INQUEST and INQUEST Lawyers’ Group
Response to the Law Commission’s
Consultation on Mental Capacity and
Deprivation of Liberty

November 2015
Background and summary of proposals

1. This document is the response of INQUEST and its Lawyers Group to the Law Commission’s consultation on mental capacity and deprivation of liberty.

2. INQUEST is a charity providing specialist advice to bereaved families, lawyers and the wider public. Our casework priorities are deaths in custody (including police, prison, immigration detention and deaths of detained patients). We also work on other cases that involve multi agency failings and/or raise wider issues of state or corporate accountability. This can include deaths in care homes where the deceased is subject to Deprivation of Liberty Safeguards (DOLS).

3. INQUEST co-ordinates the INQUEST Lawyers Group (ILG) which is a national network of over two hundred lawyers who provide preparation and legal representation for bereaved families. The ILG also promotes and develops knowledge and expertise in the law and practice of inquests by providing training and acting as a forum for the exchange of ideas and experience. ILG members have been involved in thousands of inquests into deaths in custody/detention over the last thirty years. The most recent case includes that of Connor Sparrowhawk. Connor was previously detained under a Deprivation of Liberty Safeguard Order, and was 18 years old when he drowned in the bath, following an epileptic seizure, at Short Term Assessment and Treatment Team Unit - run by Southern Health NHS Foundation Trust.

4. We develop policy proposals and undertake research to lobby for changes to the inquest and investigation process, to reduce the number of deaths arising in these circumstances and to improve the treatment and care of those within the institutions where these deaths occur.

5. Given the area of our expertise, this response focuses on exclusively on provisional proposals 15-6 – 15-8 of the consultation document.

Corrections

6. Before detailing our response to the proposals below, we provide some corrections to the legal summary provided at the beginning of this section of the consultation document.

7. Firstly, para 15.50 asserts that the family of the deceased might insist that the coroner calls certain witnesses at an inquest and claims that they are entitled to do this as interested persons. This is incorrect. As interested persons, they have the right to request that the coroner calls certain witnesses but the final decision lies with the coroner who may or may not accommodate the request.
8. At para 15.51 it is asserted that Lady Justice Hallett held that there was little practical difference between the scope of an inquest where Article 2 is engaged and one where it is not\(^1\). This is an inaccurate summary of her conclusions which should correctly be confirmed as follows:

*There is now in practice little difference between the Jamieson and Middleton type inquest as far as inquisitorial scope is concerned. The difference is likely to come only in the verdict and the findings.*

9. Also at para 15.51 this misrepresents the scope of the coroner’s duty to produce a Prevention of Future Death Report. This duty arises in circumstances where the coroner has concerns as a result of something revealed in the inquest process that there is a risk of other deaths occurring\(^2\). This duty arises irrespective of whether the inquiry being conducted is Article 2 compliant or not.

10. Para 15.52 states that for those detained under the Mental Health Act, the Article 2 investigatory duty *can* apply to them, when it fact it *does* apply.

**Provisional Proposal 15-6:** the Criminal Justice Act should be amended to provide that inquests are only necessary into deaths of people subject to the restrictive care and treatment scheme where the coroner is satisfied that they were deprived of their liberty at the time of their death and that there is a duty under article 2 to investigate the circumstances of that individual’s death.

11. Paragraph 15.44 of the consultation document details the circumstances in which a coroner is required to carry out an investigation and makes reference to s1 of the Coroners and Justice Act 2009. Various case law has provided additional clarity to the circumstances in which an inquest should be held and confirms that the circumstances are much wider than section 1 may suggest at first glance. A ‘violent death’ includes self-inflicted and accidental deaths and ‘unnatural’ includes circumstances in which there is suspicion of foul play or other wrongdoing, and this includes neglect.

12. The definition of state detention is provided by s48(2) of the 2009 Act and provides as follows:

\[(2)\] A *person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998 (c. 42).*

\(^1\) R *(Sreedharan)* v HM Coroner for the County of Greater Manchester [2013] EWCA 181, [2013] Med LR 89 at [18]

\(^2\) Schedule 5, para 7 of Coroners and Justice Act 2009
13. Lady Hale’s judgment at paragraph 46 of the case of *Cheshire West*\(^3\) sets out very clearly the extent of a disabled person’s rights under the European Convention on Human Rights:

> 46 Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focussed right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.

14. The Chief Coroner very much had this in mind when he issued his Guidance\(^4\) which confirmed his view that all deaths which occurred where the deceased was subject to DOLS fall with the definition of state detention under s48(2) of the 2009 Act and the duty to hold an inquest is triggered.

15. INQUEST approves of the Chief Coroner’s conclusion in this regard and considers that any lesser provision would be contrary to the principles of Article 2 and Article 5 of the ECHR.

16. Under the current DOLS scheme, local authorities, in their responsibilities as supervisory bodies and funders of care packages, are inextricably involved in approving placements of individuals. The fact of state control cannot therefore be artificially removed to reduce the burden on coroners to hold inquests. This will not change under the Commission’s proposed scheme.

17. In addition to the fact of the local authority’s involvement, section 73(2) of the Care Act 2014 provides that care providers are to be taken for the purposes of section 6(3)(b) of the Human Rights Act 1998 to be exercising a function of a public nature in providing care or support whether to a resident of a care home or to an individual in their own home (or indeed to their carer) provided the service is arranged for by the local authority or paid for by them.

18. Accordingly, INQUEST concurs with the legal interpretation set out at para 15.53 of the consultation document.

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\(^3\) Surrey County Council v P and others; Cheshire West and Chester Council v P and another [2014] UKSC 19

\(^4\) Chief Coroner’s Guidance No. 16 Deprivation of Liberty Safeguards
19. It is accepted that the number of inquests being held following the judgment in *Cheshire West* has increased in line with the increasing number of DOLS authorisations. However, INQUEST rejects any proposal which would seek to diminish the requirement for inquests to take place in these circumstances.

20. By drawing a distinction between those who die under the proposed restrictive care and treatment scheme as opposed to other aspects of protective care, a hierarchy of rights is created. This is in addition to the hierarchy of rights that will be created between people who are detained under Mental Capacity Act 2005 and those who are detained under the Mental Health Act 1983.

21. Individuals detained under the current DOLS scheme have the right to challenge that authorisation under s21A of the Mental Capacity Act 2005. Practitioners representing those individuals often come across hostility or upset from family members who feel personally criticised for decisions they have supported to move a family member into a care home. It would be absurd if those practitioners were to discontinue those challenges because of family wishes.

22. The same principle should apply to deaths occurring in those circumstances. INQUEST fully appreciates how difficult a coroner’s investigation can be for families and routinely supports families with this process. However, the coroner’s investigation is an essential safeguard in ensuring that those who die whilst under the control of the state did not die deaths that were preventable and seeks to identify any lessons that can be learned to stop preventable deaths from occurring in the future. From our experience, families are concerned about the possibility of poor care and treatment of their relative, and a properly conducted inquest provides them with the only opportunity to investigate the circumstances surrounding a death.

23. It is also clear that coroners will require additional resources to ensure that all inquests take place within a reasonable period of time so as to avoid unnecessary delays. INQUEST supports such resources being given.

24. Additionally, the proposal puts a high burden on coroners to determine at a very early stage whether the investigation obligation that arises under Article 2 is engaged. Pressure of this sort is likely to result in incorrect decisions being taken and carries the risk that deaths which should be investigated, will not be, falling foul of the state’s obligations under Article 2.

25. In summary, many of the problems identified by the consultation are practical rather than legal and can be broken down as follows:-

   a. Family anxieties
   b. Anxieties around organ donation and prompt burials and cremation
c. Burden on coroners
d. Funding for families
e. The opportunity for families to play a meaningful part in the investigation process

26. It is INQUEST’s view that these practical problems can and should be remedied by the allocation of additional resources and more efficient administrative procedures. It is beyond the scope of this paper to fully consider the extent of additional resources and improved administration required.

27. In conclusion, INQUEST considers that the proposed amendment would not comply with the UK’s obligations under Article 2 of the ECHR.

**Question 15-7: should coroners have a power to release the deceased’s body for burial or cremation before the conclusion of an investigation or inquest?**

28. A coroner must release the body for burial or cremation as soon as it is reasonably practicable and where this cannot be completed within 28 days, the coroner must notify the next of kin or personal representative\(^5\). However, a coroner can only authorise release of the body if the coroner is satisfied that it is no longer needed for the purposes of the investigation\(^6\).

29. If the Law Commission is presented with evidence that delays are occurring and causing distress to families or preventing organ donation wishes from being carried out, INQUEST considers that the Chief Coroner should be asked to issue further guidance to coroners.

**Question 15-8: is the current law on reporting deaths to coroners satisfactory?**

30. INQUEST considers that the law on reporting deaths to coroners should be tightened. Section 18 of the 2009 Act grants the Lord Chancellor the power to issue regulations requiring medical practitioners to notify a senior coroner of deaths occurring in prescribed circumstances. No regulations have been issued. Our findings show real concerns regarding the quality of information provided about a death, which impacts on the type of investigation/inquest held.

INQUEST

02 November 2015

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\(^5\) Regulation 20 of Coroners (Investigations) Regulations 2013/1629

\(^6\) Regulation 21 of Coroners (Investigations) Regulations 2013/1629