



House of Commons

House of Lords

Joint Committee on Human
Rights

**Human Rights and
the Government's
response to COVID-19:
The detention of young
people who are autistic
and/or have learning
disabilities**

Fifth Report of Session 2019–21

*Report, together with formal minutes relating
to the report*

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Joint Committee on Human Rights

The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases); proposals for remedial orders, draft remedial orders and remedial orders.

The Joint Committee has a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

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Publication

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Summary

Last year, the Joint Committee on Human Rights published a report on the detention of young people with learning disabilities and/or autism in Assessment and Treatment Units (ATUs) and other mental health hospitals which concluded that young people's human rights are being abused; they are detained unlawfully contrary to their right to liberty, subjected to solitary confinement, more prone to self-harm and abuse and deprived of the right to family life.

Now that institutions are closed to the outside world as a result of the Covid-19 pandemic, the risk of human rights abuses are even greater. Unlawful blanket bans on visits, the suspension of routine inspections, the increased use of restraint and solitary confinement, and the vulnerability of those in detention to infection with Covid-19 (due to underlying health conditions and the infeasibility of social distancing) mean that the situation is now a severe crisis.

Claims of unprecedented progress and reports of new taskforces and strategies from those overseeing the detention system sound encouraging but stand in stark contrast to the evidence we heard from mothers of young people who are detained within it during the crisis.

This report makes a series of recommendations which must be urgently acted on in order to put a stop to these human rights abuses. These include:

- NHS England must write immediately to all hospitals, including private ones in which it commissions placements, stating that they must allow families to visit their loved ones, unless a risk assessment has been carried out relating to the individual's circumstances which demonstrates that there are clear reasons specific to the individual's circumstances why it would not be safe to do so.
- Figures on the use of restrictive practices, including physical and medical restraint and any form of segregation, detailing any incidences which go beyond 22 hours per day and amount to solitary confinement, must be published weekly by the institutions. These figures must be provided to the Secretary of State for Health and Social Care and reported to Parliament.
- The Care Quality Commission (CQC) should carry out all their inspections unannounced; this is particularly important where any allegation of abuse is reported by a young person, parent, or whistle-blower.
- The CQC must prioritise in-person inspections at institutions with a history of abuse/malpractice, and those which have been rated inadequate/requires improvement.
- The CQC should set up a telephone hotline to enable all patients, families, and staff to report concerns or complaints during this period.
- The CQC must report on reasons for geographical variation in practice with resultant harmful consequences.

- Now, more than ever, rapidly progressing the discharge of young people to safe homes in the community must be a top priority for the Government. The recommendations from the Committee's 2019 report must be implemented in full.
- Comprehensive and accessible data about the number of those who are autistic and/or learning disabled who have contracted and died of Covid-19 must be made available and include a focus on those in detention, for whom the state has heightened responsibility for their right to life.

1 Introduction

1. In November 2019, the Joint Committee on Human Rights, published a report on the detention of young people with learning disabilities and/or autism in Assessment and Treatment Units (ATUs) and other mental health hospitals [hereafter referred to as the “2019 report”].¹² This concluded that in many cases these young people’s human rights are being abused; they are detained unlawfully, contrary to their right to liberty, subjected to solitary confinement, more prone to self-harm and abuse and deprived of the right to family life. The report called for an overhaul of inspections and changes to the Mental Health Act 1983 (MHA) to protect those detained from breaches of their human rights. It also recommended a Number 10 unit with Cabinet level leadership to urgently drive forward reform. The Government’s response to the report was expected in February but has been delayed due to the pandemic.

2. On 19 March 2020 we announced an inquiry into the implications for human rights of the Government’s Covid-19 response. As part of this inquiry we took evidence on 18 May from parents of young people who are autistic or have a learning disability and are currently detained under the Mental Health Act 1983. These were Adele Green, whose 20-year-old son Eddie has a learning disability and has been detained for seven years, since he was 13, and Andrea Attree whose 23-year-old daughter Dannielle is autistic and has been detained on and off for over 10 years. Their evidence was powerful and compelling. We are very grateful to them for putting the reality of what is currently happening to young people in detention on the record. We also heard evidence from Dr Kevin Cleary, Deputy Chief Inspector for Hospitals, Care Quality Commission; Kate Terroni, Chief Inspector for Adult Social, Care Quality Commission; Ray James, National Director Learning Disability, NHS England and NHS Improvement; and Claire Murdoch, National Director Mental Health, NHS England and NHS Improvement, for which we were also grateful. The aim of the session was to examine the impact that the coronavirus crisis has had on the human rights of these young people. This report makes a series of recommendations based on the evidence we heard.

3. This inquiry has focused on the situation in England as health and social care matters are devolved to Wales, Northern Ireland and Scotland.

4. We are grateful for the assistance of a specialist advisor Alex Ruck-Keene, Barrister at 39 Essex Chambers, in this inquiry.³

1 Joint Committee on Human Rights, Second Report of Session 2019, [The detention of young people with learning disabilities and/or autism](#), HC 121 / HL Paper 10

2 We recognise that not all those young people living in ATUs and mental health hospitals are formally detained under mental health or mental capacity legislation. However, we have serious concerns about the treatment of ‘informal’ patients some of whom have told us that they fear challenging their situations for fear of being ‘sectioned’. Therefore, we use the term ‘detained’ in a broad sense to refer to all those young people who are autistic and/or have learning disabilities in ATUs and mental health hospitals. In this report when we refer to young people who are detained it should be read as including those in any institution registered by the Care Quality Commission as a hospital, operated by either an NHS or independent sector provider and providing mental or behavioural healthcare in England

3 Declaration of Interests: Member of the Law Society’s Mental Health and Disability Committee; and Court of Protection Rules Committee and the ‘HIVE’ group.

2 Visits and the right to family life

The impact of visiting restrictions on young people

Adele Green, mother of Eddie, a young man with a learning disability:

“When the lockdown came, it was quite quick in the sense that the hospital placed a blanket ban on anybody going in and anybody going out. Within a week, with the fear and anxiety, he tried to take his own life, which really blew us away. We were mortified. [...]

We last visited on 14 March. As part of the discharge process, we met in the community and experienced a meal together, which we had not done for over 12 months, so it was really lovely. Lockdown commenced in the following week, and we have not been able to visit since.”⁴

Andrea Attree, mother of Dannielle, an autistic young woman:

Andrea told us that she has been permitted to visit her daughter, but only once, on her birthday. This has been extremely distressing for Dannielle:

“We had that visit and afterwards she was an absolute mess. I have not been able to visit since. I have continued to point out that this is having a detrimental effect on her long-term health, with an escalation in her anxiety-driven behaviour. She is expressing herself in ways that I have never seen before. It is absolutely devastating. She is ligaturing regularly. She is self-harming to extremes, banging her head. She has smashed all her knuckles on her hand. We had a CTR [Care and Treatment Review] last week and today I had an email to say I can visit her at the weekend, so there has been a breakthrough.”⁵

The right to family life

5. Article 8 of the European Convention on Human Rights (ECHR) provides a right to respect for private and family life. When a young person who is autistic and/or has a learning disability is detained, their rights under Article 8 ECHR and those of their family are engaged. Detention (including detention to assess or treat mental ill health) entails inherent limitations on private and family life. However, the European Court of Human Rights has held that it is an essential part of a detainee’s right to respect for family life that the authorities enable detainees or, if need be, assist detainees in maintaining contact with close family.⁶ It has also made clear that blanket bans on visiting are unlawful.⁷

6. The additional distress and anxiety caused to young people by not being able exercise their right to family life is putting other human rights more at risk too. It is leading to an increase in the use of forcible restraint and solitary confinement, potentially engaging the right to freedom from inhuman and degrading treatment (Article 3 ECHR). In turn this is disrupting plans to discharge them to safe homes in the community prolonging inappropriate and harmful detention, contrary to Article 5 ECHR which provides a right to liberty and security of person.

4 [Q28](#) [Adele Green]

5 [Q28](#) [Andrea Attree]

6 *Khoroshenko v Russia* [2015] ECHR 637 at paragraph 106.

7 *Khoroshenko v Russia* [2015] ECHR 637 at paragraph 126, citing *Trosin v Ukraine* [2012] ECHR Application No. 39758/05. See also *Munjaz v United Kingdom* [2012] ECHR 1704 at paragraph 79 on the importance for mental health patients of any restrictions on rights other than the right to liberty being justified on an individual basis.

NHS England guidance on visiting and the Code of Practice to the Mental Health Act 1983

7. On 8 April, NHS England (NHSE) issued guidance on hospital visiting, which applied to all hospitals, not just mental health hospitals [the “8 April guidance”]. This stated that visiting was suspended but set out a limited number of exceptional circumstances where one visitor, an immediate family member or carer, was permitted to visit. This included if: “you are supporting someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient to be distressed.”⁸ Read properly, this guidance did not justify blanket bans upon visitors in mental health settings.

8. On 5 June 2020 NHSE issued new guidance lifting the national limitation on visiting imposed under the 8 April guidance [“the 5 June guidance”].⁹ That guidance specifically refers to mental health, learning disability and autism inpatient settings. It advises that visiting shall instead be subject to local discretion by trusts and other NHS bodies. Even if trusts could have interpreted the 8 April guidance as justifying blanket bans upon visitors in the mental health context, the 5 June guidance removes any room for doubt that such blanket bans are not permitted.

9. Both sets of guidance need to be read alongside the Mental Health Act Code of Practice, which makes clear the importance of visiting to patients and the inappropriateness of blanket bans.¹⁰ NHS England and the Department of Health and Social Care published on 19 May legal guidance which includes a section that, in effect, amounts to a modification of the Code of Practice¹¹ to reflect the impact of the pandemic. Notwithstanding that impact, the guidance makes clear that decisions on limiting visits should be made on an individual basis and based upon active risk assessments, rather than blanket bans. In other words, the guidance makes clear - and we agree - that the Department considers that there are no cogent reasons for departing from the position on visiting set down in the Code of Practice. It therefore appears to us that any mental health hospital which maintains a blanket ban on visitors is not only breaching the European Convention on Human Rights, but it is also acting unlawfully in failing to comply with the statutory Code without cogent reasons for so doing.

10. Given the failure of some institutions to comply with earlier guidance, we remain concerned that some young people may continue to be denied visits unlawfully. Furthermore, if nationwide visiting restrictions are brought back at some point in the future, we fear that this could result in the widespread re-imposition of unlawful blanket visiting bans which fail to take account of the individual circumstances of young people in mental health settings.

8 NHS England [Visitor Guidance](#) 8 April 2020

9 NHS England [Visiting healthcare inpatient settings during the COVID-19 pandemic](#) 5 June 2020

10 [Mental Health Act Code of Practice](#) (for England), paragraphs 8.5 and 11.4. Equivalent provisions appear in the Code of Practice for Wales.

11 Annex D to the updated NHS England [legal guidance](#) for mental health, learning disability and autism and specialised commissioning services 19 May 2020.

Alternative means of contact

11. In both Eddie and Dannielle’s case, limited access to alternative means of family contact was available, but their mothers told us that online communication, for example through Skype or Facetime, did not work well for their children. For example, Adele told us:

“We have been offered the Skype facility, which in some ways is helpful, but he gets upset post Skype. [...] The technology is not the best. Sometimes there is no sound; sometimes there is no picture, which is frustrating for me. He has waited so long just to see another person, so I think it is incredibly frustrating for him. It is not enough.”¹²

Conclusion

12. **Blanket visiting bans are contrary to the rights of both patients and their families under the European Convention on Human Rights, the Code of Practice to the Mental Health Act 1983 and NHS England guidance. Failure to adopt an individualised approach to the safety of visits will breach the Article 8 rights of both the patients and their families.**

13. *NHS England must write immediately to all hospitals, including private ones in which it commissions placements, stating that they must (whatever nationwide restrictions may be re-imposed in future), allow families to visit their loved ones, unless a risk assessment has been carried out relating to the individual’s circumstances which demonstrates that there are clear reasons specific to the individual’s circumstances why it would not be safe to do so. Where a mental health hospital does identify cogent reasons for prohibiting visits to a particular individual, the reasons for this decision must be provided in writing both to the patient and to their family. Such decisions must be reviewed on a regular basis, at least every 48 hours.*

3 Use of restraint and solitary confinement

Young people's experiences of restraint and solitary confinement during the pandemic

Adele Green, mother of Eddie, a young man with a learning disability:

"Unfortunately, Eddie has been subject to restraint and seclusion and has been overmedicated, so he has been restrained through the medication as well. When he was restrained, because of the mix of staffing, types of restraint were used that possibly should not have been. There is an ongoing investigation into that, because he was harmed during it. He has experienced time in a seclusion cell within the hospital. Because of excessive head-banging when he was not coping, it was deemed that they needed to move him. It is mortifying to hear that all this is happening to your child."¹³

Andrea Attree, mother of Dannielle, an autistic young woman:

"[Dannielle] has been restrained most days over the last week or so. Most of those restraints, as Adele just said, are not appropriate. She knows the rules and regulations and will report that back to me. Because it is mainly agency staff coming in, they do not always have the knowledge to respond as they should with Dannielle. She is in solitary confinement in two rooms. She has access between the two because there is a bathroom. When she becomes very unsettled, they lock her in the one room. That restricts her further."¹⁴

14. Andrea and Adele both told us that their children had been subjected to increased use of restraint; seclusion (possibly amounting to solitary confinement);¹⁵ and over-medication, during the period of the Covid-19 outbreak (see box above). There were several, often related, reasons for this, including; increased use of unfamiliar agency staff; measures taken to prevent the virus spreading within the institutions; and increased anxiety levels among young people due to the lack of family visits.

The right to freedom from inhuman and degrading treatment

15. The increased use of restrictive practices can create conditions that amount to a violation of the right to freedom from inhuman and degrading treatment (Article 3 EHCR). Article 3 requires the State to ensure that persons are detained in conditions which are

13 [Q28](#) [Adele Green]

14 [Q28](#) [Andrea Attree]

15 The definition of solitary confinement is set out in the Istanbul Statement on the Use and Effects of Solitary Confinement: "Solitary confinement is the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic." Istanbul Statement on the Use and Effects of Solitary Confinement 9 December 2007 at p 1. The Istanbul definition is also used by the UN Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment, Juan Méndez, who referred to "solitary confinement" as "the physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day" and prolonged solitary confinement as exceeding 15 days. Report submitted to the UN General Assembly in August 2011 by Juan E Méndez, the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment, paras 25 and 26.

compatible with respect for their human dignity, and that the manner of their detention does not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in such a measure.¹⁶

16. The evidence we heard from Adele and Andrea is that the conditions their children are being held in at present are extremely distressing. Andrea told us that in the 10 years in which Dannielle has been in and out of hospital she has never seen her so distressed. To communicate her desperation to staff, Dannielle has been self-harming and using her own blood to scribe on the wall.¹⁷ There is also evidence that restraint is not being used as a measure of last resort. Andrea gave us this example:

“[Dannielle] became very distressed on Saturday evening. The staff would not come in and talk to her. She climbed on a chair to break the CCTV so they could not just watch her from the viewing room; they would have to come into the room. They grabbed her from the chair and put her face down in the safety pod. She has a bruise on her nose and grab marks on her arms.”¹⁸

17. In both Eddie and Dannielle’s case it is they themselves who have told their mothers about the use of restraint on them and alerted them when the wrong types of restraint have been used, causing them pain and injury. In the 2019 report the Committee recommended that on every occasion that anyone is restrained or kept in conditions amounting to solitary confinement their families must be automatically informed. Families continue to be kept in the dark about what is happening to their loved ones without such a requirement in place.

The incidence of restrictive practices

18. We asked the witnesses from NHSE and the Care Quality Commission (CQC) whether the use of restraint and solitary confinement in these institutions was going up or down during the lockdown. Dr Kevin Cleary from the CQC told us that the data they have received does not yet show a clear pattern, however it has increased in some organisations.¹⁹ Claire Murdoch, from NHSE, reported that there had been no increase in the trend of long-term segregation or seclusion. In relation to the use of restraint she said that they did not have contemporaneous enough data to say definitively whether the use of restraint had risen or not but based on intelligence they had received they did not believe it had.²⁰

19. The apparent discrepancy between NHSE data and that provided by the CQC highlights the urgent need for more accurate information in real-time. An independent task force was set up by NHSE in October 2019 to improve specialist children and young people’s inpatient mental health, autism and learning disability services in England, overseen by the Children’s Commissioner. We are encouraged to hear they are doing work in this area. The current situation means that accurate and trusted statistics are needed more urgently than ever.

16 Stanev v Bulgaria [2012] ECHR 46 (Application No. 36760/06)

17 [Q28](#) [Andrea Attree]

18 [Q28](#) [Andrea Attree]

19 [Q35](#) [Dr Kevin Cleary]

20 [Q35](#) [Claire Murdoch]

Conclusion

20. Restraint must only ever be used as a last resort where absolutely necessary. Solitary confinement of children, and prolonged solitary confinement of adults, is contrary to the UN Mandela Rules on Prisoners and must be avoided. In order to understand how restrictive practices are currently being used, figures on their use, including physical and medical restraint and any form of segregation, detailing any incidences which go beyond 22 hours per day, must be published weekly by the institutions. These figures must be provided to the Secretary of State for Health and Social Care and reported to Parliament.

21. On every occasion that anyone is restrained or kept in conditions amounting to solitary confinement their families must be automatically informed.

4 Inspections

22. With families banned from visiting their loved ones and the Care Quality Commission (CQC) not carrying out routine inspections, these institutions are even more closed than before, and those in them are even more vulnerable to abuse. We are very concerned that the abuse that was happening in some services before lockdown, which was exposed by the media, may be even worse now.

Inspections during Covid-19

23. On 16 March 2020 the CQC wrote to health and social care providers announcing that it was suspending routine inspections in order to reduce the pressure on health and social care services.²¹ Dr Kevin Cleary told us that the regulator has nevertheless continued to carry out some inspection visits on a risk basis, taking into account an institution's culture, the type of patients it looks after, complaints and whistleblowing. Two such physical inspections had to date been carried out in Child and Adolescent Mental Health (CAMHS) units, with two more planned. All such visits are currently unannounced.²²

24. In addition to these physical visits, Mental Health Act reviewers are undertaking "virtual visits" in which they talk remotely to staff, patients and mental health advocates to get a picture of what is going on in the organisation. This information is then used as a basis for deciding whether a further visit is required. Last year Panorama revealed horrific abuse of patients at Whorlton Hall, which the CQC had failed to detect during a series of in-person inspections. The regulator attributed this failure to the difficulty of getting beneath the skin of the closed culture of such institutions. Given this, we have no confidence that the CQC will be able to get behind the closed culture of an institution during a "virtual visit."

25. Following the Panorama programme, the CQC asked Professor Glynis Murphy to carry out a review into its regulation of Whorlton Hall between 2015 and 2019. Her first report published on 18 March 2020 concluded that the abuse could have been detected sooner if the CQC had carried out more unannounced visits and made a number of recommendations for how inspections must be improved in the future.²³ Dr Kevin Cleary told us that any visits the CQC makes at the moment are unannounced and that this would be the case for the majority of visits for the foreseeable future.²⁴

26. Individuals and/or their families are being encouraged to proactively communicate with the CQC to complain about poor or abusive care, through its online 'Give Feedback on Care' service.²⁵ However, as we heard from Andrea and Adele, they have no confidence that if they report their concerns to the CQC, these will be adequately addressed. Andrea told us that she had reported her concerns about her daughter's care to the CQC and that

21 Care Quality Commission, [Routine inspections suspended in response to coronavirus outbreak](#), 16 March

22 [Qq33 and 34](#) [Dr Kevin Cleary]

23 Care Quality Commission, [CQC publishes independent review into its regulation of Whorlton Hall between 2015 and 2019](#), 18 March 2019

24 [Q34](#) [Dr Kevin Cleary]

25 This is primarily an online service, although it is possible to access telephone help, if you find it difficult to do things online.

they had visited Dannielle as a result, concluding that “in the circumstances, her care was satisfactory.” Asked by Joanna Cherry MP, what she thought of that response Andrea said: “I emphatically disagree with that. It is not satisfactory at all. She is not safe.”²⁶

The state’s positive obligation to protect against torture, inhuman or degrading treatment

27. The state is under various legal duties, including a positive obligation to protect against torture inhuman or degrading treatment (Article 3 ECHR). If, in response to Covid-19, institutions increase the use of restraint, segregation, and solitary confinement of young people detained by the state; the state fails to accelerate the safe discharge of young people from detention; and the regulator is only carrying out inspections in a very small number of cases, this cumulatively risks violations of Article 3.

Conclusion

28. ***We are pleased to see the CQC are now switching to unannounced inspections. The CQC should carry out all their inspections unannounced; this is particularly important where any allegation of abuse is reported by a young person, parent, or whistle-blower.***

29. ***The CQC must prioritise in-person inspections at institutions with a history of abuse/malpractice, and those which have been rated inadequate/requires improvement.***

30. ***A telephone hotline should be established to enable all patients, families, and staff to report concerns or complaints during this period.***

31. ***The CQC must report on reasons for geographical variation in practice with resultant harmful consequences.***

32. ***The CQC must monitor how providers are supporting the right to family life of young people, including by facilitating family visits, and report this as standard within their inspection reports.***

33. ***Following the exposure of abuse at Whorlton Hall, the CQC’s work to incorporate Professor Murphy’s recommendations into a new strategy to improve the regulation of mental health, learning disability and/or autism services must continue at a greater pace.***

34. ***The Government must ensure inspectors have sufficient and appropriate personal protective equipment (PPE) so they can carry out inspections safely.***

5 Inappropriate detention and failure to discharge

Inappropriate and harmful detention

35. The 2019 report concluded that many young people who are autistic and/or have a learning disability are being detained inappropriately and in breach of their human rights. Their detention, without access to appropriate treatment, was found to risk violating their Article 5 right to liberty and security. In some cases, it may even reach the threshold of degrading treatment contrary to Article 3. The lack of access to appropriate treatment for young people in detention continues during the pandemic.²⁷

36. The experience of being detained at this time is also increasing the harm that detention is causing to young people. Adele told us that because there were other patients on Eddie's ward who had the virus, he has been unable to leave his room for seven and a half weeks. This, coupled with increased levels of agency staffing due to absences, has been extremely difficult for him to cope with, leading to an increase in medication, restraint, seclusion and self-harm. In Dannielle's case, Andrea reported to us that even her daughter's basic needs are not always being met. She is left for days in the same clothes and some days she does not eat as she is not given appropriate food.²⁸

37. Young people are also now at an additional risk of harm in hospital: that of contracting Covid-19. The European Court of Human Rights has found that states are under a positive obligation pursuant to Article 2 to take appropriate steps to safeguard the lives of those within its jurisdiction in circumstances where their right to life may be at stake,²⁹ including in the context of healthcare provision.³⁰ For a positive obligation under Article 2 to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals. This test is clearly met in the context of the current pandemic. Adele told us that she was worried that Eddie was not safe from infection in the hospital, where there are a number of people who have the virus. The hospital has a shortage of personal protective equipment ('PPE').³¹

38. We are also concerned to hear from both Adele and Andrea that their children are increasingly self-harming in response to the current restrictive regimes. Where individuals are in mental health detention, authorities are required to demonstrate special care in guaranteeing such conditions as correspond to the person's special needs resulting from his or her disability or condition, as an aspect of their obligation to protect their right to life.³² We are concerned that, at present, mental health hospitals are not merely failing to protect these young people from self-harm but are in fact increasing the risk to their lives from such self-harm.

27 [Q28](#) [Adele Green]

28 [Q28](#) [Andrea Attree]

29 Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania [2014] ECHR (Application no. [47848/08](#))

30 Calvelli and Ciglio v. Italy [2002] ECHR Application No. 32967/96; Vo v. France [2004] ECHR (Application No. 53924/00)

31 [Q28](#) [Adele Green]

32 Fernandes de Oliveira v Portugal [2019] ECHR 106 at paragraph 113.

Discharges during the pandemic

39. Even before the onset of Covid-19, progress was still not being made quickly enough to discharge young people, with an unacceptable variation in discharge rates across the country. The latest figures from April 2020 show that 595 children and young people under the age of 25 remain in detention in specialist inpatient units, down from 665 in April 2019.³³

40. Now, there is an additional imperative to get people out of inappropriate detention quickly—to prevent them becoming infected with the virus in settings where social distancing is hard to maintain. Ray James from NHSE told us that “there was a significant increase in the rate at which people were being discharged from hospital, from specialist in-patient settings, at the beginning of the Covid outbreak.” However, we heard rather different evidence from Adele and Andrea, who told us that that plans for Eddie and Dannielle to be discharged had been disrupted by the pandemic (see box below). A common and significant challenge which has hampered discharge plans has been a reduction in the number of skilled support workers available to support young people in the community.³⁴

Experiences of delayed discharge due to the pandemic

Adele Green, mother of Eddie, a young man with a learning disability:

“[Eddie] was actually about to start the discharge process back to his local community. There is quite a distance from where we live to where we visit, so that required some in-depth planning. He had a care provider and a bed in a type of sheltered accommodation ready and waiting. We were just about to start that lengthy transition. Unfortunately, that is when the lockdown started for us and everything since has stopped.”³⁵

Andrea Attree, mother of Dannielle, an autistic young woman:

“At the moment [Dannielle] is in seclusion, not too far from us. Her previous providers were deemed unsafe by a [Care and Treatment Review], so she was moved quite quickly, back into a more local bespoke environment. There was nowhere for her to go. She is there and awaiting specialist treatment. Our local authority has let us down catastrophically. We missed a window of opportunity for a specialist bed in a specialist unit, so we are now desperately looking up and down the country for somewhere to create a bespoke package for her. Covid-19 has put a lot of obstacles in the way.”³⁶

Conclusion

41. **Now, more than ever, rapidly progressing the discharge of young people to safe homes in the community must be a top priority for the Government. The recommendations from the Committee’s 2019 report must be implemented in full. In particular, legislation must be introduced to ensure the availability of sufficient community-based services. The required amendments to the Mental Health Act 1983 to prevent inappropriate detention, must not be delayed.**

33 NHS Digital, Learning Disability Services Statistics, [Learning Disability Services Monthly Statistics - \(AT: April 2020, MHSDS: February 2020 Final\)](#), 21 May 2020

34 [Q31](#) [Ray James]

35 [Q28](#) [Adele Green]

36 [Q28](#) [Andrea Attree]

6 Data on Covid-19 infections and deaths

42. On 7 May we wrote to Rt Hon Matt Hancock MP, the Secretary of State for Health and Social Care, to ask him to commit to publishing the number of those who are autistic and/or who have a learning disability who have contracted and have died from Covid-19. In addition, we asked to be provided with figures, broken down by age group, on the number of those who are autistic and/or who have learning disabilities in mental health inpatient units (both mainstream and specialist units) who have i) contracted and ii) died from Covid-19.³⁷

43. In her response on 16 May, Helen Whately MP, Minister for Care, notified the Committee that on 14 May, for the first time, NHSE had released data collected on the number of people with learning disabilities and/or autism who had died as a result of Covid-19 in hospital.³⁸ This has been published weekly since then and as at 26 May, the figure stands at 477 people.³⁹ On 18 May, a second data set was published showing the number of deaths in any location reported to the Learning Disabilities Mortality Review programme where the person notifying the death has indicated that Covid-19 is suspected or confirmed as the cause of death. The number of deaths recorded in this data set is 530.⁴⁰ Professor Chris Hatton from Lancaster University has analysed these and other relevant data sources and reached the stark conclusion that “[p]eople with learning disabilities are at much greater risk of death from COVID-19 than the general population, particularly at times when pandemics are at their peak.”⁴¹

44. At the Committee’s oral evidence session on 18 May, Ray James was able to tell us that no deaths of children or young people under the age of 25 had been reported in specialist in-patient units during the Covid-19 outbreak and there had been fewer than five deaths of people over the age of 25.⁴² Following the session NHSE wrote to the Committee and notified them that between 5 and 10 people died as a result of Covid-19 following transfer to an acute hospital. None of these people were aged under 25.⁴³ NHSE has not to date, been able to provide us with data on the number of people diagnosed with Covid-19 in specialist inpatient settings.

45. *It is essential that we have comprehensive and accessible data about the number of those who are autistic and/or learning disabled who have contracted and died of Covid-19. This must include a focus on those in detention, for whom the state has heightened responsibility for their right to life. The data must be presented to show the number of those who have died in acute hospitals, having been transferred from other settings, and be published on a weekly or daily basis and be broken down by age.*

37 Letter to Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, [requesting information on people who are autistic and/or who have learning disabilities in mental health inpatient units who have contracted and died from COVID-19](#), dated 7 May

38 Letter from Helen Whately MP, Minister of State for Care, Department of Health and Social Care, to Chair, [regarding data on impact of COVID-19 on people with Learning Disabilities and Autism](#), dated 16 May 2020

39 NHS England, COVID 19 total announced deaths 26 May 2020 – weekly tables

40 NHS England, [Covid-19 deaths of patients with a learning disability notified to LeDeR](#), 18 May 2020

41 Professor Chris Hatton, [What we know \(so far\) about the deaths of people with learning disabilities in England during COVID-19](#) (2 June 2020)

42 [Q36](#) [Ray James]

43 Letter to Rt Hon Harriet Harman MP, Chair, from NHS England and NHS Improvement, [regarding follow up information](#), dated 27 May 2020

7 Conclusion

46. Prior to the virus, the human rights of young people who are autistic and/or have learning disabilities in detention were being breached.

47. Now that institutions are closed to the outside world the risk of human rights abuses are even greater. Prohibitions on family visits, the suspension of inspections, the increased use of restraint and solitary confinement, and the vulnerability of those in detention to infection (due to underlying health conditions and the infeasibility of social distancing) mean that the situation is now a severe crisis. There are increased risks of violations to the right to life (Article 2 ECHR), freedom from inhuman and degrading treatment (Article 3 ECHR), liberty and security (Article 5 ECHR), respect for family life (Article 8 ECHR) and non-discrimination (Article 14 ECHR).

48. To put a stop to these human rights abuses we urge the Government to implement in full both the recommendations set out in this report and those in the 2019 report as a matter of urgency.

Conclusions and recommendations

Visits and the right to family life

1. Blanket visiting bans are contrary to the rights of both patients and their families under the European Convention on Human Rights, the Code of Practice to the Mental Health Act 1983 and NHS England guidance. Failure to adopt an individualised approach to the safety of visits will breach the Article 8 rights of both the patients and their families. (Paragraph 12)
2. *NHS England must write immediately to all hospitals, including private ones in which it commissions placements, stating that they must (whatever nationwide restrictions may be re-imposed in future), allow families to visit their loved ones, unless a risk assessment has been carried out relating to the individual's circumstances which demonstrates that there are clear reasons specific to the individual's circumstances why it would not be safe to do so. Where a mental health hospital does identify cogent reasons for prohibiting visits to a particular individual, the reasons for this decision must be provided in writing both to the patient and to their family. Such decisions must be reviewed on a regular basis, at least every 48 hours.* (Paragraph 13)

Use of restraint and solitary confinement

3. *Restraint must only ever be used as a last resort where absolutely necessary. Solitary confinement of children, and prolonged solitary confinement of adults, is contrary to the UN Mandela Rules on Prisoners and must be avoided. In order to understand how restrictive practices are currently being used, figures on their use, including physical and medical restraint and any form of segregation, detailing any incidences which go beyond 22 hours per day, must be published weekly by the institutions. These figures must be provided to the Secretary of State for Health and Social Care and reported to Parliament.* (Paragraph 20)
4. *On every occasion that anyone is restrained or kept in conditions amounting to solitary confinement their families must be automatically informed.* (Paragraph 21)

Inspections

5. We are pleased to see the CQC are now switching to unannounced inspections. *The CQC should carry out all their inspections unannounced; this is particularly important where any allegation of abuse is reported by a young person, parent, or whistle-blower.* (Paragraph 28)
6. *The CQC must prioritise in-person inspections at institutions with a history of abuse/malpractice, and those which have been rated inadequate/requires improvement.* (Paragraph 29)
7. *A telephone hotline should be established to enable all patients, families, and staff to report concerns or complaints during this period.* (Paragraph 30)

8. *The CQC must report on reasons for geographical variation in practice with resultant harmful consequences. (Paragraph 31)*
9. *The CQC must monitor how providers are supporting the right to family life of young people, including by facilitating family visits, and report this as standard within their inspection reports. (Paragraph 32)*
10. *Following the exposure of abuse at Whorlton Hall, the CQC's work to incorporate Professor Murphy's recommendations into a new strategy to improve the regulation of mental health, learning disability and/or autism services must continue at a greater pace. (Paragraph 33)*
11. *The Government must ensure inspectors have sufficient and appropriate personal protective equipment (PPE) so they can carry out inspections safely. (Paragraph 34)*

Inappropriate detention and failure to discharge

12. *Now, more than ever, rapidly progressing the discharge of young people to safe homes in the community must be a top priority for the Government. The recommendations from the Committee's 2019 report must be implemented in full. In particular, legislation must be introduced to ensure the availability of sufficient community-based services. The required amendments to the Mental Health Act 1983 to prevent inappropriate detention, must not be delayed. (Paragraph 41)*

Data on Covid-19 infections and deaths

13. *It is essential that we have comprehensive and accessible data about the number of those who are autistic and/or learning disabled who have contracted and died of Covid-19. This must include a focus on those in detention, for whom the state has heightened responsibility for their right to life. The data must be presented to show the number of those who have died in acute hospitals, having been transferred from other settings, and be published on a weekly or daily basis and be broken down by age. (Paragraph 45)*

Declaration of Interests

Lord Brabazon of Tara

- No relevant interests to declare

Lord Dubs

- No relevant interests to declare

Baroness Ludford

- No interests declared

Baroness Massey of Darwen

- No relevant interests to declare

Lord Singh of Wimbledon

- No relevant interests to declare

Lord Trimble

- No interests declared

Formal minutes

Wednesday 8 June 2020

Virtual Meeting

Members present:

Ms Harriet Harman MP, in the Chair

Ms Karen Buck MP Lord Brabazon of Tara

Dean Russell MP Lord Dubs

Baroness Massey of Darwen

Draft Report (*Human Rights and the Government's response to COVID-19: The detention of young people who are autistic and/or have learning disabilities*), proposed by the Chair, brought up and read.

Ordered, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 48 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to both Houses.

Ordered, That the Chair make the Report to the House of Commons and that the Report be made to the House of Lords.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of House of Commons Standing Order No. 134.

[Adjourned till 22 June at 2pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 18 May 2020

Adele Green, mother whose son has learning disabilities and is currently detained; **Andrea Attree**, mother whose autistic daughter is currently detained

[Q27–30](#)

Dr Kevin Cleary, Deputy Chief Inspector of Hospitals (and lead for mental health and community services), Care Quality Commission; **Kate Terroni**, Chief Inspector of Adult Social Care, Care Quality Commission; **Ray James CBE**, Director, Learning Disabilities, NHS England and NHS Improvement; **Claire Murdoch**, National Director Mental Health, NHS England and NHS Improvement

[Q31–37](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

COV numbers are generated by the evidence processing system and so may not be complete.

- 1 Supplementary evidence from the Care Quality Commission ([COV0124](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2019–21

First Report	Report Draft Jobseekers (Back to Work Schemes) Act 2013 (Remedial) Order 2019: Second Report	HC 149 HL 37
Second Report	Draft Human Rights Act 1998 (Remedial) Order: Judicial Immunity: Second Report	HC 148 HL 41
Third Report	Human Rights and the Government's Response to Covid-19: Digital Contact Tracing	HC 343 HL 59
Fourth Report	Draft Fatal Accidents Act 1976 (Remedial) Order 2020: Second Report	HC 256 HL 62
First Special Report	The Right to Privacy (Article 8) and the Digital Revolution: Government Response to the Committee's Third Report of Session 2019	HC 313