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Judgment: approved by the Court for handing down (subject to editorial corrections)*	*Delivered:* **27/09/2021**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION

OFFICE OF CARE AND PROTECTION

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Between:

A HEALTH AND SOCIAL CARE TRUST

Applicant

-and-

A MOTHER AND A FATHER

Respondents

-and-

A GUARDIAN AD LITEM

Notice Party

IN THE MATTER OF RD (A MALE CHILD AGED 12 YEARS)

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Mr H Toner QC with Ms J Lindsay BL (instructed by the Directorate of Legal Services) for the Trust
Ms Ramsey QC with Ms Lavery BL (instructed by Trevor Smith & Co solicitors) for the mother
Mr G McGuigan QC with Ms McHugh BL (instructed by McCourt & Maguire solicitors) for the father
Ms L Murphy (instructed by Breda Cunningham solicitor) for the guardian ad litem
Ms S O'Flaherty (instructed by the Official Solicitor)

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McFARLAND J

[1] This judgment has been anonymised to protect the identity of the child. I have used the cipher RD for the name of the child. These are not his initials. Nothing can be published that will identify RD.

[2] This is an application by a Trust seeking to invoke the inherent jurisdiction of the court and in particular seeking a declaration that the current interim care plan for

RD involving any deprivation of RD's liberty is lawful and that any limited and purposive physical restraint is also lawful. After a hearing on Friday 24 September 2021 I gave an oral ruling granting the relief sought by the Trust. These are the reasons for that ruling.

[3] The proceedings are running parallel to care proceedings before the High Court which are fixed for hearing in early December 2021. Following a police protection order of 26 January 2020 and an emergency protection order of 28 January 2020, an interim care order was granted on 6 February 2020. Under the interim care plan, RD is currently residing at a residential unit. The Trust, although exercising parental responsibility under the interim care order, cannot consent to any deprivation of liberty. Keehan J in *Re D* [2015] EWHC 3125 stated:

> *"Where a child is in the care of a local authority and subject to an interim care, or a care order, may the local authority in the exercise of its statutory parental responsibility (see s.33(3)(a) of the Children Act 1989) consent to what would otherwise amount to a deprivation of liberty? The answer, in my judgment, is an emphatic "no." In taking a child into care and instituting care proceedings, the local authority is acting as an organ of the state. To permit a local authority in such circumstances to consent to the deprivation of liberty of a child would (1) breach Article 5 of the Convention, which provides "no one should be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law", (2) would not afford the "proper safeguards which will secure the legal justifications for the constraints under which they are made out", and (3) would not meet the need for a periodic independent check on whether the arrangements made for them are in their best interests."*

[4] RD is presenting with extreme behavioural difficulties. After appropriate assessments the staff at the residential unit consider that the following restrictive practices are required to manage RD:

(a) External doors are locked to ensure safety as the unit is adjacent to the public road;

(b) During transportation management of potential aggression ("MAPA") techniques are used on an emergency basis for a short time;

(c) During periods of extreme behaviour RD is directed to his room;

(d) During visits to a contact centre external gates are closed as it is adjacent to the public road;

(e) Water and electrical sockets are restricted in use in his room due to RD's

fascination with water and risk to his safety and the safety of others;

(f) Internal doors may be locked on a temporary basis.

[5] There is in place a Restrictive Practice Plan which is kept under regular review.

[6] No real issue is taken about the suitability of the accommodation or any of these practices as part of the interim care plan by either of the parents, the guardian ad litem (as a notice party) or the Official Solicitor, who was invited by the court to represent the interests of RD in the declaratory relief proceedings. It is also accepted by all the parties that the Restrictive Practice Plan amounts to a deprivation of RD's liberty, see the judgment of Lord Kerr in *Cheshire West* [2014] UKSC 19 at [78]:

> *"All children are (or should be) subject to some level of restraint. This adjusts with their maturation and change in circumstances. If MIG and MEG had the same freedom from constraint as would any child or young person of similar age, their liberty would not be restricted, whatever their level of disability. As a matter of objective fact, however, constraints beyond those which apply to young people of full ability are – and have to be – applied to them. There is therefore a restriction of liberty in their cases. Because the restriction of liberty is – and must remain – a constant feature of their lives, the restriction amounts to a deprivation of liberty."*

[7] Article 5(1) of the European Convention on Human Rights provides as follows:

> *"Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save … in accordance with a procedure prescribed by law."*

[8] McBride J in *Re PT* [2017] NIFam 1 was considering the position of an incapacitated adult and she set out four key questions to be considered when dealing with applications of this nature (see [25]). I consider that the same questions apply to children:

> *"The court considers that 4 questions need to be addressed in this case:*
>
> *a. Does PT lack capacity?*
>
> *b. Is there a gap in the existing legislation, thereby permitting the exercise of the inherent jurisdiction?*
>
> *c. Is the care plan in PT's 'best interests'?*

d. Is the care plan compliant with the ECHR?"

[9] The answer to question (a) concerning the capacity of RD has not been assisted by the inability of the Trust (or other parties) to retain the services of a suitable expert to make a competency assessment. Numerous experts in the fields of psychiatry and psychology have been approached. There is therefore no expert evidence on this issue. The Trust rely on a number of factors, namely the age of RD (12 years 4 months), the general psychological and psychiatric opinions expressed in connection with RD's treatment and care planning, the social work reports, RD's recorded chaotic behaviour and his general inability to communicate.

[10] It is not necessary to catalogue this body of evidence for the purposes of this judgment but it is set out in the various reports submitted to the court. It is sufficient to state that RD suffers from moderate learning disability and developmental delay. He presents with a very wide range of challenging behaviour which exposes him, staff and others to a risk of significant harm. This includes self-injurious behaviour, attempted arson, sexualised behaviour, risk of absconding and risk of electrocution. He displays potential cognitive ability by expressing approval or disapproval with a thumbs up or thumbs down gesture but until very recently has been mute. In recent days he has started to use short phrases to express himself.

[11] During submissions there was some discussion about a presumption of competency. McBride J referred to this in *Re PT* at [26]. I, however, consider that she was referring to adults (those aged 18 and over). The same cannot be said for all children. It may well apply to children aged 16, as that age is recognised in several statutes as giving children certain competencies. In a case of a child aged 15 or under, the position is much less certain. I consider that there would be no presumption either way, and it is therefore a burden on the party seeking a finding of a lack of competence to prove it, on the balance of probabilities.

[12] The seminal judgment relating to the competence of a child is the decision in *Gillick –v- West Norfolk and Wisbech Authority* [1986] AC 112. From this decision is derived the phrase "*Gillick competence*." The case decided that a child under 16 was capable of consenting to medical treatment if the child was capable of understanding what was proposed and of expressing his own wishes. However, *Gillick competence* is not quite as straightforward as everything depends on the context and in particular what the child is being asked to consent (or not consent) to. In *Gillick* it was advice about and assistance with birth control.

[13] The use of the "*Gillick competence*" test was considered to be appropriate by the Court of Appeal in *Re S* [2014] NICA 73 when considering whether a looked after child could consent to living outside Northern Ireland (see Gillen LJ's judgment at [45]) and by Cobb J in *Re S* (see [14] below) when considering a child's competence to consent to her child being adopted. In *Re D* [2019] UKSC 42 the Supreme Court was considering the issue of parental consent to the deprivation of liberty of a

looked after child (which is not the issue in this case). Lady Black was of the view that *Gillick* was more to do with medical treatment as opposed to deprivation of liberty cases and care was needed not to read it across into such cases. She was, however, willing to accept the validity of the argument that it applied to deprivation of liberty of children under 16, but not for older children (see [88] and [89]). On this point, Lady Hale at [50], in *obiter* comments expressed doubt as to the ability of parents to consent to the deprivation of liberty for their children under 16.

[14] The key factors with regard to a child's competence would appear to be:

a) Age

b) Maturity

c) Mental capacity, including cognitive functioning

d) Understanding the issues involved, including advantages, disadvantages and long-term impact of any decision

e) Ability to receive and assimilate advice

f) An ability to set aside external pressures or influence

[15] Cobb J in *Re S* [2017] EWHC 2729 dealt with whether a young mother (her age was not stated but she was under 16) had the competence to consent to her child being adopted. At [17] Cobb J considered that three principles should be applied when considering a child's competence:

> *"i) The determination of a child's competence must be decision-specific and child-specific. It is necessary to consider the specific factual context when evaluating competence, for "removing the specific factual context from some decisions leaves nothing for the evaluation of capacity to bite upon"* (City of York Council v C *[2013] EWCA Civ 478 at [35]);*
>
> *ii) Just because S lacks litigation competence in the placement order proceedings for example does not mean that she lacks subject matter competence (say, in relation to consent):* Sheffield City Council v E *[2004] EWHC 2808 (Fam) at [23] ("someone can have capacity for one purpose whilst simultaneously lacking capacity for another purpose");*
>
> *iii) The assessment of competence must be made on the current evidence, and in respect of this current and specific decision."*

He then continued at [18] to set out the key factors which should be shown to demonstrate decision-making competence:

> *"The child should be of sufficient intelligence and maturity to:*
>
> *i) Understand the nature and implications of the decision and the process of implementing that decision;*
>
> *ii) Understand the implications of not pursuing the decision;*
>
> *iii) Retain the information long enough for the decision-making process to take place;*
>
> *iv) Weigh up the information and arrive at a decision;*
>
> *v) Communicate that decision."*

[16] Having considered all the evidence concerning his age, his mental health, his level of functioning within the unit and all the other evidence concerning his behaviour as recorded and assessed by social work staff, I consider that when dealing with a question whether RD would possess decision-making competence I consider that he would not. In particular he does not display sufficient intelligence and maturity. His impulsive style of behaviour would suggest he lacks the ability to receive advice, retain that advice and weigh up the advantages and disadvantages to him. There may be evidence of an ability to communicate a decision with his ability to use a thumbs up or thumbs down gesture, but overall the compelling evidence suggests that he lacks competence. I therefore find that the Trust has proved that RD lacks competence.

[17] Given the behaviour that he is displaying I also consider that the Trust have shown that the use of the restraints is in RD's best interests.

[18] With the inability of the Trust to exercise parental responsibility to deal with this issue, there is a gap in the legislation and the court can consider invoking its inherent jurisdiction.

[19] I also consider that the ongoing review of the Restrictive Practice Plan and the making of the order for a limited period up to 7 December 2021 (the intended conclusion of the care order proceedings) ensure that the restraints on RD's liberty are compliant with his human rights particularly in respect of his Article 5 right (right to liberty) and his Article 8 right (right of respect for his private and family life).

[20] I will therefore make the order sought by the Trust for a duration up to 7 December 2021. The court will list the matter for further consideration on that date.

[21] The Trust should submit the draft order for approval of the court.