding, on the basis of an informed clinical assessment and against the background of a desperate need for beds, to discontinue in-patient care in an individual case and, accordingly, to require the patient to leave the hospital. The present is certainly not one.'* [57] The court found that in any event, the evidence did not demonstrate that MB's discharge would lead her to experience *'suffering rising to the level of severity required to engage Article 3 ECHR,'* particularly where she would be in receipt of 24-hour care package on her discharge.

20. In support of its ratio, the court in *MB* looked to two cases, *Pretty v DPP* and *R v North West Lancashire Health Authority*, both of which present different and more complicated pictures of what is required by Article 3. The judgment cites *Pretty v DPP* for the proposition that the Article 3 positive duty requires only that a state take 'reasonable steps' to prevent suffering of a level to engage Article 3. The cited paragraph of the judgment relates to the Secretary of State's submissions, and states, *inter alia*:

> *The negative prohibition in the article is absolute and unqualified but the positive obligations which flow from it are not absolute: see Osman v United Kingdom, above; Rees v United Kingdom (1986) 9 EHRR 56…states…may not take direct action in relation to an individual which would inevitably involve the inflicting of proscribed treatment upon him (D v United Kingdom (1997) 24 EHRR 423).*

21. The House of Lords judgment in *Pretty* was appealed to the European Court of Human Rights in Pretty v UK. The Strasbourg court found that:

a. The 'treatment' prohibited by Article 3 refers to *'"ill-treatment" that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering… The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible.'*
b. Looking primarily to *D v United Kingdom*, the Strasbourg court considered that a state's responsibility may be engaged by removing a person who was very unwell to a place where 'no effective medical or palliative treatment' was available.
c. In the *Pretty* cases, neither the House of Lords nor the Strasbourg Court made a finding that only 'reasonable efforts' to avoid suffering rising to the level required to breach Article 3 were necessary.

22. The *MB* judgment also cites *R v North West Lancashire Health Authority* in support of the proposition that Article 3 is *'not designed for circumstances…where the challenge is as to a health authority's allocation of finite funds between competing demands.' North West Lancashire* related to a challenge to a policy decision by the health authority not to offer sex reassignment surgery *'in the absence of overriding clinical need'*. While the above statement is included within the ratio, the key finding made by the Court of Appeal was that the suffering which the claimants argued that they experience if denied the surgery clearly would not meet the threshold to engage Article 3.

23. The threshold for the suffering required to engage Article 3 is high, but where such suffering arises, the obligations of the state to prevent it are less flexible than is suggested in *MB*. Considering *D v United Kingdom*:

> *49. The Court must reserve to itself sufficient flexibility to address the application of that Article in other contexts which might arise. It is not therefore prevented from scrutinising an applicant's claim under Article 3 where the source of the risk of proscribed treatment in the receiving country stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of that country, or which, taken alone, do not in themselves infringe the standards of that Article. To limit the*

application of Article 3 in this manner would be to undermine the absolute character of its protection.

16. We would thus consider the conclusions in *MB* should be treated with some caution.

Annex

Wigan BC v Y (Refusal to Authorise Deprivation of Liberty) [2021] EWHC 1982 (Fam) (MacDonald J):

a. Age: 12.
b. Detention setting: Acute hospital.
c. Child's background: '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.' [1] Y appears to have been the victim of significant abuse and neglect by his family, and had been attempting suicide and engaging in self-harming behaviours in the months leading up to the application. He was taken into care in the weeks prior to the application, and had made a very serious suicide attempt shortly thereafter. After the suicide attempt, he was taken to an acute hospital. The local authority sent staff to care for him in hospital (and in particular, to provide restraint as required), but the hospital raised concerns about both the attendance and qualifications of the staff. He continued to attempt to engage in severe self-harming behaviour during his time in hospital.
d. Mental Health Act?: Y was assessed as not being eligible for detention under the Mental Health Act; CAMHS considered that Y's presentation was due to 'distress, change and adjustment' and he did not have a mental illness. CAMHS recommended that '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.' [16] A further assessment led to another conclusion that Y was not detainable under the Mental Health Act and his presentation was 'trauma-based.'
e. Conditions of detention: Y was medically fit for discharge from shortly after the beginning of his stay in hospital; he was receiving no treatment relating to his presentation as '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.' [2] Y was placed on a clinical ward under extremely high levels of restraint. '[H]e 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's 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.' [3] Y was repeatedly handcuffed and restrained on a mattress on the floor. There was consistent chemical restraint, and police were frequently involved; at one time, fifteen officers were in attendance. The court presented the facts starkly at [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.

f. Alternative options: A two-bedroom property had been located to set up a bespoke placement for Y, but no staff was available and thus Y could not yet move there. The other option was to return to the care of Y's father, but '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.' [32]

g. Reasons for refusing the deprivation of liberty authorisation:

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…

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…

52…In circumstances where the hospital ward is the only "placement" available for Y,…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…

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…

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….

59. …I cannot in good conscience conclude that the restrictions in respect of which the local authority seeks authorisation from the court are in Y's best interests, having regard to Y's 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's 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.

A County Council v A Mother & Others [2021] EWHC 3303 (Fam) (Holman J):

a. Age: 14.5
b. Detention setting: Acute hospital.
c. Child's background: Child had been in care from the age of six. Approximately 8 months prior to the judgment, the child's long-standing foster care placement broke down, after which she spent three months further with the adult child of the foster carers before this situation also broke down. She then moved to a residential children's home, where she engaged in considerable self-harming behaviour. 'This included banging her head against a wall, running away, stating that she wished to die, and damaging property. In September 2021 she self-harmed again and was admitted to hospital. During that admission, the residential home in which she had been living gave notice that they would not have her back. She remained in hospital for some time until a second residential home was identified for her in south London, a quite considerable distance from the area of the local authority in which she had previously lived. During her period in hospital the child had been assessed as being on the autistic spectrum and this particular residential home is experienced in caring for such children. She moved there during September 2021. Initially she appeared to be reasonably settled, but in early November 2021 there was a marked deterioration in her behaviour. That may or may not have been triggered by her mother making contact with her for the first time in several years. At all events, she resorted again to head banging, cutting her limbs, much verbal and physical aggression, damage to the property, and attempts to abscond. In the period between 5 and 8 November 2021 she was admitted three times to hospital under forms of police restraint. I have been

told that on one occasion while she was in hospital, no less than seven police officers were required to restrain her. The second residential home has now refused to have her back.' [4-5]

d. Mental Health Act?: The child was assessed by CAMHS one month prior to the judgment. She was given a formal diagnosis of 'Emotional dysregulation secondary to developmental traumas and attachment/abandonment issues on a background of autistic spectrum disorder, moderate learning difficulties, and probable attention deficit hyperactivity disorder.' [6] She was prescribed a sedating drugs in hospital 'including risperidone, promethazine, and lorazepam. Dr HM records that on examination the child was fidgety, and her conversation was limited and very rigid and concrete. There was no evidence of any new major mental disorder. She did not appear to be depressed. She talked about wanting to die, but did not indicate any actual plans to kill herself, although she is an impulsive person. She was not psychotic. She was oriented in time, place, and person, but showed no insight. Dr HM records that she:"...is not Gillick competent to consent to treatment plans, including medication."' CAMHS summarised its findings as:

> *"...is a 14-year-old presenting with distress following review in new placement and contact with parents. She has attachment/abandonment issues upon a background of neurodevelopmental conditions of ASD and LD - she also shows signs of ADHD - and her presentation should be seen in this context rather than the onset of a new acute mental disorder. Her current location in A&E is not particularly therapeutic and there is no indication she requires admission to a general adolescent unit. With her current profile, this would increase her risk and be another placement..."* [9]

CAMHS recommended 'that the child should return to the residential home in which she had been living in south London with three to one observation 24 hours a day.' [11]

e. Conditions of Detention: The child had been medically fit for discharge since shortly after her admission. 'She has, on occasions, absconded from the hospital and been taken back by police, and on at least one occasion handcuffs were required to be used. While in the hospital she has frequently locked herself in the bathroom, lain on the floor, and banged her head. She has broken her bedroom window and attempted to harm herself with a piece of broken glass. She has frequently been sedated with some of the oral medication to which I have referred, and also olanzapine.' [12] The child was living on a paediatric ward with children with a variety of serious health conditions. Evidence from the hospital was that the child was aggressive to others and visibly self-harming on the ward, to the 'serious detriment' of herself, the other patients and staff. The child had repeatedly absconded, with as many of seven police officers required to bring her back. There were incidents in which she was punching glass panels and head-banging on the ward; ligaturing; and biting staff. These incidents led to physical and chemical restraint being used. The child's behaviour was very distressing to the children and families on the ward (including to multiple oncology patients who wished to leave the hospital out of fear, and a child receiving palliative care who was distressed by

the situation on the ward). The hospital submitted that the conditions of her detention were 'not only "not in her best interests" but are positively "damaging for her and her future".' [29] The hospital stated that it would discharge her if the deprivation of liberty authorisation was not renewed; it reluctantly agreed to keep the child for two more days if the order was extended.

f. Alternative options: Secure accommodation had been sought, but none was available. The local authority provided 'a schedule in which numerous organisations and establishments are referred to…in summary,…no provider has been willing or able to offer a placement for a range of reasons. These include that they are unable to meet the child's needs within their establishments, and/or that placing her alongside the children currently in the respective home is likely to break down existing placements, and/or that she needs "a solo residential home", and/or that they have no educational facilities attached to their homes, and/or, most generally, that she has special needs which they are unable to meet within their facilities, or simply that they have no vacancies.' [18]

g. Reasons for refusing deprivation of liberty authorisation:

32. This child has now already been in that hospital for eleven days. The local authority have been well aware for many, many weeks now that they have a very troubled child on their hands who is going to need a very high level of care and supervision. They obtained the order from me last Friday night. They have had another four and a half days to come up with some alternative plans. I broke off at about 12 noon today to give them yet further time to see what proposals they could come up with. I was told at 2.00 p.m. and again at 3.00 p.m. that they still do not have any establishment in which they can place her. I was told in the most vague and general of terms that the local authority feel that they may be forced to, and may be able to, rent some accommodation somewhere within their county and may, in due course, be able to employ and supply three trained workers to care for her. However, all this lacked any specificity or detail whatsoever. I have absolutely no information (nor, indeed, do the local authority) of the address, or facilities of any proposed rented accommodation. I have absolutely no names of any proposed carers, nor their qualifications or experience. However, the local authority plead with me to make some sort of DOLS type order to give a veneer of legality to what they seek and propose.

33. In my view, there has to be some limit to these repeated applications to this court for DOLS type orders…

36. … I have been told that "there is no other option available" but I am also clearly told, most clearly through the evidence of [the hospital], that the situation in which this child is currently being held not only "is not in her best interests" but is positively "damaging for her and her future."

37. I do not have a solution to this case. Clearly, it is the duty of the local authority to whose care this child was entrusted over seven years ago to keep her safe. Provided they act in good faith and do the very best they

can, the lawfulness of what they do may be justifiable by a doctrine of necessity. I make crystal clear, as I have done many times during the course of this hearing, that I am not in any way whatsoever indicating to the hospital trust that it MUST now discharge this child, still less ordering it to do so. It must make its own decisions. If it does decide to keep her longer, then it also may be able to justify such a decision by a doctrine of necessity. But I am sorry to say that, at the end of this long day, I am simply not willing myself to apply a rubber stamp and to give a bogus veneer of lawfulness to a situation which everybody in the court room knows perfectly well is not justifiable and is not lawful.

Nottinghamshire County Council v LH, PT and LT [2021] EWHC 2584 (Fam); *Nottinghamshire v LH, PT and LT (No. 2)* and [2021] EWHC 2593 (Fam) (Poole J):

a. Age: 12.
b. Detention setting: Psychiatric inpatient unit.
c. Child's background: LT had diagnoses of Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder; she was also described as 'extremely anxious' and suffering from panic attacks. She was also considered likely to have 'attachment issues' and to be showing symptoms of trauma. LT's mother had historically made reports of struggling to care for care for LT and her sister, and had been struggling with her own mental health. LT's mother had reported to the local authority that she was feeling suicidal due to LT's behaviour and violence towards family members. The court summarised at paragraphs [6]-[8]: 'From June 2021 problems within the home, and the challenging nature of LT's behaviour, escalated alarmingly. There were numerous reports of LT being violent in the home, absconding, running out in front of traffic, and requiring restraint by police officers due to her aggression. On 15 August 2021, despite two support workers being present in the family home to assist, LT managed to jump from her upstairs bedroom window. LT's mother made repeated requests for LT to be accommodated by the local authority as she was unable to cope with her at home. On 7 September 2021, the mother's partner, H, reportedly strangled LT. K told police that she saw LT's eyes roll backwards and she was frothing at the mouth. He was subsequently arrested and is on police bail with a condition excluding him from the family home. He has a history of alcohol abuse and is currently in a psychiatric unit as a voluntary patient having expressed suicidal thoughts. On 14 September, LT was alleged to have assaulted her sister, K. When police were called, LT absconded, ran into traffic and attacked the arresting officers. It took six police officers to restrain LT over a period of two hours. In the police car LT began trying to ligature herself with the seatbelts.
d. Mental Health Act?: LT was detained under s.136 Mental Health Act after the incident above. She was taken to a place of safety at "A Hospital":

    8. …On assessment it was considered that LT was not suitable for detention under the MHA 1983. A is an adult hospital. No alternative bed could be found and so, late on 15 September 2021, LT was admitted to the unit for acute adolescent psychiatric admissions at B Hospital, where she remains.

9. *LT has been diagnosed with Autistic Spectrum Disorder (ASD) and more recently Attention Deficit Hyperactivity Disorder (ADHD). Alongside this she is extremely anxious and has frequent panic attacks. Attachment difficulties are also evident given her disruptive upbringing and the relational difficulties she has experienced. Dr N advises the court that LT might now also be exhibiting trauma symptoms. In the opinion of the clinicians who have seen LT, Dr N advises, she is "not detainable [under the Mental Health Act 1983] on the grounds that she is still not suffering from a mental illness of a nature or degree which makes it appropriate for her to receive treatment within a hospital setting." She does not have a psychiatric condition. Dr N advises that her degree of distress is due to her social circumstances and her presentation "must be viewed in the context of serious safeguarding concerns within the family home, exacerbated by parental difficulty in maintaining safety." LT needs a therapeutic placement.*

e. Conditions of detention: LT's admission was unplanned and unsupported "by any clinical evidence that it was either necessary or appropriate from a treatment perspective.'[1] LT was being staffed by three support workers provided by the local authority and was surrounded by adolescents with acute psychiatric conditions. LT's presence was said to be distressing to the other patients on the ward and to be 'triggering' them, and the unit had to operate at less than full capacity due to the resources being diverted to LT's care (resulting in psychiatric inpatient care being unavailable to adolescents who needed and would benefit from such care). Since her admission approximately eight days prior to the judgment, LT had attempted to ligature at least ten times, with restraint then being used to remove these. LT had been aggressive towards staff, and drugs were being used to sedate her. Being on the ward was 'having a detrimental effect on LT's mental health and she is rapidly learning maladaptive coping mechanism.' [1] It was considered that LT's condition would not improve on the ward, and would 'result in a long-term negative impact on her behaviour. There is a high risk of her becoming not only institutionalised but also becoming one of many sad revolving door cases.' [1]
f. Alternative options: The local authority had no alternative option for her residence save to return to her family; the risks in doing so were 'grave' as her mother was unable to keep her safe.
g. Reasons for refusing the deprivation of liberty authorisation:

14. *As I have indicated, the court is not being asked to direct where LT should be accommodated, but to authorise and thereby render lawful, the deprivation of her liberty at the psychiatric unit. By Art 5(1) of the ECHR no-one shall be deprived of his liberty save in circumstances described by Art 5 and in accordance with a procedure prescribed by law. The inherent jurisdiction has been described as the "ultimate safety net". Lady Arden said in Re T (above) at [192]:*

> *"The inherent jurisdiction plays an essential role in meeting the need as a matter of public policy for children to be properly safeguarded. As this case demonstrates, it provides an important*

means of securing children's interests when other solutions are not available."

In many cases the High Court does exercise the inherent jurisdiction to authorise the deprivation of a child's liberty in unregistered placements, which the courts are ill-suited to monitoring, on the grounds that there is no other available solution. In the present case, however, the proposed continued accommodation of LT in a psychiatric unit cannot possibly be described as a means of properly safeguarding her. Depriving her liberty in that setting would not provide her with a safety net - it would not keep her safe or protect her. To the contrary every hour she is deprived of her liberty on this unit is harmful to her. Her accommodation on the unit has exposed her to new risks of harm and will continue to do so. I cannot find that it would be in LT's best interests to be deprived of her liberty on the psychiatric unit.

15. If the inherent jurisdiction is a means of meeting the need as a matter of public policy for children to be properly safeguarded then, in my judgment, it is also appropriate to take into account the adverse impact of continued authorisation on the other vulnerable children and young people on the unit.

16. The existing authorisation continues until 4pm today. No plan has been made in the event that I do not extend that authorisation even though I asked the local authority to address that eventuality at the last hearing. Despite the uncertainty and discomfort that my decision will cause, I am not prepared to authorise the continued deprivation of LT's liberty on the psychiatric unit beyond the time previously authorised. Any further applications should be reserved to me.

17. Naturally, the court is acutely concerned for LT and what will happen to her now. It is deeply uncomfortable to refuse authorisation and to contemplate future uncertainties. However, LT is a looked after child and the local authority must find her an alternative placement - it has a statutory duty to provide accommodation for her and to safeguard and promote her welfare whilst in its care, under Part III of the Children Act 1989. The state has obligations under Arts 2, 3 and 8 of the European Convention on Human Rights (see Sir James Munby in Re X (No. 3) (A child) [2017] EWHC 2036 at [36]). I do not doubt that the local authority has striven to find alternative accommodation but that the national shortage of resources has led to the current position. Nevertheless, authorisation of the deprivation of LT's liberty in a psychiatric unit which is harmful to her and contrary to her best interests would only serve to protect the local authority from acting unlawfully, it would not protect this highly vulnerable child.

h. Post script: In its second reported judgment, the court subsequently granted a short authorisation of LT's deprivation of liberty in a bespoke placement, though continued to decline to authorise her detention in hospital.

An NHS Trust v ST (Refusal of Deprivation of Liberty Order) [2022] EWHC 719 (Fam)

a. Age: 14.

b. Detention setting: Acute hospital, general paediatric ward.
c. Child's background: The child, ST, had Autistic Spectrum Disorder, a moderate learning disability and challenging behaviours. She was not considered to be *Gillick* competent in relation to issues regarding her care and treatment. Prior to her admission to hospital, ST had been living with her parents and siblings in the family home. Her parents had struggled to manage her escalating behaviours and physical violence in the context of emotional dysregulation over months, with her siblings locking themselves in their bedrooms for safety and ST's mother's mental health being significantly impacted. ST was supported on a 6:1 basis while in school. ST had repeatedly attempted to abscond, and had on one occasion been found in a stranger's house hiding in the bed. ST lacked road awareness and was vulnerable in the community. Prior to the hospital admission, ST's family had taken her to hospital on at least one prior occasion; her community CAMHS psychiatrist had advised against her admission to hospital as it was not an appropriate place of safety in a crisis. However, she was admitted to hospital after her family again took her to hospital and refused to take her home. This occurred after the family had become so fearful of her behaviour they had resorted to locking her in the dining room. It was not clear that the family was receiving any help from the local authority at this time, and the judgment notes the family's distress at leaving her at the hospital.
d. Mental Health Act?: ST had involvement with the CAMHS team prior to her admission to hospital and had been prescribed risperidone to assist with her behaviours.
e. Conditions of detention: ST was admitted to hospital as a place of safety and had no need for treatment. The local authority had commissioned a team of two carers and two security guards to supervise ST on a 4:1 basis; there had been a high turnover in the staff supervising her on this basis. ST was frequently waking up to find unfamiliar adults supervising her, which appeared to scare her and adversely impact on her behaviour. ST was prevented from leaving the ward, which had a locked door. The lock had been removed from ST's ensuite door and she was supervised in the toilet. She had increased levels of risperidone to manage her behaviours, and physical and oral chemical restraint were used. ST had had a number of 'incidents' in which she had been restrained by multiple people and given chemical sedation.
f. Alternative options: The local authority sought to apply for a care order on the day of the hearing (which was granted); alternative options had been mooted, but each would be subject to further assessment by the placements.
g. Reasons for refusing the deprivation of liberty authorisation:

> *32. I have decided that I cannot, in all good conscience, conclude that it is in ST's best interests to authorise the deprivation of her liberty constituted by the regime that is being applied to her on the hospital ward. I cannot, in good conscience, conclude that it is in the best interest of a 14 year old child with a diagnosis of Autistic Spectrum Disorder and moderate learning disability to be subject to a regime that includes regular physical restraint by multiple adults, the identity of whom changes from day to day under a rolling commercial contract. I cannot, in all good conscience, conclude that it is in ST's best interests for the distress and fear consequent upon her current regime to be played out in view of members*

of the public, doctors, nurses and others. I cannot, in good conscience, conclude that it is in ST's best interests to be subject to a regime whose only benefit is to provide her with a place to be, beyond which none of her considerable and complex needs are being met to any extent and which is, moreover, positively harmful to her. My reasons for so deciding are as follows.

33. Whilst I accept that the placement options that have now been mooted by Manchester City Council will not be immediately available, I am satisfied that the current circumstances are so antithetic to ST's best interests that it would be manifestly wrong to grant the relief sought. This conclusion is further reinforced by the fact that such placement options that have been mentioned will not be available for some weeks in any event.

34. I stated during the course of the hearing that the combination of ST's needs and the attempts of the Trust, in good faith, to meet those needs in a placement that is entirely unsuited to that task, has resulted in a situation that is a brutal and abusive one for ST. I do not resile from that statement. Within this context, I am satisfied that not even the necessity of keeping ST safe in circumstances where no alternative placement is available can justify such authorisation, because it simply cannot be said on the evidence before the court that the placement she is in currently is keeping her safe….

37. Further, and as I noted in Wigan BC v Y (Refusal to Authorise Deprivation of Liberty), the fact that the hospital ward is a wholly inappropriate venue for the deprivation of ST's liberty forces medical staff to step outside the normal safeguards that are put in place in that environment. ST is being prescribed tranquilising medicine orally for the purposes of chemical restraint. The hospital takes the view that without this chemical sedation ST's behaviour would now be unmanageable. Whilst it is said that this tranquilising medication is being administered in accordance with internal guidance provided by the relevant internal medication protocol, I remain to be convinced that this is an appropriate course of action without authorisation of the court in circumstances where the purpose of the medication is plainly one of restraint, and hence, arguably, the deprivation of ST's liberty. I likewise remain to be convinced that this is not the position simply because the regime of chemical restraint has been in place for only a short period following a deterioration in ST's behaviour.

38. Finally, beyond the hospital ward providing ST with a place to be accommodated, the evidence before the court identifies not a single positive for her flowing from her present circumstances. There is no evidence that her behaviour is being improved by the current regime, no evidence that her educational needs are being appropriately met and no evidence as that there an exit plan being worked towards to minimise the period of time ST must be subjected to this regime. Within this context, once again, I cannot see how the court can possibly conclude that the authorisation sought by the Trust can, in any sense, be said to be in ST's best interests.

39. *Having regard to the matters I have set out above, the only possible reasoned conclusion the court can reach on the evidence is that it is manifestly not in ST's best interests to authorise her deprivation of liberty on the paediatric ward. In the circumstances, no party seeks seriously to dispute that her current situation constitutes a breach of her rights under Art 5 of the ECHR. As I have observed in other cases, judgments given by a court should be sober and measured. Superlatives should be avoided and it is prudent that a judge carefully police a judgment for the presence of adjectives. However, in the circumstances of this case, I am satisfied that it is not an exaggeration to say that to grant the relief sought by the Trust in this case would be to grossly pervert the application of best interests principle…*

A post script to the judgment states: *'Over the course of the weekend following the hearing, the local authority identified a bespoke, short-term placement for ST and has now applied itself for a declaration authorising ST's deprivation of liberty in that placement. The Local Authority continues to search for a residential educational placement for ST.'*