

Written evidence from Richard Charlton (HCS0054)

Personal Background

- I am a Director at Richard Charlton Solicitors, a niche firm practicing exclusively in Mental Capacity and Mental Health Law based in Folkestone, Kent. We represent clients across the South East, but particularly in care homes and other institutions in Kent, Surrey, Sussex and Hampshire.
- I have been a qualified solicitor since 1996 and have previously worked as a social worker. Much of my work has been with those suffering from forms of mental disorder, in a range of jurisdictions, but more recently with those subject to both the Mental Capacity and Mental Health Acts.
- I was involved in the implementation of the Mental Capacity Act, and previously represented clients lacking the relevant mental capacity under the Inherent Jurisdiction in the High Court.
- Our firm has conducted around 120 cases in the Court of Protection in the last three years concerning those in care settings. In the majority of our cases we are instructed by the Official Solicitor as litigation friend on behalf of the protected person.
- I was previously President of Mental Health Lawyers Association ("MHLA") in 2014 - 2015. I was Chair of MHLA 2001 - 2014. I have recently returned to the MHLA as Vice Chair, and convenor, of their Court of Protection Committee. I also represent the MHLA on the Court of Protection Users Group.
- I was selected as the first Mental Health Legal Aid Lawyer of the Year in 2004; and in 2015 shortlisted for the Law Society Excellence Awards in the Human Rights category.
- I was appointed a senior Peer Reviewer in Mental Health Law by the Ministry of Justice in 2007 and a Law Society Mental Health Panel Assessor in 2012. I was appointed Law Society Welfare Mental Capacity Assessor in 2017.
- I have been listed as a Grade 1 leading practitioner in Health & Social Law in the independent Chambers Law Directory since 2004.
- I have conducted in excess of twenty legally reported cases in this area of law one being the case of Re UF [2013] EWHC 4289 (COP) which forced the Government to restore free legal aid in Court of Protection proceedings to those deprived of their liberty under the Mental Capacity Act.
- I have given evidence as an expert in this field of law and practice to parliamentary committees and to the High Court.
- I have previously served as Director of the Legal Aid Practitioners Group and a member of the Law Society's Mental Health & Disability Committee.
- I have regularly taught at all levels up to University Masters level and have written and broadcast regarding developments in this area of law.

The information and views expressed in this submission are my own, but have I have in part been assisted by my colleagues at work any by my role in the Mental Health Lawyers Association.

What human rights issues need to be addressed in care settings in England, beyond the immediate concerns arising from the Covid-19 pandemic?

Human Rights are at the heart of care settings, be they concerning those in care or nursing homes; or a form of care in the community. The subjects of these rights are often extremely vulnerable, frequently with diagnosis of dementia or learning disabilities, and sometimes with limited communication skills. A measure of civilisation in any society must be the way such rights are applied

Article 2

An obvious very grave concern is the state's duty to preserve life as per Article 2. I understand that the committee has already considered the premature discharge of hospital patients to care homes at the commencement of the pandemic and how this endangered (and ended) many lives of residents which would not otherwise have been lost. I understand also that this issue will be considered further in the Government's inquiry on the pandemic, together with the delayed provision of protective clothing for staff, further allowing the endangerment of residents in care settings.

Decisions authorising Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) also raised substantial concern. No standard form is nationally used for this, but such a decision is required to have the same components. A survey carried out by this firm indicated that on many occasions neither the protected person, nor members of the family, or other carers, had been consulted prior to the relevant DNACPR Form being signed, moreover that the subject of the form was classified as "frail" simply because they had dementia. A copy of our article on this point is appended here. Whilst it is understood that procedures are now being more regularly followed, in compliance with s4 MCA, vigilance is clearly still required, especially at a time when the care system is under great stress.

In order for life to be protected in care settings, care recipients require sufficient numbers of trained staff. It is clear that there are insufficient staff, for example <https://www.theguardian.com/society/2022/jan/15/vulnerable-adults-left-without-care-in-england-as-staff-crisis-worsens>

This shortage applies in both residential and care settings. Clearly such a shortage puts lives at risk, and threatens "inhumane and de-grading treatment" for elderly and disabled clients by receiving inadequate care. Staff shortages impact Human Rights in other ways as well. Despite the easing of pandemic restrictions, many of our clients are denied access to the community, including visits to family members, because there are insufficient staff to support. In some cases clients in care homes are unable to source care to return to their homes, even if such care is privately funded, because of the lack of qualified care staff.

On inquiry of care home managers, a combination of the trauma of the pandemic; the shortage of EU staff post Brexit; and competing higher wages from other areas of employment are responsible for the staff shortage. It is understood that the Government is now taking steps to ease visa requirements for foreign staff to fill such vacancies but this is yet to show through in our areas of work.

<https://www.theguardian.com/society/2021/dec/24/uk-immigration-rules-to-be-ease-as-shortages-of-care-workers-worsen>

Articles 5 & 8

Access to rights regarding deprivation of liberty and a right to private life both need substantial strengthening in care settings. Regrettably it is often a lottery as to whether a resident is seen to be deprived of his/her liberty (as opposed to being left de facto detained), and therefore obtain family/or professional advocacy assistance in challenging their deprivation of liberty in a care setting. However, as outlined below, those tasked with bringing cases to court often fail to refer such cases, frequently based on a mistaken view of the resident's best interests. Only a tiny percentage of those objecting to their detention in a care setting will ever see their case brought to court. I challenge any one to spend any period of time in a care home and not find a substantial number of residents indicating they want to get out and go home. Such sentiments may sometimes be fancible, or passing, but if you strip these away a sizeable number will want either the ability to go home, or simply to go out when they want.

A consistent concern of solicitors working to represent those in care settings is the difficulty detained residents have in accessing both their services and those of care or other advocates to challenge Art 5 deprivation of liberty issues and the right to private and family life (Art8).

There are around 500,000 people living in care homes as at 2020, <https://www.statista.com/statistics/1082379/number-of-people-living-in-care-homes-in-the-united-kingdom/>.

.....With about 418,000 in England and 25,000 in Wales, representing the English and Welsh jurisdiction. (Around 35,000 in Scotland and 12,000 in Northern Ireland for completeness). It is unclear how many of these are detained but the number of legal aid applications to challenge detentions in such placements in detention in this period was 1,897 (around another 700 legal aid certificates were issued for other issues, which also probably involve various elements of coercion or detention). This demonstrates an extremely small percentage of detained patients exercising their right to go to an independent court. In turn, however, whether such residents are recognised as meeting the "acid test" of detention starts with the care provider. If the provider takes the view that the client is detained, they refer the case for assessment for a standard authorisation under Sch A1 of the MCA, whilst in the interim providing an urgent authorisation. Many of the cases where we represent residents include a period where the client has been de facto detained. Once a resident is detained under a standard authorisation, then they should receive support either from an appointed family member or an independent advocate appointed by the responsible authority (effectively the local authority) to bring a case to the Court of Protection. In a significant number of cases, regrettably, such advocates act as gatekeepers from making any such referral, even if the resident is objecting.

Legal aid implications

The availability of legal aid is another major barrier for those detained and objecting to this in a care setting. For those who are detained under a "standard authorisation" under Sch A1 MCA in a registered care home, nursing home, or hospital, means-free legal aid is available to bring a case in the Court of Protection.

However, for those detained in supported living or in a community setting, only means-tested legal aid is available for applications under s16 MCA. Given severe financial restrictions on

legal aid eligibility substantial payments generally have to be paid after £3000 worth of savings, with all legal aid ceasing to be available after £8000 of capital. This Government has indicated it will review such restrictions, yet they currently remain effectively denying many of those objecting to their detention any access to an independent court. Recently the situation has got worse regarding such eligibility restrictions as there has been a dramatic increase in those detained in supported living as housing benefit is payable, thereby reducing costs; and, in the pandemic, the inability of detained residents to spend their benefits or other income, artificially raising their capital so that exceed the financial limit.

Sometimes cases yo-yo when a client whose case commenced as detained resident in a care home, and therefore with means-free legal aid,; however during the proceedings she or he gets transferred to supported living and is no longer eligible for legal aid. Frequently proceedings are then delayed (these of course should be speedy to comply with Article 5) whilst a fresh application for legal aid is made and the decision as to whether the client's ongoing proceedings should be paid from savings of say £10000. And, of course, the client will have to start paying a sizeable monthly contribution even if they have savings more than £3000 in many cases, with these payments frequently distressing the client, who will sometimes say they did not chose to be locked up.

The government has recently delayed further the introduction of the Liberty Protection Standards (LPS), due in April of this year. No new date has yet to be announced. It is very difficult to see how effective these will be in practice without sight of the new Code of Practice. However, the role of the care home manager, and the effectiveness of the professional advocacy service will be critical. There appears an assurance that means-free legal aid will be available for challenges to the Court of Protection. However, most surprisingly the Department of Health on their Impact Assessment of LPS, appears to consider that the number of challenges will decline to 0.5% of those detained. This would seem a disturbing low number of cases, and equally disturbing are the limited resources consequentially allocated to the appeals process.

Of further note with respect to legal aid and the Court of Protection, is that due to restrictive changes in legal aid availability for judicial review, there are far fewer such challenges with respect to public law decisions under the Care Act 2014. Indeed, recent figures released by the Legal Aid Agency indicate that such cases have all but collapsed. Care Act decisions are of course critical in supporting the private lives of many vulnerable people, and this new restriction must be considered with great alarm. The lack of adequate community support reflects back up the chain to hospitals and care homes, and, of course, failures in community care mean that detention in an institution for many becomes more likely.

An additional implication of the collapse of judicial review challenges is that the Court of Protection is called on more often with respect to inadequate community support for the protected party, albeit that that this court does not have the powers of the Administrative Court to order certain provisions, or at least that public law decisions are re-made. The result is that the Court of Protection frequently does what it can to pressure the relevant public bodies (frequently the local authority) with respect to improving community care support, but also that that Court takes longer to make a final determination on account of inadequate Care Act decisions.

The availability of access to an independent court for those detained under the MCA is in stark contrast to those detained under the Mental Health Act, where means-free legal aid is always available, and where a statutory referral system means that almost everyone subject to the detention, or restriction, under the Act must have a review by the independent court, the Mental Health Tribunal, on a regular basis.

How effective are providers at respecting the human rights of people under their care?

Clearly there is considerable variety in the levels of protection of human rights. Issues raising Art 2 breaches are referred to above, and certainly some care homes have been better in managing infection control than in others.

DNRCPR was mentioned above in the context of Art 2. These decisions were made by medical staff. However, it is of concern that many providers, in our experience, did not appear to intervene in this decision or alert family members, although we accept this is a very small sample.

Providers took a very cautious view to allowing access by family members to care residents. Whilst such caution might be understandable regarding the covid risk and the protection of life, it frequently exceeded what was being advised by the Department of Health. Such lack of access was often extremely distressing for both family members and the care home residents; and in our view was a factor in further dementia decline and premature death in such residents. Some care homes did respond by building “summer houses” or “pods” outside, although this was frequently belated. Of course, concerned family members are frequently the best advocates that a vulnerable care home resident can have.

Unfortunately, electronic communication by ipad or computer took a long time to be established with many care providers. It was a surprise that most homes appeared to have no such equipment in any event and weeks passed as the pandemic progressed without some provision in many cases. This lack of any form of ipad etc impacted on those of us attempting to enforce residents access to rights, including specialist advocates and solicitors. On occasion my firm had to obtain orders from the court that a provider obtain an ipad in order to ease communication. In the interim it was frequently extremely distressing for vulnerable clients, frequently with various degrees of impairment, to attempt to talk to someone they had never met, or could not remember on the telephone. Such conversations would of course usually be without privacy.

As solicitors acting for vulnerable care home residents, we became more reliant on care home records to understand the condition of our clients as we were not able to visit them in person. However, despite court orders, care homes were frequently very slow to respond. Whilst, at one level, this might be understandable given pandemic conditions, many care home managers failed to appreciate the ongoing significance of Art 5 challenges by their residents. Records at care homes need to be comprehensive, evidence of matters not referred to is often submitted. It takes extensive forensic examination to work the real picture out. Also, there should be clear indicators as to when safeguarding alerts should be raised. Often the same incidents that have previously taken place without any action became subjects of safeguarding investigations when cases come under scrutiny through this disclosure.

With regards to ongoing Art 5 challenges in the Court of Protection, we have to acknowledge the exemplary steps that this court has taken in the pandemic. From early in the pandemic, the President made it very clear of the ongoing significance and priority of the court's work, especially with regards to this detained under the MCA. In tandem with this, all in the court, from the judiciary to the administrative staff, have pulled out all the stops to ensure this was a priority. We now regularly receive emails from the court throughout the weekend to reduce the backlog in this vital work. And, in the meantime, the court has shifted from a paper-based jurisdiction, at the beginning of the pandemic, to an electronic one; with video hearings quickly being established in preference to telephone ones. All this has happened despite a lack of adequate investment in the court service, but has clearly been possible because of the commitment of those involved.

In addition, remote hearing may assist the Court of Protection to sometimes discharge its duties more quickly to have at least remote directions hearing. However, where the protected party needs to attend court then a return to in-person hearings will generally be preferable to allow full participation in the court process.

Whether these changes equip the Court of Protection for the arrival of the LPS, however, will be another question.

How effective are regulators in protecting residents from human rights breaches and in supporting patients and residents who make complaints about their care provider?

We are aware that Care Quality Commission responded to a number of complaints during the pandemic and in our view provided an adequate role. We are aware that the CQC has added covid/health assessments to their work, which has provided a useful prompt/requirement for care and nursing homes. However, in the pandemic, direct access by the CQC was at times more limited.

In addition, we are aware of prompt action by the local government ombudsman with respect to local authority breaches.

However, we should add that those in bespoke community settings, and supported living, are not registered with the CQC, and the onus is on the local authority to both see that any detention is authorised, perhaps through the Re X procedure. Regrettably local authorities are often behind in such authorisations, and in our experience it is quite common for residents to be unauthorised for an extended period of time. Unfortunately, as a result of case law, claims under the Human Rights Act for such unlawful detention frequently only attract nominal damages, particularly where the person would be otherwise detained which, in turn, provides little incentive for the relevant public bodies to prioritise authorising the detention.

What lessons need to be learned from the pandemic to prevent breaches of human rights legislation in future?

Clearly lessons as to infection control, and the significance of this in care and nursing homes, are essential in the preservation of life in care settings.

In addition, the essential requirement for family access to residents, as now, in part being catered for by "summer house" arrangements. Family members need not just physical contact with their loved one, but also need to properly assess their physical and mental condition.

The provision of adequate electronic communication, be it ipad or computer screen, between resident and family is now generally well-established, although in many cases could still be improved. This should have been in position before the pandemic for distant family and friends who could not visit in person, and indeed has already been in place in many long-term secure psychiatric units in the NHS for some time; and of course prisons have had link-ups with the courts for many years.

Many other in-person visits remain essential, both for ourselves and other professionals. We cannot fully communicate with our detained clients unless we are in-person with them, and also ensure the frequent requirement for privacy. It is sometimes difficult for a resident to say they want to be discharged, with the care home manager standing next to them holding an ipad. Similarly for professional advocates and social workers, personal attendance is still a necessity. The benefit, also, of such in-person contact for the care home resident cannot also be underestimated, with a series of voices on the phone, or images on a screen, being confusing, perhaps even alarming for the resident, especially if there are issues of poor hearing or eyesight. It will be essential to support such contact as far as is possible in any future pandemic.

The role of regulators, including the local authority, the CQC, needs to be fully maintained as far as is possible; with safeguarding alerts initiated as far appropriate. Extending monitoring to electronic communication and “summer house” provision should also be considered.

The most frequently asked initial question of those who are detained in care settings is “why I am I being locked up here, I have done nothing wrong?”. This is frequently followed by fear when the knowing that the Court of Protection is examining their case as the detainee thinks of a criminal court sentencing them. Such people require substantial in-person reassurance such that they can appreciate this court is acting to afford them their Human Rights.

I must finally add that it is a pleasure to make this submission to an inquiry which is shining a light on some of the most vulnerable in our society.

16/02/2022