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Case No: FD24C40475

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/05/2024

Before :

MRS JUSTICE LIEVEN

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Re MK: Deprivation of Liberty and Tier 4 Beds

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Ms Katie Gollop KC (instructed by **Hill Dickinson**) for **Warrington and Halton Hospitals NHS Foundation Trust** (the Applicant)
Ms Janice Wills (instructed by **Warrington Borough Council**) for **Warrington Borough Council** (the First Respondent)
Ms DK, the Second Respondent, **represented herself**
Ms Annie Leaker (of **Paul Crowley Solicitors**) for **MK** (the Third Respondent)
Ms Arianna Kelly (instructed by **Hill Dickinson**) for **Cheshire and Wirral Partnership NHS Foundation Trust** (the Fourth Respondent) **and NHS England**

Hearing dates: **23-24 May 2024**

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Approved Judgment

This is a transcript of an ex tempore judgment

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MRS JUSTICE LIEVEN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Lieven DBE :

1. This is yet another judgment concerning the lack of provision, and the inappropriate provision, of accommodation for deeply troubled young people under the age of 18 years, and an application for a deprivation of liberty safeguards ("DOLS") order in a totally unsuitable placement. I would like to note at the outset that the decrease in judgments in such cases is a function of the existence of the National DOLS list, there are fewer cases going to full-time High Court Judges, and is not a function of there being fewer cases or fewer troubled children.

2. This case raises starkly the issue of the State's obligation to protect life under Art 2 European Convention on Human Rights ("ECHR"). It first came before me out of hours in an application made by what, in colloquial terms, is the general NHS Trust responsible for an acute hospital ("the hospital"). The application was made out of hours. Only Warrington and Halton Hospitals NHS Foundation Trust ("Applicant Trust") and the Fourth Respondent, Cheshire and Wirral Partnership NHS Foundation Trust, the Mental Health NHS Trust responsible for Tier 4 beds in the relevant area, including X House (a secure paediatric mental health unit), ("the Mental Health Trust") were in attendance. I granted the application for the young person, MK, to be deprived of her liberty until the following day and relisted the matter so that she could be represented, and so that the Local Authority ("LA") and NHS England could attend. I am very grateful to all parties for attending before me at short notice and providing helpful documentation.

3. Representation of the parties has been as follows. Miss Gollop KC represents the Applicant Trust. Ms Wills represents the LA. Ms Leaker, who has represented MK in the care proceedings and is probably the person who knows her best, represents MK. Miss Leaker considers MK to be *Gillick* (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7) competent and she has now separated herself from the views of her Guardian. The Guardian, Mr Hewitt, was unrepresented but spoke to me directly. Ms Kelly represents the Mental Health Trust and NHS England.

Background

4. I have largely gleaned the factual background from the statement of the safeguarding lead at the Applicant Trust. MK is a 17 and a half year old girl. She is subject to a care order and therefore a looked after child. She has a significant mental health history with difficulty regulating emotions, fluctuating mood, and suicidal ideation. She is currently an in-patient in a paediatric unit children's ward of a general hospital run by the Applicant, which is not intended to be a secure unit. The ward has 24 beds and I assume a broad range of sick children in the other beds.

5. Historically, MK has been known to Mental Health and Children's Services since at least November 2020 when she was admitted to a Tier 4 bed at X House for the first time. Since then she has been admitted to the general hospital on at least 41 occasions. She was admitted to the general hospital on 31 December 2022. On 9 February 2023 she was readmitted to A House initially pursuant to s.2 Mental Health Act 1986 ("MHA") for assessment.

6. After detention pursuant to section 2 MHA was discharged, she was made subject to a DOLS order, pursuant to the inherent jurisdiction of the High Court at the same

place. She left A House at the end of April 2023 and went to a placement in Bradford. There, she was subject to a DOLS order which authorised 2:1 supervision. In December 2023 the placement ended because of safeguarding concerns and she returned to Warrington to an LA provided, interim placement in the community.

7. She then moved on 9 February 2024 to a supported living placement where she was no longer subject to a DOLS order. She had a period of some 6 weeks there when she did not attend the hospital and seemed relatively settled. She then re-presented at the hospital on 27 March 2024 with an intentional overdose. Sadly, since April 2024 she has had very frequent attendances there, largely for taking overdoses of paracetamol. There has been something of a change in MK's behaviour, and the risks to her, since late March 2024.

8. On 15 May 2024 MK was found trying to climb across a motorway bridge. She had taken an intentional overdose of 32 paracetamol tablets but did not share that information with her carers until the following day. She was taken to the hospital and underwent a s.2 MHA assessment by two s.12 doctors and an Accredited Mental Health Professional ("AHMP"), Mr C, to determine whether she should be detained. All three considered that MK met the s.2 criteria for detention. However, in order for a young person to be detained under the MHA in a Tier 4 placement, or placed in a Tier 4 placement, there is an access assessment procedure, performed by the NHS, to determine whether a placement or bed will be offered.

9. The nature of that procedure was explained in detail by Macdonald J in *Blackpool Borough Council v HT and others* [2022] EWHC 1480 (Fam). I do not intend to repeat what he set out with considerable care in that judgment at [36] to [40], but the process he sets out there is central to this case.

10. The AMHP Mr C explains in his statement that the MHA assessment was undertaken. Previous admissions under s.2 had been to A House which is the Tier 4 provision in the area provided by the Fourth Respondent. However, the Tier 4 access assessment then undertaken did not support admission to a Tier 4 bed stating more needed to be tried in the community. MK was then discharged back to her placement in the community.

11. On 18 May MK was seen in the hospital having disclosed the overdose on 15 May. She was declared medically fit to be discharged. The Tier 4 assessment team was unable to see her there because of competing demands and MK returned again to her placement. Another MHA assessment with the AMHP Mr C present, took place on 18 May at MK's placement with the Tier 4 assessors present. Again, the Tier 4 access assessment group did not offer her a Tier 4 bed.

12. MK took a further overdose of paracetamol on 18 May, and was taken to the hospital in the early hours of 19 May. On the advice of the CAMHS team, MK was detained pursuant to s.5(2) MHA to allow for reassessment. She pulled out a cannula and absconded but was returned to the ward and resumed treatment. On 21 May there was a further access assessment of MK by the Tier 4 assessment group which again led to no offer of a bed. In effect, an impasse was reached.

13. As explained by Macdonald J, unless a bed is offered by the Tier 4 provider, a person cannot be detained pursuant to s.2. In effect, Mr C, and those assessing her as needing

detention could not detain her because the Fourth Respondent was not offering a bed. The situation which now arises is that MK is in the paediatric ward in a general hospital, not being detained under s.2 MHA. In those circumstances, the Applicant NHS Trust applied to the High Court for a DOLS order in respect of keeping MK in that paediatric ward.

14. I should say a little more about MK's presentation. What is clear from the papers is that her mental state has significantly deteriorated in the last few weeks. Whereas some of the earlier reports refer to her taking overdoses, but with them perhaps being characterised as something of a cry for help, in the last few weeks she has become much more determined about ending her life. Dr M, a CAMHS consultant psychiatrist with the Mental Health Trust, in a report dated 23 May 2024, refers to the access assessment made on 21 May 2024, and to reports from MK's carers that MK *"is now not letting carers know when she takes overdose and is refusing medical treatment after overdoses. They reported that [MK] has more recently spoken about ending her life. They said that a carer followed [MK] when she absconded from ward and that [MK] sat on the road until the police picked her up and brought her back to the ward."*

15. The evidence appears to be clear that this is a young person who is becoming increasingly dysregulated and whose suicidal intent is becoming more formed. In terms of her diagnosis, in Dr M's report, she says that MK is *"is a young person with difficulties to regulate emotions, difficulties to tolerate distress, feelings of numbness/ emptiness, interpersonal difficulties, risk behaviours and long standing thoughts that life is not worth living. Her presentation is in line with a young person with features of emotionally unstable personality disorder."* Dr M also refers to a useful, short recommendation from her colleague, Dr I, made in 2023 following MK's last discharge from A House. I quote this in full:

> *"[MK] requires a safe, stable living environment to address the effects of her unstable upbringing to date. She will need time to settle in any new placement and develop trusting relationships with those caring for her. This will understandably be difficult for [MK] given her life experiences to date and she will be expected to push boundaries and test those relationships. This is likely to be in the form of absconding and also continued episodes of self-harming behaviours.*
>
> *It is therefore really important that any placement fully commits to [MK] and does not seek to serve notice when she presents with self-harming behaviours. They should be experienced in caring for young people who have suffered significant trauma and can provide appropriately boundaried and nurturing care and support.*
>
> *Once she is established in a settled and safe placement, it is hoped that she can begin to engage with therapeutic work to address her previous trauma and develop coping skills and strategies to manage these complex feelings and triggers when they arise."*

16. Dr M then says despite this:

> *"It appears that despite this recommendation [MK] has been subject to three placement changes since her discharge in April 2023 which has the effect of preventing any chance of making positive progress implementing psychological support."*

17. It may be noted that since Dr M's report, MK has had a large number of further moves between hospital and community placements, which can only have served to further destabilise her psychological and emotional well being.

18. I recently gave judgment in *Warwickshire County Council v JR and Others* [2023] EWHC 564 (Fam) where I set out the Nuffield Family Justice Observatory's ("NFJO") *Principles of Care for children with complex needs and circumstances: Principles of Care Framework 2023* which applies to young people such as MK. Yet again this is a case where no one can dispute the nature of the recommendations, which themselves accord with the NFJO principles, but the provision actually made for MK is not even beginning to meet those recommendations.

19. Dr M takes much the same line as Dr I and explains the rationale for not offering MK a Tier 4 bed. She says:

> *"We do not support admission to T4 services for further assessment and treatment in an inpatient setting. The young person has been admitted to A House for assessment and treatment on two previous occasions and the health needs can be understood as emotional crisis in context of several stressors rather than due to severe and enduring mental illness. Moreover, admission to inpatient psychiatric unit may cause side effects including increase in severity of risk behaviours, 'contagion effect' due to unhelpful dynamics with peers and institutionalisation."*

She then sets out recommendations for community assistance from Tier 4 services, as well as other CAMHS services.

20. I turn to the position of the parties. Miss Gollop starts with the proposition that a general paediatric ward is a manifestly unsuitable place for a child such as MK. On the ward, it is extremely difficult to stop MK absconding when she wants to. It is an inappropriate environment in which to deliver any therapy, and her presence there impacts on other children and the staff. Next, Miss Gollop submits that MK is detainable under s.2 MHA. Miss Kelly accepts that MK has a mental disorder for the purposes of the MHA, namely emerging Emotionally Unstable Personality Disorder ("EUPD"). Miss Gollop submits, and Miss Kelly did not take a position on this point, that her condition is of a nature and severity to meet the definition in the MHA. On 15 May at the assessment I have referred to, the conditions for detention under s.2 were met save that there was no offer of a bed from the assessment body. Miss Gollop then submits that it is not in issue that, as Dr I says, MK requires a safe, stable, consistent environment where she can get treatment. She might go so far as to accept that a Tier 4 bed would be countertherapeutic. However, Miss Gollop submits that the immediate need is to prevent MK from significantly harming herself, absconding and committing suicide, or dying through misadventure brought on by dysregulation. Plainly that need is more easily achieved in a Tier 4 bed with the potential for locked doors and segregation, than the paediatric ward of a general hospital, or a placement in the community in what can only be described as unsuitable accommodation.

21. Miss Wills for the LA agrees with the case put forward by the Applicant Trust and submits that in the immediate term, MK's need is for a Tier 4 bed. In a Position Statement, she puts forward the LA's fall back position if the Tier 4 bed is not offered which is that the LA will, because it has no choice, provide a placement in the community. That would be in an Airbnb, not designed to be a therapeutic placement, which is a mid-terraced house of normal construction. The LA would also provide, again because they have no choice, a series of carers who would try to keep MK safe to the best of their ability. There is absolutely no criticism in this case of the efforts made by the LA to try to put in place the most suitable arrangements it can make. What is crystal clear from the LA's Position Statement is that no community placement can provide MK with anything that can be described as suitable care, because it is very unlikely to be able to keep her safe. Great efforts have been made by the LA to find a suitable therapeutic placement, but there simply are no such placements available that are prepared to offer MK a bed.

22. Miss Leaker appears on behalf of MK herself. She has known MK for some time having represented her in the care proceedings, and of those in the hearing, she probably knows MK best. She considers her *Gillick* competent and MK and I note that the Children's Guardian have parted ways. Miss Leaker tells me that MK does not want to be in hospital or placement or subject to a DOLS order. She would prefer to be in an Airbnb property to any hospital, including A House.

23. Mr Hewitt (the Guardian) spoke on his own behalf and clearly stated his very grave concern about the risk to MK. He pointed out that the previous DOLS order in the community did not manage to keep her safe and he expressed his view that the general hospital staff and staff in the community cannot keep her safe. He strongly supported the submission that MK should be placed in a Tier 4 bed.

24. Miss Kelly for the Mental Health Trust did not dispute the legal analysis set out by Miss Gollop, and did not take a view on whether MK is, in principle, detainable, the Mental Health Trust not having conducted the MHA assessment. However, she said that MK's two admissions to A House have, in therapeutic terms, achieved nothing. The admissions in A House have been positively harmful to MK because of peer pressure and the presence of other girls, who describe themselves as "the suicide squad", and one girl in particular who appears to have a detrimental effect on MK. I note from the LA's Position Statement that this girl is due to move out in a couple of weeks' time. Being in A House serves to escalate her presentation.

25. Miss Kelly submitted, and this was supported by Dr M, who spoke directly to me, that if MK is admitted, it is not possible to ensure that she will not abscond from A House. I found that extremely difficult to understand. MK can be placed on a locked ward and, if necessary, segregated, although I accept that would be unfortunate. When she was at A House but detained under a DOLS order not s.2 MHA, MK was allowed out on leave and was able to abscond. But I find it very difficult to believe that if detained pursuant to s.2 MHA, it is not possible for A House to prevent her from absconding or taking an overdose.

Conclusions

26. I turn to my conclusions. My powers are very limited. As a Family Division judge I cannot force NHS England or the Tier 4 assessment unit to admit MK to a Tier 4 bed,

or to provide her with treatment it believes to be countertherapeutic. I can authorise the Applicant Trust to deprive MK of her liberty and I can set out the facts and my analysis to try to persuade the Mental Health Trust and NHS England to focus on what in my view is the real issue in the case.

27. It is now accepted that the conditions for detention under s.2 MHA are met. The definition of "mental disorder" within the MHA includes Personality Disorder. It is a common misconception put forward in these cases that when a young person is experiencing emotional distress due, it is said, to "environmental" factors or behavioural issues, that they do not fall within the MHA. That is plainly wrong. I refer to a desktop second opinion report from Dr A at a different mental health Trust on 22 May obtained by the Fourth Respondent Mental Health Trust that:

> *"We share the view that this is not an acute mental state presentation that would require admission for further period of assessment or treatment, and we have been unable to identify any clinical goals or interventions that would necessitate an admission to inpatient hospital setting.*
>
> *We agree that a hospital admission is unlikely to alter risks in the medium to long term and more likely scenario that admission is likely to increase risks to self."*

28. A mental disorder as defined by the MHA, whether in a person under or over 18 years, includes a Personality Disorder. Whether that is emerging, as it may be in a young person under 18 years, or established as in an adult makes no difference for the purposes of the MHA. The fact that a person has such a disorder does not mean it is beneficial to them to be detained but does mean that the person is detainable because they meet the MHA criteria.

29. Miss Kelly submits that it is not in MK's best interests to be placed in a Tier 4 bed and that admission to such a bed would be countertherapeutic for her. MK needs stability and consistency and admission to Tier 4 has achieved little in improving her presentation. I entirely accept that that may be the case in terms of psychological therapy and future effective functioning. But in my view that is slightly beside the point in the crisis situation now faced by MK and those responsible for her care and best interests.

30. I remind the Mental Health Trust of the House of Lords' decision in *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74 paragraphs 68 and 72:

> *"68. In terms of article 2, health authorities are under an over-arching obligation to protect the lives of patients in their hospitals. In order to fulfil that obligation, and depending on the circumstances, they may require to fulfil a number of complementary obligations.*
>
> *...*
>
> *72. Finally, article 2 imposes a further "operational" obligation on health authorities and their hospital staff. This obligation is distinct from, and additional to, the authorities' more general obligations. The*

> *operational obligation arises only if members of staff know or ought to know that a particular patient presents a "real and immediate" risk of suicide. In these circumstances article 2 requires them to do all that can reasonably be expected to prevent the patient from committing suicide. If they fail to do this, not only will they and the health authorities be liable in negligence, but there will also be a violation of the operational obligation under article 2 to protect the patient's life. This is comparable to the position in Osman and Keenan. As the present case shows, if no other remedy is available, proceedings for an alleged breach of the obligation can be taken under the Human Rights Act 1998."*

31. Those observations have been endorsed by the Supreme Court in *Rabone v Pennine Care NHS Trust* [2012] UKSC 2 following cases such as *Osman v UK* [2000] 29 EHRR 245 at [115]-[116]. The purpose of treatment in these extreme cases is to keep the patient alive. If MK succeeds in killing herself, then to put this in the most brutal of terms, any future intervention to help her mental health will fall away. MK's life is at great risk, as is shown beyond any doubt by her actions over the last few weeks.

32. The State is therefore on clear notice of its positive obligation under Art 2 ECHR to take all reasonable steps to keep this patient alive in circumstances which fall directly within [72] of *Savage* as set out above. Unless MK is provided with a very high level of supervision and containment, she will abscond and there is a real and immediate risk that she will buy paracetamol and try to kill herself. The obligation at present is simply to keep her alive and in that context, the fact that her treatment needs may not be well met in a Tier 4 bed simply misses the point. In my judgement, it must be the case that the State is more likely to achieve its obligations under Article 2 by keeping her in a locked unit, than either on a general paediatric ward or in Airbnb with high turnover of staff and not physically designed for containment.

33. It is nothing short of tragic that I am told by the Mental Health Trust and NHS England that the environment at A House will increase MK's mental distress. However, that is not a matter for me. I fully appreciate that the Mental Health Trust does not want and should not in an ideal world, be forced to use Tier 4 as a containment facility for a suicidal person. However, unless and until somewhere else is found that can effectively protect MK from a significant risk of killing herself (whether through suicide or misadventure) and meet her therapeutic needs, it is, in my view, in her best interests to be admitted to a Tier 4 bed. Arts 2 and 3 ECHR are engaged and the State, particularly NHS England, is on notice of what was said by the House of Lords in *Savage*: *"article 2 requires them to do all that can reasonably be expected to prevent the patient from committing suicide."*

34. All of that said, as Ms Kelly points out, what I have set out above concerning Article 2 is obiter, in the sense that the Court cannot order NHS England to agree to MK being placed in a Tier 4 bed. I therefore have no real choice but to make a DOLS order authorising MK's continued deprivation of liberty on the paediatric ward of the general hospital.