
LIBERTY

PROTECTING CIVIL LIBERTIES
PROMOTING HUMAN RIGHTS


# Briefing on Deprivation of Liberty Safeguards – Policing and Crime Bill

**January 2017**

**About Liberty**

Liberty (The National Council for Civil Liberties) is one of the UK's leading civil liberties and human rights organisations. Liberty works to promote human rights and protect civil liberties through a combination of test case litigation, lobbying, campaigning and research.

Liberty provides policy responses to Government consultations on all issues which have implications for human rights and civil liberties. We also submit evidence to Select Committees, Inquiries and other policy fora, and undertake independent, funded research.

Liberty's policy papers are available at
http://www.liberty-human-rights.org.uk/policy/

**About Rethink Mental Illness**

Rethink Mental Illness is a charity that believes a better life is possible for people affected by mental illness. Since 1972 we have brought people together to support each other. We run services and support groups that change people's lives and challenge attitudes about mental illness. We support almost 60,000 people every year across England to get through crises, live independently and realise they are not alone. We give information and advice to 500,000 more and change policy for millions.

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**About Mind**

We're Mind, the mental health charity for England and Wales. We believe no one should have to face a mental health problem alone. We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

**Introduction**

1. At Committee Stage of the Policing and Crime Bill, Baroness Finlay tabled an amendment to remove the automatic requirement of an inquest for those subject to Deprivation of Liberty Safeguards (DoLS). With the Government's support, it passed Committee stage in the House of Lords and was added to the Bill after clause 145 and is listed as amendment 135 for consideration in the House of Commons.

2. DoLS were introduced for an extremely important purpose: to fill the gap that had been left in mental health provision wherein those without capacity faced entirely inadequate legal safeguards on their detention. There are some fundamental problems with the system, which require reform to provide better protection for some of society's most vulnerable.

3. However, we caution against attempts at piecemeal and one-sided reform of this system with no consultation and little Parliamentary discussion. We are extremely concerned that the new clause makes a very significant change to the functioning of DoLS and fundamentally alters a significant safeguard without informed public debate and substantive parliamentary consideration. Changes need to be made, but on the basis of comprehensive and evidence-based proposals for reform.

4. In fact, the clause will reduce the number of vulnerable people entitled to an automatic coronial inquiry into their death at the exact time when new evidence from the CQC suggests that the NHS referral process – which would fill the gap in the absence of the automatic requirement for inquests – is experiencing system-wide failings.[1] In addition, Freedom of Information Act requests have shown that since 2011 only 137 (35%) of the 397 deaths categorized as 'unexpected' were the subject of an investigation.[2] The CQC also found that families are often ignored, or treated as antagonists rather than participants in investigations into the deaths of their family members.

5. Amendment 135 will likely have the unintended consequence of exposing more vulnerable people to the serious failings identified by the CQC and others in the investigation of deaths.

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[1] *The Guardian*, 'Hospitals fail too often to investigate deaths, NHS watchdog finds', 13 December 2016, available here: https://www.theguardian.com/society/2016/dec/13/hospitals-fail-too-often-to-investigate-deaths-nhs-watchdog-finds.

[2] *The Guardian*, 'Revealed: NHS hospitals investigate one in seven deaths of vulnerable patients', 25 April 2016, available here: https://www.theguardian.com/society/2015/dec/20/revealed-nhs-hospitals-investigate-1-in-7-deaths-of-vulnerable-patients.

**Liberty, Rethink Mental Illness, and Mind urge Members of Parliaments to vote to 'disagree' with amendment 135.**

***A brief history of DoLS***

6. DoLS were introduced by a 2007 amendment to the Mental Capacity Act 2005. They were created in response to the judgment of the European Court of Human Rights in *HL v. the United Kingdom*.[3] In 1999, HL – a severely autistic man without capacity to consent to hospital treatment – was admitted to Bournewood Hospital. However, since he was not detained under the Mental Health Act (MHA), and could not consent to any informal admission for treatment, he was detained and treated under the common law doctrine of necessity.

7. He was prevented from leaving the hospital and denied access to his carers, who challenged the hospital's decisions before the European Court of Human Rights. It found that HL was deprived of liberty under Article 5, and his right against arbitrary detention was violated as a result of the UK's failure to have his detention "prescribed by law". As it found, there was a conspicuous "lack of any formalised admission procedure", a crucial safeguard on detention necessary to render it lawful. There was also no procedure by which HL could apply to a court to determine the lawfulness of his detention, another important safeguard on the detention of some of society's most vulnerable.

8. As a result, DoLS were introduced. These are applicable to any individual in England and Wales who is 18 years of age or over, and (i) has a mental disorder (as defined by the MHA, but also including mental disabilities, including learning difficulties), (ii) lacks capacity to consent to admission to hospital for care or treatment, and (iii) has a clinical need for care and treatment in circumstances amounting to a deprivation of liberty in hospital or a care home, care being in his or her best interests and necessary to protect him or her from harm.

9. DoLS set out conditions on the lawfulness of any deprivation of liberty of individuals without capacity. A person without capacity can only be deprived of their liberty where (a) it is a consequence of giving effect to an order of the Court of Protection or (b) it has been standardly or urgently authorised by the individual's hospital or care home.

***The duty to conduct an inquest***

[3] App. Np. 45508/99.

10. Section 1 of the Coroners and Justice Act 2009 (CJA) provides that a senior coroner must conduct an investigation into a person's death of which they are aware in their area wherever (i) the death was unnatural or violent, (ii) the cause is unknown, or (iii) it occurred in state detention. Amendment 135 alters the CJA to provide that no one subject to DoLS can be deemed to be in state detention for the purposes of section 1 CJA. The amendment therefore removes the automatic requirement that coroners investigate the death of anyone subject to DoLS.

11. Substantive safeguards are needed for those detained by the state, wherever this occurs and no matter who the detainee is. The amendment risks undercutting the crucial decision of the Supreme Court in *Cheshire West*, which held that those with mental health problems and psychosocial disabilities have just the same rights in detention as anyone else. Article 2 of the Human Rights Act 1998 requires the Government to investigate the deaths of anyone who dies whilst detained by the state. Those with disabilities are entitled to just the same protection as any other detainee. Amendment 135 purports to giving those detained under DoLS lesser rights than other detainees, reinstating the unfair system of unequal treatment for those detained as a result of their disabilities.

12. When the new clause was proposed, its supporters raised concerns that some families are suffering real distress at the prospect of inquests into the deaths of loved ones whose deaths are in no way suspicious, but which are mandatory since they occurred in state detention. Grieving families deserve to be treated with respect and sensitivity after the death of a loved one, and overly-invasive responses by the authorities have caused distress for some. However, these problems must be addressed in a manner that improves the way in which proceedings are conducted rather than by abolishing the requirement to conduct full and proper investigations.

***System-wide failings***

13. Late last year, the CQC published a highly critical report into the investigation of the deaths of some of society's most vulnerable, which was undertaken after the death of Connor Sparrowhawk, an 18-year old who drowned whilst in the care of Southern Health NHS Trust, whose failures and neglect was found by a coroner to have contributed to his death.[4] These included investigating only 1% of all deaths among

[4] Care Quality Commission, 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England', December 2016, available here: https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf.

patients with learning disabilities and only 0.3% of the deaths of those aged over 65 with mental health problems.[5]

14. The Trust originally classified his death as due to natural causes, and a later independent inquiry found that the Trust had failed to investigate over 1,000 unexpected deaths of people with learning disabilities and mental health problems, including 77 deaths which were classified as 'critical incidents' which were nevertheless not investigated. Just 1% of unexpected deaths for people with learning disabilities had been investigated.

15. The CQC review found that hospitals are failing to investigate far too many deaths in what amounts to a system-wide problem, particularly for those with a mental health problem or a learning disability. As Professor Sir Mike Richards, the CQC's chief inspector of hospitals, stated of their findings, *"Families and carers are not always properly involved in the investigations process or treated with the respect they deserve. We found this was particularly the case for families and carers of people with a mental health problem or learning disability which meant that these deaths were not always identified, well investigated or learnt from."*[6]

16. As the CQC concluded, *"the level of acceptance and sense of inevitability when people with a learning disability or mental illness die early is too common"*.[7] The Health Secretary has stated that stated in the House of Commons that *"those words have the Government's wholehearted support"*.[8] Amendment 135 will do nothing to reverse the level of acceptance the CQC identified nor in any way address the problem – in fact, it may worsen it.

17. Figures released by *The Guardian* have already revealed that the problem is widespread and serious. As it reported earlier in 2016:

> "Data released to the Guardian under freedom of information (FOI) laws show that hospitals in England have investigated just 222 out of 1,638 deaths of patients with learning disabilities since 2011.

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[5] *The Guardian*, 'Southern Health trust interim chair resigns', 19 September 2016, available here: https://www.theguardian.com/society/2016/sep/19/southern-health-trust-interim-chair-tim-smart-resigns.
[6] *The Guardian*, 'Hospitals fail too often to investigate deaths, NHS watchdog finds', 13 December 2016.
[7] CQC, 2016, p. 2.
[8] See Hansard, Volume 618, Column 627, available here: https://hansard.parliament.uk/commons/2016-12-13/debates/A9008047-29BB-48FC-93C7-1CBD7A849F77/CQCNHSDeathsReview.

> "Even among deaths they classed as unexpected, hospitals inquired into just over a third. Only 137 (35%) of the 397 deaths in that category were the subject of an investigation, despite longstanding concerns that these patients receive poorer care and are at higher risk of dying while in hospital."[9]

18. Far from demonstrating an excess of investigations, these shocking figures, along with the CQC's findings, show that there are already serious failings in the way those with mental disabilities are treated. They are simply not receiving the safeguards to which they are entitled.

19. Moreover, the CQC found that families are being failed by their lack of involvement in investigations. It found repeated failures not to include them, or to only involve them in a "tokenistic" or even "antagonistic" way – with families are "often not listened to". Amendment 135 will do nothing to improve the families' involvement in investigations into the deaths of their relatives. Indeed, it may even worsen it, as the investigations may simply not take place. This cannot be the appropriate response to these serious and alarming findings.

***Careful review is needed to protect society's most vulnerable***

20. Changes may need to be made to support families within the inquest process, or to assist coroners in conducting their investigations in a timely and appropriate manner. Additional resources should be deployed where they are necessary to do justice to the individual cases and to provide full support to the families involved. But substantive legal changes must only be made alongside wholesale consideration of the regime, which remains only 7 years old. Serious parliamentary scrutiny needs to be undertaken to identify the changes needed to properly improve the system, not isolated and untested amendments.

21. Liberty, Rethink Mental Illness, and Mind are extremely concerned that amendment 135 of the Bill will prejudice, if not forestall, real reform to the DoLS system to the benefit of some of society's most vulnerable and their families. It will do nothing to address the serious failings identified by the CQC and others in the investigation of deaths in hospital – and it may even exacerbate them.

22. Change may be necessary, but piecemeal reform without proper consultation or comprehensive assessment is not the answer. Most importantly, this amendment should be reconsidered in light of the CQC review, and the crucial need for

[9] *The Guardian*, 'Revealed: NHS hospitals investigate one in seven deaths of vulnerable patients', 25 April 2016.

safeguards for society's most vulnerable whilst in the care of the state. Liberty, Rethink Mental Illness, and Mind urge Parliamentarians to vote to 'disagree' with amendment 135 in the Bill.