Neutral Citation Number: [2017] EWHC 2036 (Fam)

Case number omitted

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
Sitting at MANCHESTER
Judgment handed down at LIVERPOOL

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 3 August 2017

Before :

SIR JAMES MUNBY PRESIDENT OF THE FAMILY DIVISION

- - - - - - - - - - - - - - - - - - - -

In the matter of X (A Child) (No 3)

- - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - -

Mr Michael Jones (instructed by the local authority) for the applicant Cumbria County Council
Ms Rebecca Gregg (instructed by Gaynham King & Mellor) for X
Mr Simon Rowbotham (instructed by Denby & Co) for X's guardian
Mr Mungo Wenban-Smith (instructed by Hill Dickinson LLP) for the relevant NHS Clinical Commissioning Group
Ms Elizabeth Wheeler (of DAC Beachcroft LLP) for NHS England

Hearing dates: 31 July, 1 August 2017

- - - - - - - - - - - - - - - - - - - -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

SIR JAMES MUNBY PRESIDENT OF THE FAMILY DIVISION

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 child and members of her 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.

Sir James Munby, President of the Family Division :

1. This case was last before me at Kendal on 15 June 2017: *Re X (A Child) (No 2)* [2017] EWHC 1585 (Fam). At that time, X, as I shall continue to refer to her, was only a few days short of her 17th birthday and was detained, pursuant to a Detention and Training Order imposed by the Youth Court, in a secure unit which I shall continue to refer to as ZX. She was, at that time, expected to be released in mid-August 2017.

2. I do not repeat what I said in my previous judgment about the background to these proceedings. Anyone reading this judgment should at this point read my previous judgment. It requires to be read in full, and considered very carefully indeed, by everyone concerned professionally or otherwise with X. For present purposes I can be comparatively brief.

3. For the reasons set out in that judgment, I made a care order, even though there was no plan as to what should happen when X was released from ZX. I quote from the judgment (para 19), where I referred to:

> "the enormity of the task facing the local authority and the stark reality that, for whatever reasons, the local authority has not yet been able to articulate any workable care plan for X, let alone to identify where she might be accommodated and what services should be made available for her. I can only echo and endorse the guardian's bleak assessment:
>
> > "there is currently *no plan* as to what will happen, where she will go, what support will be in place.""

4. I went on (paras 26-28):

> "26 In these circumstances the court is placed in very considerable difficulty. The need for a final care order is overwhelming. It is imperative in X's interests (a) that the local authority has parental responsibility and (b) that X can enjoy, now and, after she leaves care, in accordance with the 'leaving care' legislation, all the benefits which will accrue to her if there is a care order. But there is at present no realistic care plan available for me to approve, other than (see below) a plan of action which it is hoped will lead to the formulation of a proper care plan. Yet my ability to make a care order, given X's age, will be gone in a matter of days. What am I to do?
>
> 27 The conundrum can properly be solved because, as is common ground between the local authority and the guardian, and I agree, (a) if an appropriate placement for X can be found which properly meets her very complex needs, it is likely to involve a deprivation of her liberty requiring judicial sanction and (b) … that sanction is, in the circumstances, properly a matter for the Family Division rather than the Court of Protection …

> 28 What, therefore, I can, and do, approve, for the purposes of the care order, is a plan of action which, it is to be hoped, will lead to the formulation of a properly worked-up care plan that can be put before me for my approval, exercising the inherent jurisdiction, *before* X is released from ZX."

I summarised (para 30) the components of the plan of action.

5. Hence the latest hearing before me, at Manchester, on 31 July 2017.

6. Before proceeding any further I need to emphasise the central, dominating reality of this case. ***On a large number of occasions while at ZX, X has made determined attempts to commit suicide***. Following a visit to see X on 8 June 2017, the guardian recorded in an email dated 9 June 2017 what she had been told by the staff at ZX:

> "The entire staff group's opinion that:
>
> • '***X's goal is not to go to [her home town] it is to kill herself***' (emphasis added)
>
> • X's intention to kill herself has 'intensified' in the past 2 weeks
>
> • ***The care plan to send her back to any community setting, especially [her home town] 'is a suicide mission to a catastrophic level'. Staff do not think it will take more than 24 to 48 hours before they receive a phone call stating that X has made a successful attempt on her life*** (emphasis added).
>
> …
>
> *The staff group all agree that X will not manage in the community, that she requires long-term adolescent mental health unit input* (emphasis added)."

7. A report from ZX dated 14 June 2017 was profoundly disturbing. It included this:

> "*It is a shared view between staff and CAMHS specialist clinicians that ZX is not the correct placement for X based on her current and on-going presentations. It is felt that we are unable to meet the escalation of her needs and a more clinical environment would be more appropriate* (emphasis added)."

8. I concluded my judgment as follows (paras 34-35):

> "34 Without, I hope, trespassing on matters which will be before me for decision at the next hearing, I need to say this. There is, as is apparent from what I have already said, a substantial body of professional opinion that what X needs – and, it might be thought, desperately needs – is therapy in some

> appropriate clinical setting. That body of opinion needs to be taken very, very seriously, as I am sure it will be.
>
> 35 The final point is this. If there is no effective, realistic and above all *safe* plan in place for X when she is released from ZX, the consequences, given her suicidal ideation, do not bear thinking about. If the fears of ZX are well-founded – and this, for the time being, is the basis upon which we *must* proceed – we should be left with little but the hope that the police would have had occasion to take X into custody before she was able to cause herself irreparable harm. Is that really the best the care system and the family justice system can achieve?"

9. The care order that I made on 15 June 2017 contained the following recital, which I emphasised in my judgment (para 31):

> "The court has expressed the need for the local authority to make urgent enquiries in relation to potential placements for X forthwith. It has been clear that there must be no delay in instigating these enquiries; the local authority will make such enquiries forthwith."

10. I could hardly have been clearer, both in describing X's needs and in stressing the imperative to find an appropriate placement for her *before* her release from ZX. For all that has actually been achieved in the last few weeks, however, despite unrelenting efforts both by the local authority and by other agencies, I might as well have been talking to myself in the middle of the Sahara.

11. On 29 June 2017, Dr Amith Paramel, a Consultant Psychiatrist, completed a NHS England Form 2 *Access Assessment for Inpatient Services for Children & Young People* in relation to X. He recorded having been told that "the medium secure network … are of the view that her risk to others does not meet the threshold for a medium secure unit." His own view was expressed as follows:

> "[X] would benefit from a period of assessment (possibly under detention) to assess her mental health needs. Given her history of aggression and violence she will not be suitable for a general adolescent unit. Short term PICU [psychiatric intensive care unit] admissions would also be unsuitable for her. [X] struggles to make meaningful and therapeutic relationships and hence a short term admission would be counterproductive.
>
> A low secure unit which has the option to provide longer term input would be able to meet her needs."

12. I need to explain at this point the difference between low and medium secure units as set out in NHS England Form 1 *Guidance re decision-making when making a secure adolescent inpatient referral*.

13. So far as material for present purposes, the referral criteria for Low Secure Provision are:

> "The young person is liable to be detained under either Part II or Part III of The Mental Health Act 1983
>
> AND:
>
> The young person is not safely managed in an open environment and is assessed as having needs than cannot be managed by shorter term admission to a psychiatric intensive care unit (PICU)
>
> AND:
>
> The young person presents a risk of harm to others; themselves or suffers from a mental disorder that requires inpatient care, specialist risk management procedures, and specialist treatment intervention."

The referral criteria for Medium Secure Provision include:

> "The young person presents a significant risk to others of one or more of the following:
>
> - Direct serious violence liable to result in injury to people
> - Sexually aggressive behaviour
> - Destructive and potentially life threatening use of fire".

Form 1 sets out a number of "Important Considerations", including:

> "Young people with mental disorder who present a grave danger to the general public … should be referred to the medium secure network.
>
> … Young people with brief episodes of disturbed or challenging behavior as a consequence of mental disorder (including neurodevelopmental disorders) are usually most appropriately cared for in PICU."

14. Thus, and this is the relevant point for present purposes, the important distinction is between risk of harm to self or others and "significant" risk to others.

15. I referred in my previous judgment to various reports from Dr Audrey Oppenheim, a Consultant Child and Adolescent Psychiatrist. Since the last hearing, she has prepared a further report, dated 20 July 2017, following a visit to X at ZX on 10 July 2017. This report requires to be read in full, and considered very carefully indeed, by everyone concerned professionally or otherwise with X.

16. I confine myself here to the most important passages. First, Dr Oppenheim's diagnosis:

> "There are increasing concerns about [X]'s mental state … For much of the time [X] is actively expressing a wish to die and taking every measure available to harm herself.
>
> … there was no evidence to support a diagnosis of moderate to severe depression or a presentation with a mood related psychotic illness. [X] appeared to be in a "fugue" or trance like state during periods of restraint but she appears to be listening to conversations and able to choose to make requests … even at times where she does not appear to be responding to staff requests.
>
> … In my opinion, even if [X]'s current high level of emotional dysregulation is related to her underlying diagnosis of Emotionally Unstable Personality Disorder (EUPD) and ADHD … there are sufficient grounds for a period of further assessment under Section 2 of the Mental Health Act …
>
> … The diagnoses of ADHD (ICD10 F90) and Conduct Disorder (ICD F91) … remain valid. She does not fulfil the criteria for a diagnosis of moderate depression, generalised anxiety or psychosis.
>
> In trying to find a diagnostic label to best fit with her current presentation when there are long periods where she is either seriously attempting self-harm, with a view to committing suicide, or in a fugue, I think the most helpful diagnostic label would be that of a Reactive Adjustment Disorder (ICD10 F43.2). [X]'s trance-like behaviour is linked to her frustration, agitation and profound disappointment that her only wish is to return home to her mother … cannot be fulfilled and she is hopeless as to her future.
>
> Using this diagnostic framework, one could hypothesise that her current pattern of extreme behaviour is a mal-adaptive coping mechanism arising out of great distress, which provides a possible way forward in terms of psychotherapeutic support and gradual adaptation to a revised future. However, in order to help [X] adapt she needs to be in a setting that cannot only support her but gradually challenge her unhelpful cognitive beliefs and provide her with more adaptive coping strategies."

17. Next, Dr Oppenheim's view as to the unsuitability of ZX for X:

> "I understand that [ZX] have refused to keep [X] on welfare grounds because her needs are such that she often requires nursing over and above that which would normally be provided by [ZX] staff.
>
> … the team have no option but to primarily physically restrain [X], if she is threatening to self-harm and cannot be kept safe,

> as there is no ability to follow a process of rapid tranquilisation using a medication based approach since none of the staff have a nursing or medical background.
>
> … the emotional and behavioural distress exhibited by [X] through fugues cannot be adequately contained or managed in [ZX], despite the best efforts of a highly committed and caring staff group.
>
> … in her current setting the focus of care has necessarily been narrowed to that of keeping her safe."

18. Dr Oppenheim's opinion is clear:

> "It is undesirable, but it may be necessary, to consider a move to a suitable acute mental health bed before transfer (presumably under Section 3 MHA) to a longer-term placement in a psychotherapeutic unit which can adequately address her extensive therapeutic needs. I understand there are severe difficulties in finding a low secure adult bed and that [X] would not qualify for a medium secure adult bed. NHS England is involved in the search for a suitable alternative placement and [name of unit] have agreed to assess [X] although there is a long waiting list for beds.
>
> … I would support the longer-term plan to move her to low secure mental health unit that has a particular expertise in working with young people with EUPD that can provide her with a secure base to work through and come to terms with her experiences of trauma and rejection. I would agree with the view that therapy will need to be long term and of at least 12-18 months duration. Having spent so many months recently in institutionalised settings, [X] will require a very graded approach to rehabilitation and care in the community …
>
> … [X] requires a move now to an acute psychiatric unit with sufficient health staff in place to meet her needs and keep her safe.
>
> In my opinion, a transfer of care to a mental health unit is now unavoidable, even if it introduces an additional move of placement whilst [X] waits for an appropriate therapeutic unit to become available, a wait which could extend for at least six months. [X] should be transferred under the provisions of Section 2 of the Mental Health Act for further assessment of her current mental health needs.
>
> … [X] requires a fresh approach and additional mental health resources in order to make progress …"

19. Dr Oppenheim's description of X's life at ZX is dramatic:

> "She is effectively nursed in her bedroom, but this bedroom has had to be stripped in order to make it secure, to the point where [X] has no personal items in the bedroom, no carpet, no mirror, her bed is a mattress on the floor and she has to be dressed in anti-ligature clothing. Even going to the bathroom or having a shower has to be closely supervised. There is a potential for concerns to arise about [X]'s consumption of food and drink, as the periods during the day when she is restrained become increasingly extensive.
>
> … she is now isolated from all her peers and no longer attends education, even on a minimal basis."

20. The reality of X's current situation at ZX is graphically illustrated by ZX's most recent Table of 'Reportable Incidents', which shows that during X's time at ZX – still not yet quite six months – restraints have had to be used on 117 occasions (twice during the period from 20-27 July 2017), and that there have been 102 "significant" acts of self-harm (5 during the period from 20-27 July 2017), 45 assaults and 25 attempted assaults on adults, and 16 incidents of "significant" damage to property. These bare statistics are supplemented by a 'Chronology of Events' prepared by ZX which runs to 24 closely printed pages. As Mr Michael Jones, on behalf of the local authority, correctly observes, it is clear that X's destructive behaviours remain at an extremely high level.

21. On 25 July 2017 X was assessed for possible admission to a medium secure unit in the Midlands. Her case was discussed at the national network referrals meeting (which, I am told, takes place every Tuesday) the same afternoon. The decision, as reported in a letter dated 27 July 2017 from the Consultant Child & Adolescent Psychiatrist at the unit, was that:

> "… she is not suitably placed at the moment in her current setting and … needs to be in hospital for further assessment.
>
> … although the nature of her behaviour has changed slightly …, we were not of the opinion that the level of security required to manage her had increased to meet the threshold for medium secure services. We therefore are in agreement with the psychiatrist who assessed her in June that she should be referred for a transfer to a low secure inpatient setting."

The Consultant added this, in a letter dated 1 August 2017:

> "… in accordance with guiding principles of the Mental Health Act, it is important that [X] is offered treatment and support in the least restrictive environment which is able to address her needs and risks. As her primary presentation is mainly driven by behaviours which are putting her own safety at risk, this would suggest that she needs access to a low secure facility which has the therapeutic facilities to manage her presentation, rather than a medium secure facility which typically has a different therapeutic approach."

22. At the request of the local authority, the Focus CAMHS team at ZX responsible for X produced on 28 July 2017 a detailed analysis of

> "what provision we consider would be necessary to ensure [X]'s safety and to meet her identified needs by an alternate placement following her release from [ZX], should a placement within an adolescent low secure hospital have not been identified at the point of her discharge."

They recommend, however, that:

> "this is considered with caution, given that the enclosed provision has been delivered whilst [X] has been resident within a secure environment, therefore procedural and environmental security has mitigated a number of risks, which may in fact be present in an alternate (for example community) setting, therefore consideration will need to be given to whether the identified management strategies may in fact need to increase further or be adapted within an alternate setting."

This document is so important, and so illuminating, that I set it out in full as an Annex to this judgment. Mr Jones submits, and the submission is irrefutable, that any impartial and objective reading of the document suggests that X's need for placement in a suitable, secure clinical/hospital setting is now overwhelming, a word which I unhesitatingly endorse. The local authority's view is that X's needs can only properly be met in an appropriate clinical/hospital setting. I agree.

23. The unavailing attempts to identify such a setting are evidenced by the minutes of meetings of social workers, other professionals and officials from the local authority, CAMHS, the relevant NHS clinical commissioning group, NHS England and other agencies, which took place on 3, 6, 10 and 14 July 2017, and are described in detail by X's social worker, KZ, in a statement dated 21 July 2017. I have also had the great advantage of reading the weekly 'bulletins' prepared by Mr Jones and the various position statements and other updating materials put before me by the advocates who have appeared before. I do not propose to go through this material in detail – it is largely an account of concerted effort producing virtually nothing by way of effective outcome.

24. As matters stand – this is as at 10.30 am, on Thursday 3 August 2017, as I hand down judgment – the dreadful position in which X finds herself can be summarised very simply and very starkly:

i) The regime at ZX is not meeting X's needs. The staff there, despite all their efforts, are managing little more than to contain her.

ii) What X needs – as a matter of desperate urgency – is therapy in an appropriate *clinical* setting.

iii) Placement in a PICU will *not* meet X's complex needs.

iv) What X needs as a matter of desperate urgency – this is clearly the best option for her – is placement in a Tier 4 (adolescent) low secure unit for some 18-24 months.

v) No such placement was available anywhere in this country when the hearing before me started on Monday 31 July 2017 or when the hearing concluded on Tuesday 1 August 2017, and no such placement is available as I hand down judgment on Thursday 3 August 2017. The only identified placement (the unit referred to by Dr Oppenheim) has a 6-month waiting list for beds.

vi) Indeed, as of today, Thursday 3 August 2017, no placement of any kind is available for X when she leaves ZX, as she has to no later than 3pm on Monday 14 August 2017.

25. I repeat with all the emphasis at my command the considered view of the staff at ZX:

> "***to send her back to any community setting, especially [her home town] 'is a suicide mission to a catastrophic level'. Staff do not think it will take more than 24 to 48 hours before they receive a phone call stating that X has made a successful attempt on her life.***"

26. The latest position statement prepared by Mr Jones is dated 28 July 2017. In the course of his submissions he said this:

> "A central concern in this case, which cannot be ignored, is not only the complete inadequacy in respect of available child and adolescent mental health placement provisions, but also the apparent lack of availability of any suitable temporary placements.
>
> … To say the current situation in England and Wales for children with [X]'s (it is accepted unusually high) level of needs is of concern is perhaps an understatement. This is a child who is subject to a care order and who is accordingly owed support by the local authority pursuant to its duties to her as a looked after child. This is also a child who has significant mental health and emotional issues, which make her behaviours both dangerous and uncontrollable. More than this, she is highly vulnerable. Despite all of these factors, she has been placed in a situation where weeks and months have gone by with there being no placement available for her countrywide … The provisions for placement of children and adolescents requiring assessment and treatment for mental health issues within a restrictive, clinical environment is worryingly inadequate. One has to question what would have happened in this case had [X] not received a criminal sentence? Given the level of her behaviours, where would she have been placed? What provider would have accepted her given that secure units were unwilling to do so prior to her receiving a custodial sentence?

> This child has fallen into a "gap" in the system. Her behaviours are so extreme that no residential or supported living placement sourced by children's services can meet her needs, whilst there is clearly inadequate provision from the NHS and health services of placements, which can manage her mental health needs. Her time at [ZX] has amply demonstrated that placement in secure accommodation cannot meet her needs and is inappropriate.
>
> … This case has demonstrated the inadequacy of the current secure accommodation resources in England and Wales (leading to this local authority having to place in Scotland) and has now gone on to demonstrate the inadequacy of suitable provisions for children with high level of mental health issues, which necessitate assessment and treatment in a secure setting. Placements for vulnerable children and adolescents, be it within secure accommodation of mental health provisions, are a scarce resource."

27. I agree with every word of that. My only cavil is that Mr Jones' language is perhaps unduly moderate. The lack of proper provision for X – and, one fears, too many like her – is an outrage.

28. Mr Jones appropriately took me to the Royal College of Psychiatrists 2015 Faculty Report of the Faculty of Child and Adolescent Psychiatry, FR/CAP/01, *Survey of in-patient admissions for children and young people with mental health problems.* Its sixth recommendation was as follows:

> "We strongly recommend that careful thought is given to services for vulnerable and high-risk children and young people. We welcome the Government's recent announcement that they will ban the use of police cells as 'places of safety' for children. However, we urge the Government to prioritise investment in crisis care services for children and young people and urge NHS England, clinical commissioning groups and social services to ensure that adequate emergency care pathways are in place as a matter of urgency."

29. The Survey contained the following details:

> "Accessing in-patient beds became much more difficult over 2013. Over 70% of respondents experienced frequent difficulties ('often' or 'always'), and over 50% found the situation much more difficult than the previous year.
>
> … Bed access difficulties affected all types of bed provision, but predominantly generic adolescent beds …
>
> Overall, 79.1% of respondents reported safeguarding concerns while waiting for a bed; 76.5% reported young people with unacceptably high risk profiles having to be managed in the

> community because of a lack of beds; 61.9% reported young people being held in inappropriate settings such as paediatric and adult wards, police cells, Section 136 suites, and accident and emergency (A&E) departments. In total, 14% of respondents' comments described patient suicide attempts while waiting for a bed, and 13% described episodes of violence."

That was in 2015. We are now in 2017.What has been done?

30. Mr Jones also referred me to the July 2017 Report of the Education Policy Institute, *Inpatient Provision for Children and Young People with Mental Health Problems.* It does not make for re-assuring reading. It comments:

> "The Government has recognised the need to provide more inpatient capacity in England, and to revise the geographical distribution of beds. This is an appropriate response to the current geographical disparity highlighted in this report. It is important, however, that there is now a sustained focus on the management of the inpatient estate across the country to make the best use of existing capacity and to monitor whether and where capacity should be increased."

31. Ms Rebecca Gregg, on behalf of X, rightly makes no criticism of the local authority's endeavours since the last hearing. But, she submits:

> "… it is difficult to read the updates and not form the view that [X]'s care plan is being primarily determined by a lack of adolescent mental health resources. That appears most telling in respect of the now repeated failures to section [X]. The conclusion that the absence of a suitable bed within a hospital setting is the driving factor in the decision not to undertaken a mental health assessment of [X] is becoming irresistible.
>
> It cannot be right that such a vulnerable child with, a lengthy documented history of the most extreme and determined self harm, should have her medical care plan dictated by an absence of resources, as opposed to her identified needs.
>
> To read that the only available low secure bed identified within this jurisdiction [in fact no longer available] is the subject of competition from another child who is currently assessed as having greater needs than [X] is frankly alarming in respect of both children."

Who could possibly disagree?

32. I have been greatly assisted by two officials from NHS England, the Deputy Head of Mental Health Commissioning for the North West Hub and the Secure and Specialised Case Manager for the North of England Specialised Team, North West Hub, who have attended the hearing while at the same time continuing their frantic

efforts to find an appropriate placement for X. I understand from them that there are, across the country, six low secure units at which X could in theory be placed – if any of them had an available bed. Absent an unexpected early discharge, however, none has an available bed for several months. I emphasise that neither of these committed public servants is to be criticised for the present state of affairs. They can only do their best, as they are doing, having regard to the resources made available to them. They are not responsible for the provision of those resources – that is the responsibility of others.

33. Almost in desperation, and not because it believed that such a plan was appropriate for X, the local authority identified a 'fall-back' contingency plan involving placing X in non-hospital accommodation sourced or rented by the local authority where she could be placed with a 24-hour wrap around support package provided by healthcare professionals specially brought in for the purpose. Ms Gregg, as I have said, makes no criticism of the local authority's endeavours. Nor, in the circumstances, does she criticise the local authority for, quite properly, seeking to formulate a contingency placement for when X leaves ZX. But she rightly describes the prospect of such a community placement, even one with wrap around medical care, as greatly concerning. I agree. In the event, and in my judgment quite rightly, by the end of the hearing on 1 August 2017 this was not an option being promoted by anyone, even on a contingency basis. Given the "Specification for Care" set out in the Annex to this judgment, such a placement would simply not be feasible, quite apart from the fact that it would not meet X's needs.

34. At the end of the hearing on 1 August 2017, I adjourned the case and fixed a further hearing for next Monday, 7 August 2017, (1) to enable further inquiries to be made as to what placements might be available for X on an interim basis, pending a low secure unit placement, in either a medium secure unit, a child and adolescent PICU, or an adult PICU and (2) depending upon the outcome of those inquiries, to determine which form of interim placement – none of which will appropriately meet X's needs – should be selected as the least worst option (a matter on which views differ).

35. In the meantime, there is a pressing need for me to hand down this judgment.

36. Dr Oppenheim's description of the conditions in which X is existing – I cannot bring myself to use the word living – is shocking. Of course, this is all driven by the imperative need to preserve X's life, but how is this treatment compatible with her humanity, her dignity, let alone with her welfare? It is no criticism whatever of the devoted staff at ZX, who are doing their very best for X in what they recognise is not the right kind of placement for her, but I am bound to question whether these conditions, particularly when imposed upon a profoundly damaged and vulnerable young woman, can really be thought to meet the requirements imposed upon us by Article 3 of the European Convention – which, without qualification, prohibits subjecting anyone to "inhuman or degrading treatment" – let alone the more demanding obligation under Article 8 to "respect" X's "private and family life." And, lest it be thought that I have overlooked the point, given the by now well documented and repeated attempts by X to take her own life, the State's *positive* obligations under Article 2 of the Convention are plainly engaged: see, for example, *Rabone and another v Pennine Care NHS Trust (Inquest and others intervening)* [2012] UKSC 2,

[2012] 2 AC 72. I remind every agent of the State involved with her of the duties owed to X under Articles 2, 3 and 8 of the Convention.

37. What this case demonstrates, as if further demonstration is still required of what is a well-known scandal, is the disgraceful and utterly shaming lack of proper provision in this country of the clinical, residential and other support services so desperately needed by the increasing numbers of children and young people afflicted with the same kind of difficulties as X is burdened with. We are, even in these times of austerity, one of the richest countries in the world. Our children and young people are our future. X is part of our future. It is a disgrace to any country with pretensions to civilisation, compassion and, dare one say it, basic human decency, that a judge in 2017 should be faced with the problems thrown up by this case and should have to express himself in such terms.

38. X is, amongst all her woes, a young person convicted in the Youth Court and a prisoner of the State. As long ago as 1910, a Home Secretary, speaking in the House of Commons, asserted that "The mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country." In modern times the principle has expanded, so that, as is often said, "One of the measures of a civilised society is how well it looks after the most vulnerable members of its society." If this is the best we can do for X, and others in similar crisis, what right do we, what right do the system, our society and indeed the State itself, have to call ourselves civilised? The honest answer to this question should make us all feel ashamed. For my own part, acutely conscious of my powerlessness – of my inability to do more for X – I feel shame and embarrassment; shame, as a human being, as a citizen and as an agent of the State, embarrassment as President of the Family Division, and, as such, Head of Family Justice, that I can do no more for X.

39. If, when in eleven days' time she is released from ZX, we, the system, society, the State, are unable to provide X with the supportive and *safe* placement she so desperately needs, and if, in consequence, she is enabled to make another attempt on her life, then I can only say, with bleak emphasis: we will have blood on our hands.

40. My judicial duty, as with every judge in this country, is "to do right to all manner of people after the laws and usages of this realm." There are occasions, and this is one, where doing "right" includes speaking truth to power. The entrance to the Old Bailey, the Central Criminal Court, admonishes those who enter to "Defend the Children of the Poor." Is less required of the Family Court or of the Family Division of the High Court? I think not.

41. I direct that copies of this judgment be sent immediately to the Chief Executive Officer of NHS England, to the Secretary of State for the Home Department, to the Secretary of State for Health, to the Secretary of State for Education and to the Secretary of State for Justice.

ANNEX

"**Specification for Care**

Risk to self

• [X] will ingest anything around her (Stones, Hair, Clothes, Screws, Concrete, Carpet etc) if given the opportunity.

• [X] will use her hair, clothing (including her own underwear) or fabrics as a ligature to self-harm with. [X] has pulled the thread out of anti-ligature blankets and clothing ripped up heavy duty carpet.

• [X] has self-harmed by banging her head, biting herself and punching herself in the face and body.

• [X] will secrete items within her clothing to ingest or self-harm with later.

• [X] will damage property to gain items to self-harm with.

• [X] has influenced other young people to get objects for her to self-harm with.

• [X] has asthma and an innocent heart murmur therefore restraining her for long periods of time could increase her risk of respiratory failure

• [X] has used secreted items including glass and pieces of ceramic to make cuts to her arms and body.

• [X] has self-harmed by picking her wounds and inserting items including staples and her own fingers into the wound. [X] will regularly remove any dressing placed on her arm – bandages should not be used due to ligature risk.

• [X] has made serious attempts to end her own life by tying socks around her neck whilst hiding out of sight of staff (below door / under blankets).

• [X] has secreted and hoarded prescribed medication.

Actions required

1. Observation Levels

• 2:1 observation at all times.

• 8 staff should be available at all times to aid in restraints. 6 staff are required to restrain [X] at a given time and 2 staff should remain available to support, swap with others and make relevant phone calls.

• [X] must be within staff eye sight at all times.

• Both staff must remain within arm’s length of [X].

• If [X] presents a risk to herself she must be immediately moved away from an area of risk.

• When [X] retires to bed on a night her staffing ratio can reduce to 1:1 with the door closed but [X] must remain within staff eye line at all times on constant observation – if staff have to open her door then she returns to 2:1 observation immediately.

• [X]'s head and neck must be visible at all times and she should show staff her hands and arms on request.

• [X] must continue to be on constant observation without exception – when using the toilet or shower she is to be observed by a female member of staff in her bedroom who is to be observed by another at the door.

2. Use of Anti-ligature

• At bedtime or at times of increased risk to self, [X] must be in anti-ligature clothing and paper underwear. Under no circumstances must she wear anything else. This should be implemented at the start of her night time routine when enough staff are around to support.

• [X] should also be put into anti-ligature clothing if she:

  o Eats anything that poses a risk (clothes included)

  o Conceals items

  o Attempts to harm herself

• Should [X]'s bra/underwear need to be taken off due to a specific risk (i.e. heightened emotional behaviour, concealing of items to self-harm with, potential/actual use of ligature), the following MUST apply:

• The use of ligature cutters must be used appropriately and by a trained individual. These will be used to cut a strap in order to facilitate the removal of the clothing item.

• At no point should the clothing be taken off [X] without the correct use of ligature cutters (i.e. not to be ripped off, forced off). The removal of any under clothing should be completed by a female member of staff.

• A coordinated team approach directed by the incident manager must be used including pre-planning of removal of clothing, assigned individual tasks during incident and post-incident support. [X]'s dignity to be maintained at all times and

the use of a blanket or covering must be used and secured at all times by a member of staff. Verbal support to also be given to [X] during and post incident.

• Be mindful that she does not like to be touched so where possible warn her that if the risky behaviour persists then she will have to be held

3. Bathroom/ Shower Protocol

• [X] should be observed by a member of female staff at all times whilst using the toilet or shower. A second member of staff should observe the first member of staff and be available to support as required. Discretion should be used to maintain dignity by means of allowing space for [X] to wash and attend to personal hygiene – i.e. step back but all times [X] must be eye staff eye sight.

• [X] should not have a sanitary bin in her bathroom. Paper disposal bags are to be kept in her cupboard and to be given when requested. During shower times only the amount required of her toiletries to be given using paper cups and she can brush her teeth in front of the designated staff.

4. Daily Living

• [X]'s bedroom should be stripped of any risk objects including personal belongings, curtains, bedding and carpet. She should be provided with items as required which should be kept in view at all times and counted back by staff before being stored safely elsewhere.

• [X] is only allowed plastic cutlery and plastic cups and not allowed in the kitchen at all.

• Staff should only provide access to items that are relevant to the activity minimising her chances of concealing items to ingest and ensure everything is removed when the activity is completed i.e. cutlery at meal times.

• All clothes to be counted in and out when given to [X] – these should also be checked to make sure that [X] has not tampered with them or attempted to damage the clothing. Staff must not give [X] damaged clothing.

• All rooms should be assessed for risk items and be searched prior to [X] being allowed access.

• [X] is not allowed access to her personal items but can request staff get these for her – this should be risk assessed on each occasion.

• Any family visits must be held in a risk free area. [X]'s family visitors should be subject to a pat-down search and searched with a metal detection device. Staff should remain in the room to witness visits at all times.

5. Health Concerns

• If there is further deterioration in presentation or an increase in self-harm then [X] should be reviewed by the overseeing Psychiatrist.

• Past psychiatric advice recommends that oral medication should be prescribed and used to reduce and minimise such behaviours that can inflict severe harm to self.

• If IM sedation is required complete observations must be taken for 4 hours after medication is administered or [X] should be taken to A&E for further assessments.

• If [X] has an open wound on her arm she regularly removes the dressing. When staff are restraining [X] protective gloves must be worn at all times for infection control.

• [X] has asthma and an innocent heart murmur. At times of restrain her observations should be monitored and restrain times minimised where possible.

• [X] will require regular physical health reviews by medical staff after incidents of self-harm.

6. Safety and Security

• Regular room searches to be carried out throughout the day.

• Only anti-ligature clothing, anti-ligature blankets and reinforced fire-retardant mattress to be left in the room at night. All other items if any are to be removed from her room prior to the door being locked.

• All door to out-side areas or areas not assessed for risk to be kept locked at all times.

Risk to others

• [X] has made threats to harm staff and other young people.

• [X] has a history of assaulting others and has assaulted staff within [ZX] by punching, kicking, biting, pulling hair, pulling fingers back, spitting, head-butting, putting people in headlocks, throwing objects and attempted strangulation.

• [X] will hold onto staff clothing to prevent them moving away from her during assault.

• [X] has attempted to assault other young people.

• [X] has damaged property.

• [X] will attempt to abscond at any given opportunity when doors are opened for short amounts of time and will push past staff to do this.

• [X] can dislocate her hands and wrists to remove her hands out of handcuffs.

Actions required

• Observations levels as above to reduce risk of harm to others.

• Staff to use restraint techniques to prevent risk of assault to themselves.

• If escorting [X] out of the accommodation for any reason 6 staff minimum to provide escort in secure vehicle.

Mental health provision

• [X] will require regular mental state examinations by registered mental health practitioners.

• [X] will require the administration of prescribed medication and regular medication reviews by a Psychiatrist.

• [X] will require daily mental health and wellbeing support and daily meaningful therapeutic activity."