Neutral Citation Number: [2022] EWHC 1480 (Fam)

Case No: PR21C00199

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/06/2022

Before:

THE HONOURABLE MR JUSTICE MACDONALD

- -

Between:

Blackpool Borough Council	**Applicant**
- and -	
HT	**First**
(A Minor by her Children's Guardian)	**Respondent**
-and-	**Second**
CT	**Respondent**
-and-	**Third**
LT	**Respondent**
-and-	
Lancashire and South Cumbria NHS Foundation Trust	**Intervener**

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Ms Jacqueline Wall (instructed by **Blackpool Borough Council**) for the **Applicant**
Miss Bentley (instructed by **RRF Solicitors**) for the **First Respondent**
The Second and Third Respondents appeared in Person
Ms Victoria Butler-Cole QC (instructed by Hill Dickinson) for the Intervener

Hearing dates: 11 May 2022

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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:

INTRODUCTION

1. In this matter I am concerned with the welfare of HT, born in 2005 and is now aged 17. HT is represented through her Children's Guardian by Ms Bentley of counsel. At present, HT is the subject of a deprivation of liberty safeguards order made following an application issued by Blackpool Borough Council, represented by Ms Jacqueline Wall of counsel. HT is also the subject of an interim care order made on 23 June 2021. She is currently placed in a placement that is not registered with Ofsted. HT is represented through her Children's Guardian, Ms Poplawski. HT's mother is CT and her father is LT. They appear before the court in person.

2. For reasons that will become apparent Lancashire and South Cumbria NHS Foundation Trust intervenes in these proceedings. The Trust is represented by Ms Victoria Butler-Cole of Queen's Counsel.

BACKGROUND

3. The background to this matter will be depressingly familiar to those who are involved with proceedings concerning the deprivation of a child's liberty.

4. Upon HT and her family moving from West Yorkshire to Lancashire in 2019, her behaviour significantly deteriorated. In May 2019 the assessing psychiatrist recommended that a Tier 4 CAMHS PICU bed was obtained for HT. However, the Access Assessment assessed HT as not requiring Tier 4 in-patient provision at that time.

5. Within this context, HT thereafter accrued a significant criminal record. This resulted from a number of offences in the community, including robbery, possession of an offensive weapon and common assault. Following her arrest for these offences, HT was placed on remand at a Secure Children Children's Home. On 30 April 2020 HT was made subject of a 12 month referral order and a 24 month detention and training order and was placed at the same Secure Children's Home.

6. HT was discharged from her detention and training order to a community placement in Yorkshire on 29 April 2021. That placement broke down on 3 May 2021. Later in May 2021 HT was detained pursuant to s.2 of the Mental Health Act 1983 in a side room on an adult mental health ward. The assessments completed at the time noted that HT assaulted multiple healthcare professionals and that detention in hospital had a detrimental effect on HT. It was considered that there were no grounds to convert the s.2 detention to a s.3 detention and HT was discharged to the care of her parents after attempts to identify a community placement were unsuccessful.

7. On 9 June 2021 HT attempted to strangle herself. On 11 June 2021, HT ingested 490 antihistamine tablets taken from her mother's bedside cabinet, requiring her to be placed in an induced coma and required intubation and sedation for the management of seizures. She was again detained under s.2 of the Mental Health Act 1983. On 16 June 2021, the decision was taken to admit HT to an adult PICU bed in circumstances where there were no Tier 4 CAMHS PICU beds available nationally and HT's risk to others would not be properly contained on a general adolescent ward. The local

authority issued care proceedings in respect of HT on 22 June 2021. HT was given a deferred discharge at a Mental Health Tribunal held on 25 June 2021.

8. HT was discharged from detention under s.2 of the Mental Health Act 1983 on 29 June 2021. She was thereafter placed by the local authority in an unregistered placement run by a private company called G whilst a search for a registered placement continued. That search, which has encompassed the entire country and has included secure accommodation provision, has proved fruitless and continues to do so.

9. The Children's Guardian has expressed a number of reservations regarding the placement at G, including HT becoming aware (after she stole the phone of a member of staff) of messages passing between staff referring to her as "a wild animal". There have also been questions over the level of supervision in fact being undertaken in respect of HT in circumstances where she has been able to access within her placement knives and screwdrivers with which to self-harm, has gained access to medication and has sent inappropriate messages to her family. Both parents complain that they are not kept up to date with respect to HT's welfare by G, notwithstanding that they retain parental responsibility for HT. The local authority is likewise concerned that it is not always being notified of significant events, or that there is a delay in doing so. Whilst the placement has repeatedly intimated that it is in the process of applying for registration with Ofsted, there has been difficulty in establishing the precise stage reached with respect to that application.

10. During the course of her current placement HT has had a number of episodes of going missing from the placement. She also started a fire in the bathroom at the placement, leading to her arrest for arson in July 2021. HT has now pleaded guilty to the offence of arson and the matter has been adjourned for the preparation of a Youth Offending Report. Her sentencing hearing is on 6 June 2022. HT has also made allegations against a family member of sexual abuse. Lead did not wish to cooperate with a police investigation in respect of those allegations.

11. More recently, on 28 January 2022 HT had to be talked down from a motorway bridge after becoming distressed and taking an excessive amount of paracetamol. Unfortunately, when the police attended HT was threatened by police with being tasered and told that she was wasting police time. The court has requested a statement from the Chief Constable of Lancashire setting out an explanation for the approach taken by the police towards a clearly distressed and suicidal 16 year old young person. The Chief Constable of Lancashire maintains that the conduct of the police during the course of the incident on 28 January 2022 was entirely appropriate. A formal complaint has been lodged by the local authority with the Lancashire Constabulary. In the circumstances, I comment no further on the matter at this stage. Following a mental health assessment undertaken pursuant to s.136 of the Mental Health Act 1983 on 28 January 2022, HT was discharged back to her placement with G.

12. Further difficulties arose in March of this year. On 16 March 2022 HT voiced suicidal thoughts to staff and intimated that she would make a further attempt on her own life. She attended the Emergency Department with members of staff from the placement. Within this context, on 17 March 2022, two medical practitioners and an AMHP completed an application for assessment under s.2 of the Mental Health Act 1983 on the basis that they considered that the s.2 criteria for admission were made

out. However, the Access Assessment thereafter completed by the unit responsible for Tier 4 CAMHS provision indicated that admission was not merited, that Access Assessment recording as follows:

> "Given that carers are willing to take HT home, and keep supporting her in the community and there is scope to increase input from MH services, alongside a short course of medication to relieve agitation and distress that HT is currently displaying, this would provide a less restrictive option than hospital admission."

13. The contended for justification for this decision was set out in further detail in the Access Assessment. In particular, it was considered that (a) the risk behaviours displayed by HT during assessment were to be supported by the care home and were a common presentation for HT, which the care home have been effectively managing, (b) HT had not presented a high risk of self-harm since 28 January 2022 when she had to be talked down from a motorway bridge, (c) HT's difficulties were of long standing with little role for assessment in hospital, (d) there was no inpatient treatment identified that could be given to HT, (e) the only potential benefit of admission to Tier 4 PICU was risk mitigation, and (f) during her previous two Tier 4 PICU admissions HT's risk had escalated significantly, so admission would not decrease the risk. Within this context, the statement of Dr Paramel contends that:

> "…clinically speaking, there was at no point a supportive gatekeeping assessment and all Adolescent Psychiatric Intensive Units would be extremely reluctant to support a young person under their care if the Gatekeeping Assessment does not support an admission. The reasons for this are likely to include:
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> i. Admission to hospital needs to be a last resort, where no other options are available. This is in line with the Guiding principles, in particular the principle of 'Least restrictive option and maximising independence' which states: "Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained' (para 1.2). Where there is an identified alternative community option, as was the case here, admission would be contrary to this principle.
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> ii. Admission to Hospital needs to have a clear purpose. Again this is in line with the Guiding principles, in particular the principle of 'Purpose and effectiveness' which states: "Care plans for detained patients should focus on maximising recovery and ending detention as soon as possible" When considered together this indicates a requirement to clearly identify a need to be in Hospital for an identified purpose of assessment and/or treatment which cannot be delivered in the community. Here there was no clear role for Hospital based assessment or treatment identified following the gatekeeping assessment, which identified that HT's clinical presentation was consistent and unchanged so as to warrant further assessment and the interventions required could not only be provided in the community, but it would be of benefit to HT to remain in with her current care team, having regard to her difficulties building therapeutic trusting relationships central to effective care and support.

> iii. Without any identified purpose for Hospital based assessment or treatment, HT would likely quickly have been identified as not meeting the criteria for detention under the MHA and being discharged. This would only have had the effect of disrupting HT's care and support provision without achieving any positive outcome for HT.
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> iv. Concerns related to increasing incidents of young people being detained on Sections of the Mental Health Act, when in crisis, which is quickly resolved however, CYP's finding themselves being stuck in hospital as delayed discharge secondary to a lack of appropriate discharge provision in the community. This having a damaging effect on those CYP by being accommodated in an inappropriate environment unnecessarily and exposed to commonly referred to 'side effects of admission' due to being accommodated in an environment with CYP with significant and enduring mental illnesses."

14. Within this context, the unit responsible for Tier 4 CAMHS provision offered community based support under Tier 1 by way of a visit from the Community Mental Health Team on the morning of 18 March 2022. That visit did not materialise due, it is said, to a miscommunication. HT was upset that no input from the CMHT was forthcoming and Dr Paramel acknowledges in his statement that one of the triggers for HT's distress is when things that have been promised do not materialise. The statement of the Network Medical Director, Dr Prashant Kukkadapu, likewise acknowledges the breakdown in communication and that this resulted in HT feeling increased levels of distress.

15. On 18 March 2022, HT's behaviour again escalated. She attempted to ligature herself, cut herself and attempted to swallow razor blades. On the morning of 19 March 2022, following two attendances by HT at the Emergency Department, the AMHP again concluded that an application for assessment pursuant to s.2 of the Mental Health Act 1983 was required. However, no Tier 4 beds were available. On 21 March 2022, following a multiagency meeting, the results of the Access Assessment were reiterated, with a conclusion that HT's presentation did not merit admission to CAMHS Tier 4 inpatient provision. Whilst the local authority considered HT's presentation to be psychotic, the unit responsible for Tier 4 CAMHS provision considered it was more suggestive of a trauma based response. The proposed course of action was for HT to return to her placement with support from the Community Mental Health Team. On 22, 23 and 24 March 2022 the Access Assessment team made attempts to call HT to agree a time to attend the property on all of these occasions HT made threats to assault and kill Access Team staff if they attended her property.

16. On 8 April 2022 a Complex Case Forum was held to consider HT's case. At that meeting it was recorded that a crisis plan was being developed along side a "hospital passport", which plan would be shared with children's services, the acute hospital LAC team, the GP and the police so as to ensure a consistent approach is taken to supporting HT when in crisis. On 14 April 2022, HT was physically aggressive during an outpatient appointment. On 21 April 2022 HT was discharged from CMHT in circumstances where HT had refused to engage with that service. With respect to the way forward, the statement of the Network Medical Director records as follows:

> "49. I have reflected on the community support provided to HT in relation to the Trust's wider obligations. The Teams have worked collaboratively to try and support HT to engage with the Community Services. HT has been offered a variety of different options to enable her to engage with this, from different professionals and services. There was a break in communication following the Mental Health Act Assessment on 17 March for which we apologise. This was rectified the same day and contact made. There were a number of MDT meetings arranged to ensure all services were involved including HT's care team. Communication arranged to keep HT involved identifying the best placed person, even as this changed. The Consultant Psychiatrist for Darwen CMHT, Dr Adelekan, was not involved actively in the MDT meeting however there was medical representation at the MDT meting to support the decision making process. As can be seen from the chronology above, the Trust has arranged and implemented a range of support services for HT since mid-March 2022 when the decision was made not to detain her under the MHA.
>
> 50. The CMHT consider that HT would benefit in the future from psychological therapy, looking initially at skills work through DBT and then reviewing to identify other possibilities. However HT is currently not able to engage in psychological therapy and she does not want to. She has presented with emotional lability, self harming behaviour, aggression and repeat attendances, and the support that has been offered is designed to help achieve a phase of stability, so that she can be in the best possible place to then access and engage with further and more long term support from CMHT. HT's care team within her placement and her Social workers are already supporting her in relation to this and will continue to do so."

17. On 6 May 2022 G gave notice on HT's placement. However, to date the placement has not acted on that notice and HT remains accommodated pending an alternative placement being located. As I have noted, the local authority acknowledges that there are concerns with respect to some aspects of the current placement. To date however, there have been 67 placement searches undertaken by the local authority but no offers of an alternative placement have resulted. The local authority has also completed a referral for a Secure Unit and that referral went live on 10 May 2022. To date, there have been no responses. In the circumstances, the local authority seeks an extension to the current DOLS order authorising the restrictions amounting to deprivation of liberty that are placed on HT in her current placement.

THE LAW

18. Applications for declarations authorising the deprivation of liberty of a child often come before this court in the context of a dispute (either apparent or real) between the applicant local authority and the relevant NHS Clinical Commissioning Group and NHS England as to whether the subject child should be provided by NHS England with a CAMHS Tier 4 inpatient bed, or be provided with a placement and services by the local authority pursuant to its under the Children Act 1989, with the deprivation of the child's liberty being authorised under the inherent jurisdiction of the High Court. That is the position that has presented itself in this case.

19. It is important to note at the outset that this should *not* be the position in this case, or indeed other similar cases. The courts have *repeatedly* emphasised the need for the State agencies engaged in cases of this nature to work co-operatively to achieve the best outcome for the child or young person. Within the context of the question of whether a child or young person should be provided with a placement by the local authority or with Tier 4 CAMHS provision, it is vital that local authorities, Clinical Commissioning Groups (which are responsible for commissioning CAMHS services for children and young people requiring care in Tier 1, Tier 2 or Tier 3) and NHS England (which is responsible for commissioning Tier 4 CAMHS services) recognise the emphasis that is placed by the courts and in the guidance on co-operation between State agencies. In the context of Tier 4 CAMHS services, the Service Specification for Tier 4 CAMHS services notes at paragraph 2.1.5 that:

> "Tier 4 Commissioners will liaise with CCGs and Local Authorities (LA) to ensure that there are no gaps in the pathway. Many young people requiring Tier 4 interventions also have significant social care and/or educational needs and these are best met through robust collaboration between agencies."

20. However, when the court is faced with a disagreement between the applicant local authority and the relevant NHS Clinical Commissioning Group or NHS England as to whether the subject child should be provided with a CAMHS Tier 4 placement or provided with services respectively, or a placement by the local authority, it is important to be clear as to the respective obligations on each of those State agencies. In this regard, with respect to the relevant obligations under the mental health legislation and guidance, the court in particular has the benefit of a clear and detailed Skeleton Argument from Ms Butler-Cole QC setting out the framework provided by the relevant provisions of the Mental Health Act 1983 and associated guidance.

21. Dealing first with the position of the local authority, the legal framework governing the local authority where it contends that a declaration authorising the deprivation of a child's liberty is required is well established.

22. Section 22(3) of the Children Act 1989 places on local authorities a duty to safeguard and promote the welfare of any child looked after by the local authority including, pursuant to s.22(3A) of the 1989 Act, a duty to promote the child's educational achievement. Within this context, s. 22A of the Children Act 1989 places a duty on the local authority to provide a looked after child with accommodation. Pursuant to s. 22G of the Children Act 1989, local authorities are subject to an overarching duty to ensure sufficient accommodation is available to accommodate children with different needs (the "sufficiency duty"). In addition, pursuant to s. 53 of the 1989 Act, local authorities are under a duty to make arrangements to secure that "community homes" are available for the care and accommodation of children looked after by them and for connected purposes. Section 22C of the Children Act 1989 provides for the ways in which a local authority may discharge its duty to provide accommodation, including placement in a children's home.

23. Within this context, in an appropriate case the court may grant a declaration under its inherent jurisdiction authorising the deprivation of the liberty of a child in a children's home registered with Ofsted pursuant to the provisions of the Care Standards Act 2000 (and, in conditions of imperative necessity, even if not yet registered) or in an

unregulated placement, i.e. a placement not subject to the regulatory regime requiring registration. Such a declaration may be made if the court is satisfied that the circumstances that will pertain for the child in the placement in question constitute a deprivation of liberty for the purposes of Art 5 of the ECHR and if it considers such an order to be in the subject child's best interests.

24. With respect to the question of whether the arrangements in the placement amount to a deprivation of liberty for the purposes of Art 5, in *Storck v Germany* (2006) 43 EHRR 6 the European Court of Human Rights established three broad elements comprising 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. Only where all three components are present is there a deprivation of liberty which engages Art 5 of the ECHR. 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.

25. Whilst the foregoing two stage legal test applicable to the making of a declaration authorising the deprivation of a child's liberty is easy to state in a few short paragraphs, the circumstances in which that test falls to be applied are, as is now well known, often notoriously difficult. As I noted in *Lancashire CC v G (Unavailability of Secure Accommodation)* [2020] EWHC 2828 the following difficulty arises in respect of the best interests test in the context of cases of the type currently before the court:

> "[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."

26. The shortage of appropriate resources goes beyond a *general* lack of placements and extends to the *type* of placement provision required. In particular, as I noted with respect to the subject young person in the case of Wigan Metropolitan Borough Council v W and others [2022] 1 FLR 1226:

> "[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 (the 1983 Act) 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."

27. The consequences of this position mean that the apparently straightforward task of applying the foregoing legal principles to the facts by answering the two questions to be determined by the court can be one of the most difficult undertaken by judges of the High Court. It also means that, in circumstances where the behaviour of the subject child can often *suggest* the existence of a mental health condition, tensions can and do arise between local authorities, Clinical Commissioning Groups and NHS England as to which of those agencies is responsible for making the appropriate placement provision of the subject child or young person. Within that context, I turn next to the provisions of the Mental Health Act 1983 and to the legal and administrative framework governing the provision of CAMHS services by Clinical Commissioning Groups and NHS England.

28. Tier 1, 2 or 3 CAMHS services are outpatient services ranging from universal services and primary care outpatient services (Tier 1) to targeted (Tier 2) and specialist (Tier 3) outpatient CAMHS services. Tier 4 CAMHS inpatient services are defined in the NHS Service Specification for Tier 4 CAMHS as follows:

> "Tier 4 inpatient CAMHS services in England offer care at four levels to support the effective management of differing nature of risk presented by children and young people who are under 18 years:
>
> • Medium secure services accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk of harm to others including those who have committed grave crimes.
>
> • Low secure services accommodate young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Young people may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with behaviour that challenges, self-harm and vulnerability.
>
> • Psychiatric Intensive Care Units (PICU) manage short-term behavioural disturbance which cannot be contained within a Tier 4 CAMHS general adolescent service. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security.

> • General adolescent services provide inpatient care without the need for enhanced physical or procedural security measures."

29. Within this context, and as I have alluded to above, there is an administrative division between the provision of Tier 4 CAMHS services and CAMHS services under Tiers 1, 2 and 3. Pursuant to the Service Specification, NHS England commissions Tier 4 Child and Adolescent Mental Health (CAMHS) services provided by Specialist Child and Adolescent Mental Health Centres, including associated non-admitted care including crisis intervention, home treatment, step-down care and other alternatives to admission when delivered as part of a provider network. By contrast, Clinical Commissioning Groups (hereafter "CCGs") commission CAMHS services for children and young people requiring care in Tier 1, Tier 2 or Tier 3. The Mental Health Act Code states as follows at paragraph 14.78 and 14.79 with respect to this division of commissioning responsibility:

> "14.78 Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, CCGs have a duty to notify local authorities in their areas of arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18. The arrangements should include details of which providers in their area can receive patients in cases of special urgency and provide accommodation or facilities designed to be specifically suitable for patients under the age of 18. CCGs should provide a list of hospitals and their specialisms to local authorities which will help inform AMHPs as to where these hospitals are. This should in turn help inform AMHPs as to where beds are available in these circumstances if they are needed.
>
> 14.79 The NHS Commissioning Board (known as NHS England) is responsible for the commissioning of secure mental health services and other specialist services. NHS commissioners should work with providers to ensure that procedures are in place through which beds can be identified whenever required."

30. Pursuant to the Mental Health Act 1983 a child or young person may be admitted and detained for assessment pursuant to s.2 of the Act or treatment pursuant to s.3 of the Act. This case concerns admission and detention for assessment under s.2 of the Mental Health Act 1983. Under s.2(1) of the Act a person may be admitted to a hospital and detained there for a period not exceeding 28 days in pursuance of an application for admission for assessment made on the basis that, for the purposes of s.2(2), the person is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period and the person ought to be so detained in the interests of their own health or safety or with a view to the protection of other persons. The application for admission for assessment must be based on the written recommendation of two registered medical practitioners.

31. Section 1 of the 1983 Act provides as follows with respect to the definition of "mental disorder":

> "**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—
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> "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—
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> (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,
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> unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.
>
> (2B) The provisions are—
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> (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."

32. The Department of Health's *Mental Health Act 1983: Code of Practice* (TSO, 2015) published pursuant to s 118(4) of the 1983 Act provides the following further 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.

33. With respect to the assessment of a mental disorder in a child, para 19.5 of the Code of Practice further 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 …"

34. Within the foregoing context, the case-law arising from the 1983 Act 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 Dhaliwal (appeal under s 58 of the Criminal Justice Act 2003)* [2006] 2 Cr App Rep 348, at para [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 classifications 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 rely 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 the 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."

35. Section 11(2) of the Mental Health Act 1983 requires that every application for admission for assessment shall be addressed to the managers of the hospital to which admission is sought. The Mental Health Act Code further emphasises that the application must state a specific hospital. Within this context, Ms Butler-Cole points to the commentary in the Mental Health Act Manual, Jones, R. 23rd Edtn. At 1-025 suggesting that it is arguably unlawful for an AMHP to make an application to detain a patient and convey him or her to hospital where it is known that a bed will not become available at the named hospital and that it is unlawful to convey a patient to hospital on the authority or an application which does not state the name of the potential admitting hospital.

36. Within the foregoing context, it is important to note that the completion of an application for admission under s.2 of the Mental Health Act 1983 does not impose a legal obligation on the hospital to admit the patient. Rather, it requires that a bed be identified and confers authority on the hospital manager to detail the patient at the

named hospital in accordance with the provisions of the Mental Health Act 1983. That is not however, the end of the process.

37. Within the foregoing framework, whilst the admission for assessment of a child or young person can be *authorised* on the written recommendation by two medical practitioners, pursuant to the NHS Service Specification for Tier 4 CAMHS services the *acceptance* of that child or young person to a Tier 4 bed pursuant to that authorisation requires a referral that complies with the National Referral and Access Process. In particular, acceptance by a Tier 4 CAMHS Service *must* be by way of an Access Assessment. In his statement, Dr Paramel, Consultant Child and Adolescent Psychiatrist with the Trust, describes the function of the Access Assessment as follows:

> "There is a gatekeeping process ('Access Assessment') which is there to determine what type of bed (i.e. General Adolescent Unit (GAU), Psychiatric Intensive Care Unit (PICU), Low Secure Unit (LSU), Medium Secure Unit (MSU) etc) is required for the admission. The assessment also has the function of providing a necessary layer of clinical evaluation about whether admission to hospital is warranted at all, in line with the MHA Code of Practice, provided by those who work within Tier 4 CAMHS inpatient services."

And

> "The gatekeeping assessment is required by commissioners and is a safeguard (as supported by NHSE) to help prevent inappropriate / unsafe admissions and ensure that any decisions to admit children and young people (CYP) to hospital are not taken lightly, that the least restrictive principle is adhered to and the decisions are underpinned by an age appropriate assessment conducted by those with CYP experience."

38. Pursuant to the Tier 4 service specification, the Access Assessment must consider the goals of a Tier 4 admission and the risks and benefits of such an admission. The latter will include consideration of whether the child or young persons needs could be better met by alternative services, including services in the community. Thus, whilst a detention may be *authorised* by an application made by two qualified medical practitioners under the Mental Health Act 1983, it is the Access Assessment determines whether in-patient admission to a Tier 4 CAMHS service is *appropriate*. In this regard, the National Health Service England specification for Tier 4 PICU beds further provides that:

> "Prior to admission an assessment must be completed by a CAMHS Consultant Psychiatrist or Specialist Trainee (ST4-6) in Child and Adolescent Psychiatry (in consultation with a CAMHS Consultant), or a senior experienced nurse or senior psychologist in consultation with a Consultant Psychiatrist."

39. In this context, it is for the hospital identified in the application for admission for assessment that determines whether it will accept a patient based on the admission criteria for Tier 4 CAMHS Services. The acceptance criteria are defined in the Service Specification as follows:

"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."

40. Equally, the Service Specification defines the exclusion criteria for Tier 4 CAMHS Services as follows:

"Exclusion criteria

- Over 18 years of age (unless this is for a short time period to complete an episode of care and appropriate safeguards are in place).

- Young people with a moderate or severe learning disability unless considered to be in their best interests and they would be able to benefit from general adolescent Tier 4 service intervention • Young people with a primary diagnosis of substance misuse.

- Young people with a primary diagnosis of conduct disorder and no co-morbid mental disorder.

- Young people whose primary need is for accommodation due the breakdown of family or other placement.

- Young people who are in need of Tier 4 CAMHS Low Secure or Tier 4 CAMHS Medium Secure care.

- Young people who are currently in secure settings (including secure welfare placements) provided by local authorities or Youth Justice, who in the first instance would be referred to the Tier 4 CAMHS Medium Secure or a Low Secure Unit.

- Young people who are deaf where care may be more appropriately be 6 provided by the National Deaf CAMHS service.

- Young people with severe autism where it is clinically assessed that care would be more appropriately provided by a specialist unit."

DISCUSSION

41. I am on balance satisfied in this case that, notwithstanding the current concerns regarding the placement with G, that it is in HT's best interests to authorise, for a further short period, the restrictions that amount to a deprivation of her liberty within her current placement. My reasons for deciding are as follows.

42. As will be apparent from the exegesis on the law set out above, and as submitted by Ms Butler-Cole on behalf of the NHS Trust, the position set out in the social work evidence in respect of this case does not describe the position *entirely* accurately:

> "As outlined within the chronology, a multi-agency meeting was held on the 21 March 2022 and the challenges were discussed in relation to the situation at that time. Two doctors and an AMPH (*sic*) advised that HT required hospital admission, however gatekeeping within Tier 4 CAMHS (The Cove) did not agree. The legality is that if an AMPH (*sic*) determines this then action should be taken to find a bed however gate keeping say it is their policy that they follow their own assessment and their assessment is that she does not require admission, this is an ongoing challenge found within the service."

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.

45. Having regard to the statements of evidence provided by the NHS Trust, and in particular to the cogent reasons set out therein as to why detention for assessment

under the provisions of the Mental Health Act 1983 would not benefit HT at this point, I am satisfied that there are no grounds in this case for the court to invite the NHS Trust to revisit its Access Assessment in respect of HT and, at this hearing, the local authority no longer presses for the court to do so. The instruction of a Child and Adolescent Psychiatrist is no longer pursued in circumstances where HT has made plain she will not co-operate with such an assessment. Within this context, the question before the court is whether a further DOLS order should be made in respect of the restrictions in place at HT's current placement with G by reference to the well established principles set out above.

46. I am satisfied that the continued restrictions proposed by the local authority amount to a deprivation of HT's liberty for the purposes of Art 5 of the ECHR. The restrictions are detailed in the statement of the social worker. Those restrictions include being prevented from leaving the placement by the use of physical restraint and 3:1 supervision by staff 24 hours per day, including supervision by waking watch and 3:1 supervision outside the accommodation building. It is plain that HT does not consent to the deprivation of her liberty, that she is subject to continuous supervision and control and that she is not free to leave.

47. With respect to the question of whether such restrictions are in HT's best interests, at the present time there is no other placement that has yet been identified for HT. Within this context, in *Tameside Metropolitan Borough Council v C and Others* [2021] EWHC 1814 (Fam) I held as follows with respect to the relevance of the absence of an alternative placement to the best interests evaluation to the court:

> "[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)* [2021] EWHC 244 (Fam) 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."

48. Within the foregoing context, I am of course conscious of the reservations expressed by the local authority, the parents and the Children's Guardian regarding the current placement. Having regard to HT's needs, I acknowledge that the evidence before the court demonstrates that the placement is struggling currently to meet those needs, as is conceded by the local authority. Against this, and having regard to her current

presentation and the risks thereby evidenced, I am satisfied that it would not be in HT's best interests for the current restrictions amounting to a deprivation of her liberty to be relaxed. The assessed risk, which risk includes the possibility that HT will seek to takes steps to end her own life, remains too high.

49. There will be cases in which the absence of an alternative placement for a child cannot justify the continuation of a current placement because the current placement is causing harm to the subject child (as was the case in *Wigan Metropolitan Borough Council v W and Others*). In this case however, whilst HT's current placement is sub-optimal, it is at least keeping her safe in the broadest sense of the word. In addition, the placement has been notified to Ofsted and efforts do continue to seek registration of the placement for the purposes of the Care Standards Act 2000. Further, HT is the subject of review on a multidisciplinary basis with a further multi-disciplinary meeting due to take place with respect to HT on 13 May 2022. Within this context, whilst there is an urgent need to identify a placement that can meet fully HT's complex needs, I am satisfied that it is in HT's best interests to grant a further *short* extension to the current DOLS order whilst further efforts are undertaken to identify such a placement. I am satisfied that such an order is both necessary and proportionate having regard to the aim it that is sought to be achieved, namely preventing HT in the interim from causing harm to herself or others.

CONCLUSION

50. For the reasons I have given, I will extend the current DOLS order until midnight on 20 May 2022. In addition to brining the matter back before the court on 20 May 2022 in order to review the progress on locating a placement better able to meet HT's highly complex needs, I shall direct that the local authority file and serve an updating statement detailing the outcome of its continuing placement search and the progress towards registration of the current placement with G. I will also direct that the local authority files and serves the Minutes of the multi-agency meeting that is due to take place on 13 May 2022.

51. This matter represents another example, amongst many examples, of a case in which the acute lack of appropriate resources, for children assessed as not meeting the relevant criteria for detention under ss 2 or 3 of the Mental Health Act 1983 (the 1983 Act) but requiring therapeutic care within a restrictive environment for acute behavioural and emotional issues arising from past trauma, creates tension between a local authorities and the NHS. As a result, the matter comes before the court with the local authority asserting that the NHS should be making provision for the child and the NHS arguing that the child does not meet the criteria for such provision.

52. As I have stated, there is within this context a need for agencies to work co-operatively in order to ensure that the correct provision for the subject child is achieved. In particular, this case highlights the need for local authorities to bear in mind that the process of obtaining a Tier 4 CAMHS inpatient bed is *not* simply dependent on the views of two qualified medical practitioners, but is also subject to an Access Assessment, at which stage Tier 4 CAMHS provision may be deemed inappropriate, notwithstanding that the application for assessment has been certified those medical practitioners. For the reasons that I have set out above, the scope for the court to intercede in respect of such a decision is extremely limited. Within this context, it is important that professionals working with the subject child have a clear

and comprehensive understanding of the operational procedures of other agencies involved with that child.

53. That is my judgment.