**Deprivation of liberty of older people in England and Wales: Submission to the United Nations Independent Expert on the enjoyment of all human rights by older persons**

**Submission from: Dr Lucy Series, a Wellcome, Senior Research Fellow & Lecturer in Law at Cardiff University, UK and Professor Judy Laing, Chair in Mental Health Law, Rights & Policy, Human Rights Implementation Centre & Centre for Health, Law & Society, University of Bristol Law School, UK.**

Our submission concerns systems of safeguards for people who are deprived of their liberty in mental health or social care (community) settings in England and Wales.

**Dr Series** is a leading expert on social care detention (deprivation of liberty in community care settings). Her socio-legal and comparative research currently focuses on deprivation of liberty safeguards under the Mental Capacity Act 2005. She has published several research papers and a monograph on this topic.[[1]](#footnote-1) Dr Series is also an expert on international human rights norms concerning legal capacity and deprivation of liberty, particularly under the European Convention on Human Rights (ECHR) and the UN Convention on the Rights of Persons with Disabilities (CRPD). Dr Series has given evidence to the UK Parliament’s Joint Committee on Human Rights on deprivation of liberty safeguards for older and disabled people in 2018[[2]](#footnote-2) and 2022.[[3]](#footnote-3) Her expert testimony to the National Institute for Health and Care Excellence has informed national clinical guidelines on mental capacity and decision making.[[4]](#footnote-4) She has been a member of the Care Quality Commission’s (CQC) advisory group on the deprivation of liberty safeguards since 2010, and was a member of the Law Society's Mental Health and Disability Group (2015 - 2020). She has previously worked with the World Health Organisation and UN human rights bodies on matters concerning legal capacity and deprivation of liberty.

**Professor Laing** is based in the Human Rights Implementation Centre (HRIC) and Centre for Health, Law & Society at the University of Bristol Law School. She has expertise in mental health law and human rights and has published extensively in these areas.[[5]](#footnote-5) Along with colleagues at the HRIC, she has worked with members of the UK National Preventive Mechanism on independent monitoring of places where people are deprived of their liberty, including commissioned research projects and training for inspectors. She is a member of the Care Quality Commission in England’s Advisory Group on monitoring the Mental Health Act. Prof Laing has advised the UK Parliament’s Health and Social Care Committee in the UK on learning disability and autism in 2021 and given evidence to the UK Parliament’s Joint Committee on Human Rights on the rights of residents in care homes in 2022. Prof Laing is currently undertaking a parliamentary fellowship on mental health law and human rights in the UK Parliament House of Commons Library and published several briefings, including on the new Liberty Protection Safeguards in the Mental Capacity (Amendment) Act 2018.

# Deprivation of liberty of older people in ‘community’ settings

## The *Cheshire West* definition of deprivation of liberty

There are more people deprived of their liberty in care homes in England and Wales than in prison. This is because since 2014 the UK has adopted a legal definition of deprivation of liberty that has attempted to eliminate discriminatory biases against disabled people (including older people with disabilities such as dementia or cognitive conditions), and which addresses the realities of people’s care arrangements on the ground (their *de facto* conditions) rather than *de jure* formally ordered detentions. This test was established by the UK Supreme Court in a case widely known as *Cheshire West[[6]](#footnote-6).* Following this ruling, a person is categorised as deprived of their liberty by their care arrangements if:

1. They are subject to ‘continuous supervision and control’ by those caring for them;
2. They are ‘not free to leave’; and
3. They lack the ‘mental capacity’ to give a legally valid consent to their care arrangements.

If all three elements of this test are satisfied, then a person is considered to be deprived of their liberty within the meaning of article 5 ECHR, meaning they are entitled to ‘safeguards’ to authorise their detention and protect their rights. This test applies regardless of whether the person’s care arrangements are in their ‘best interests’, considered ‘necessary’ or ‘normal’ for a person with a similar condition. This is because the *purpose* of the safeguards is to test out whether the care arrangements really are as necessary and proportionate as those arranging them consider them to be. Somewhat paradoxically, the *Cheshire West* test also categorises a person as deprived of their liberty if they are happy with their care arrangements because in England and Wales people who lack ‘mental capacity’ are considered unable to give a legally valid consent. We therefore do not know how many people who are categorised as deprived of their liberty are actively objecting to their care arrangements and any restrictions; estimates vary from an official prediction of 30% through to much higher proportions reportedly objecting.[[7]](#footnote-7)

To illustrate the scale of deprivation of liberty following *Cheshire West*, in a population of just under 60m people[[8]](#footnote-8) it was estimated following *Cheshire West* 300,000 that people may need deprivation of liberty safeguards in connection with their care and treatment.[[9]](#footnote-9) This does not include people who are deprived of their liberty for mental health treatment, which we discuss below. Our current data on DoLS demonstrate that this is strongly skewed towards people in ‘social care’ settings, particularly care homes, and towards older people in particular. In 2019-20 there were 172,570 applications from care homes and hospitals to ‘authorise’ deprivation of liberty for people aged over 65 (83% of the total number of DoLS applications received). Over 6% of adults aged over 85 living in England and Wales were the subject of at least one application to authorise a deprivation of liberty in a care home or hospital.[[10]](#footnote-10)

Although this may give the impression that older people living in England and Wales are more likely to be detained than elsewhere, this is an artefact of the UK adopting a more far-reaching test of deprivation of liberty. In reality, older people living in comparable jurisdictions in Europe, Australia, North America and other countries that are also reliant on institutional models of care are also likely to be similarly restricted. The difference is that in England and Wales this is explicitly recognised in law and they are afforded safeguards. Lucy’s comparative research suggests that the UK’s *Cheshire West* test of deprivation of liberty may be the most far-reaching legal test adopted globally.

## Deprivation of liberty safeguards

In England and Wales, people who are deprived of their liberty by their care arrangements are entitled to safeguards to protect their human rights under article 5 ECHR. These are mainly delivered through the Mental Capacity Act 2005 deprivation of liberty safeguards (DoLS). (NB: a person who is detained in hospital for mental health treatment may be detained under the Mental Health Act 1983 instead, which we discuss below). In 2023 a new framework of Liberty Protection Safeguards (LPS) will come into force, which provide more comprehensive coverage of community settings and a more ‘proportionate’ approach targeting stronger safeguards to situations where a person is objecting or there are concerns.

Both kinds of liberty safeguards (DoLS and LPS) aim to give people who are deprived of their liberty in care settings the following protections:

* Professional assessments of whether the person has the ‘mental capacity’ to make decisions about their care arrangements;
* Specialist independent assessments of whether any restrictions on the person’s liberty are ‘necessary’ and ‘proportionate’ with respect to the risk of harm that might befall them otherwise (this entails consulting with the person about their wishes and feelings, and considering alternative less restrictive options);
* Authorisation of ‘arrangements’ by responsible bodies (usually local councils or NHS bodies). This can involve negotiation with care providers about less restrictive ways to deliver care before authorisation is granted;
* Regular periodic reviews;
* Appointment of a person to represent the individual and their interests and help them exercise any relevant rights. This is often a family member;
* Under some circumstances, appointment of an independent advocate to support the person and assist their family in representing them or exercising their rights;
* Rights to challenge the arrangements in the Court of Protection, with entitlements to legal aid for this.

These safeguards are not perfect.[[11]](#footnote-11) They represent a trade off between the need to provide independent scrutiny of restrictive care arrangements and the scale of the population and the resources required. They also represent a delicate balance between the need for state-backed human rights the privacy of the individual and their family. We may not yet have the balance right; our research demonstrates that rights of appeal are especially week if the person (or their family) objects to their care. There are circumstances in which it is acknowledged that people who are categorised as deprived of their liberty, and their families, are ‘oppressed’ by health and care professionals imposing care arrangements that either the person or their family object to.[[12]](#footnote-12) There are also particular weaknesses in the scheme of safeguards if the older person’s family themselves support the arrangements and they object. This situation often arises where an older person is placed by their family in a care home against their wishes. In these circumstances, they may not always be supported to exercise the rights of appeal against deprivation of liberty that human rights law requires.

Nevertheless, despite these weaknesses, there is considerable support for some kind of system of liberty safeguards operating along these lines. This support has been expressed in recent consultations on the liberty safeguards[[13]](#footnote-13), in research[[14]](#footnote-14), and regulatory reports by the CQC.[[15]](#footnote-15) Lucy recently organised a series of workshops for professionals (social care, legal and advocacy), civil society organisations, and older adults, people living with dementia, people with intellectual disabilities and/or autism, and their families, to explore human rights and liberty safeguards. The resounding message from all those attending the workshops was that the safeguards are valued. Professionals valued the way they enhanced care practices and human rights awareness in care services, the extra scrutiny they brought to overly restrictive care, and led to concrete improvements. Lawyers valued the way they helped people exercise rights of challenge when they were unhappy and could lead to real improvements in the person’s situation. Families spoke of how they had used the safeguards to address problems in the care of their relatives. Meanwhile people potentially subject to deprivation of liberty in care services spoke about how they wanted the safeguards to remain and protect their human rights.

## Deprivation of liberty during the covid pandemic

However, despite the far-ranging nature of the test, during the covid pandemic the government interpreted it in an especially restrictive way, as only applying when a person was not free to leave their care setting on a permanent basis. This mean the safeguards may not have applied to people who were required to self-isolate in their rooms in care homes, or to the significant restrictions on people preventing them from leaving or receiving visitors. The families of many older people in care homes argued that this was an unlawful deprivation of liberty; the government lawyers apparently told them that it was not because in theory their relations could always choose to leave the care home permanently (they would just have to isolate if they came back).[[16]](#footnote-16) This belies the reality that most people live in care homes because they have few other choices available to them, except potentially another care home and subject to the same restrictions.

This also meant that whilst people in care homes lived under unprecedented levels of restriction and isolation, with no systematic external visitation to protect their human rights, the safeguards were likely diluted and poorly applied. Official statistics show that for the first time since *Cheshire West* the number of applications for safeguards actually fell from 2020-21,[[17]](#footnote-17) suggesting fewer people received these important human rights protections at the time they likely most needed them.

At law, however, the deprivation of liberty safeguards are only intended to be used for the protection of the individual themselves, and they cannot be applied where the person has ‘mental capacity to make choices about their care arrangements themselves. This means that the DoLS probably could not authorise most of the restrictions in care homes linked to the pandemic, which were motivated mainly on public health grounds (the protection of other residents in the care home, for example). Under English law, alternative public health detention powers were available for these circumstances, but were almost never applied. In other words, the covid pandemic engendered widespread unlawful detention in British care homes.

## Social care detention and the UN Convention on the Rights of Persons with Disabilities

The system of safeguards for deprivation of liberty in England and Wales is based on European human rights law. This reflects what is increasingly referred to as an ‘old paradigm’ of human rights, in comparison with the ‘new paradigm’ associated with the UN Convention on the Rights of Persons with Disabilities (CRPD). Deprivation of liberty on disability related grounds conflicts with article 14 CRPD.[[18]](#footnote-18) Systems of safeguards like those operated in England and Wales would also conflict with the CRPD approach.

The approach taken under the CRPD would require radical changes to care infrastructure in England and Wales, creating far more non-congregate and home-based options to support older and disabled people who draw on care services. It would require a radically new approach to legal capacity as well, that recognises and respects their choices (including risky choices). In Lucy’s recent book she argues that radical reforms of this nature are both desirable and could eliminate a very large proportion of cases of social care detention.[[19]](#footnote-19) However, she also highlights that there has been very limited consideration of social care detention by human rights bodies whose focus is on the CRPD; they have tended to critique mental health detention in hospital, but do not recognise the different set of concerns raised by social care settings. There are some circumstances where it is extremely difficult to see how we can do without some measure of ‘continuous supervision and control’ to keep a person safe without extremely harsh outcomes ensuing. For example, in the *Cheshire West* case itself, continuous supervision and control was exercised to prevent ‘P’ (a man with Down syndrome) from attempting to eat and then choke on his incontinence pads, or around road traffic. We would like to invite the UN human rights bodies to pay closer attention to the very different set of social and ethical dilemmas posed by social care detention, distinguishing these from mental health detention.

# Mental health detention of older people

# Human rights monitoring in places where older people are deprived of their liberty

The Care Quality Commission (CQC) is the independent health and social care regulator in England. It is also designated as a member of the UK National Preventive Mechanism (NPM). The UK NPM was established in March 2009 after the UK ratified the United Nations Optional Protocol to the Convention Against Torture (OPCAT) in 2003. OPCAT recognises that people in detention are vulnerable and requires States to set up a national level body that can support efforts to prevent ill-treatment. Most other countries designated one body. The advantage of the UK NPM is that it has wide ranging, multi-disciplinary and specialist expertise for a range of detention contexts, for example Her Majesty’s Inspectorate of Prisons visits prisons in England and Wales as NPM, and the CQC visits health and social care settings.

There are some fundamental aspects for the NPM to bear in mind in its independent monitoring, which requires a human rights-based and preventive approach to independent monitoring.

* A human rights-based approach – this puts the rights of people at the heart of monitoring work.

CQC has sought to incorporate a human rights approach into regulation since 2014 – see <https://www.cqc.org.uk/guidance-providers/all-services/our-human-rights-approach>. It is based on the FREDA Principles – fairness, respect, equality, dignity and autonomy, plus recognition of the right to life. CQC has also published *Equally outstanding: Equality & Human Rights good practice resource* (November 2018) for care providers to reinforce the centrality of human rights in the provision of care and services.

* A focus on the prevention of ill-treatment.

The Subcommittee on the Prevention of Torture provides [guidance to NPMs](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CAT/OP/12/5&Lang=en) on the concept of prevention, which requires a system of regular proactive visits, not just reactive by responding only to complaints/concerns. NPMs should also have a system of announced and unannounced visits of sufficient frequency/regularity.

All UK NPM members carry out an [annual self-assessment of OPCAT compliance](https://www.nationalpreventivemechanism.org.uk/opcat/spt/) and the [NPM Secretariat](https://www.nationalpreventivemechanism.org.uk/about/governance-and-structure/npm-coordination/) produces a collective NPM [annual report](https://www.nationalpreventivemechanism.org.uk/publications-resources/).

The NPM function adds a further layer to the CQC’s routine health and social care regulatory care standards work in England. However, this NPM role is not as prominent or widely known/publicised as its role as a health and social care regulator.

## Subcommittee on the Prevention of Torture guidance and report on visit to the UK

The Subcommittee on the Prevention of Torture (SPT) carried out its first country visit to the UK in September 2019 and recommended greater visibility for UK NPM bodies/work. The [SPT report to UK NPM](https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/12/SPT-Report-to-UK-NPM-CAT.OP_.GBP_.RONPM_.R1.pdf)  was also critical of the lack of formal legislative/statutory basis for the UK NPM which impacts on its credibility and effectiveness.

SPT recommends that NPM functions should be viewed as separate from ‘business as usual’ function and noted that the preventive function is not always prioritised by NPM members (CQC and Ofsted are both cited as examples of this in the SPT report, at para 80).

The SPT has also said that the NPM should adopt a preventive focus and integrate human rights-based approaches to monitoring to contribute to systemic changes. This is not just about checking for human rights breaches, but also to offer proposals as to how to reduce the likelihood of risk of torture/ill-treatment and formulate good practice/guidance. The CQC aims to do so in England through publication of ad hoc themed reports and guidance to providers e.g., CQC published a report for care providers in 2020 on identifying and responding to [Closed Cultures](https://www.cqc.org.uk/sites/default/files/20200623_closedcultures_guidance.pdf) – it identified that some services are higher risk and especially during the pandemic, as there were no visitors and acute staff/finance pressures.

## Care Quality Commission and monitoring the Mental Health Act 1983

This NPM function is explicitly acknowledged by the CQC in its work on monitoring the Mental Health Act 1983 (MHA), for example, in an appendix to recent CQC Annual [Mental Health Act Monitoring](https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act) report. The MHA creates a framework for compulsory admission and treatment of persons with a mental disorder in England and Wales. Some older people will be deprived of their liberty in psychiatric institutions under the MHA in England. There is a clear and distinct focus within the CQC on its MHA inspection visits. The CQC publishes, [MHA Annual Monitoring Reports](https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act) (which are required by the statute and laid before parliament). CQC also has designated and MHA reviewers with relevant expertise tasked with MHA monitoring (alongside CQC inspectors). The CQC’s monitoring power is grounded in s. 120 MHA which gives a statutory right to visit any in-patient detained under the MHA **in private** and speak to them about their experiences of detention. There is nothing comparable grounded in legislation currently for the DoLS, although a similar provision is proposed for the new Liberty Protection Safeguards, which are soon to replace the DoLS under the Mental Capacity (Amendment) Act 2018. The CQC’s [MHA monitoring report for 2020/21](https://www.cqc.org.uk/publications/major-reports/monitoring-mental-health-act-202021) highlights that CQC has identified people with dementia as a key focus group in its work to tackle inequalities in health and care.[[20]](#footnote-20)

## Care Quality Commission and the Deprivation of Liberty Safeguards (DoLS)

The role and effectiveness of CQC oversight of DoLS and the Mental Capacity Act 2005 is unclear. Limited data is available and there is a lack of (published) qualitative data on resident/service user experiences of DoLS in hospitals and care homes. Moreover, CQC no longer produces distinct DoLS/MCA reports. Regular reporting on this issue is generally brief, and subsumed within the larger Annual State of Care reports on the CQC’s wider regulatory and care standards functions. There is only a small section on the CQC [website](https://www.cqc.org.uk/guidance-providers/all-services/mental-capacity-act-deprivation-liberty-safeguards) with information on MCA/DoLS responsibilities and very little reported data available on their oversight work in this area.

In line with SPT guidance for NPMs, the CQC has produced some themed reports relevant to DoLS/MCA on the experiences of residents in care homes e.g. A review of dementia care in 2014 ‘[Cracks in the Pathway’](https://www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf) highlighted:

* Variable care and transitions between services poor;
* Concerns about privacy and dignity (through behaviour and disrespectful language used as well as care environments – lack of personalisation of rooms, clothing, inability to summon help/assistance, lost hearing aids/dentures not replaced);
* Poor staff training, no follow up, no quality monitoring, staffing levels/discontinuity/staff changes;
* Poor levels of involvement in decisions about care.

CQC has also recently produced some useful Covid insights and guidance for care providers e.g., into deaths in care homes and the guidance on Closed Cultures.

Despite these positive initiatives, there are still too many reports and instances of human rights breaches, inequality across services and undignified and inhumane care. For example, a report by the CQC on the use of restrictive practices in hospital and care settings found too many examples of inhumane and undignified care.[[21]](#footnote-21) And Amnesty International reported on the experiences of older people in care homes in England during the pandemic. Amnesty’s report found that older people were not protected during the early stages of the pandemic which led to significant human rights breaches.[[22]](#footnote-22)

1. See in particular: Series L, ‘On detaining 300,000 people: The Liberty Protection Safeguards’, (2019) 25 International Journal of Mental Health and Capacity Law 2, <https://www.northumbriajournals.co.uk/index.php/ijmhcl/article/view/952>; Series L, ‘Making sense of *Cheshire West*’ in Spivakovsky C, Steele L and Weller P (eds), *The Legacies of Institutionalisation: Disability, Law and Policy in the ‘Deinstitutionalised’ Community* (Hart 2020); Series L, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022). All my publications are available here: <https://www.cardiff.ac.uk/people/view/478911-series-lucy> [↑](#footnote-ref-1)
2. Joint Committee on Human Rights, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards* (HC 890, HL paper 161, 2018) <https://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/inquiries/parliament-2017/freedom-and-safety-17-19/> [↑](#footnote-ref-2)
3. Ongoing inquiry into human rights in care settings, see: <https://committees.parliament.uk/work/1495/protecting-human-rights-in-care-settings/> [↑](#footnote-ref-3)
4. National Institute for Health and Care Excellence, *Decision-making and mental capacity* (NICE guideline [NG108], 2018) <https://www.nice.org.uk/guidance/NG108> [↑](#footnote-ref-4)
5. See for example, Laing J, Perspectives on monitoring mental health legislation in England: A view from the front line (2015) 23(3) *Medical Law Review* 400-426; Laing J & Murray R, ‘An international comparison on mechanisms in mental health monitoring’ *in Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture’s 2013 Thematic Report* (Center for Human Rights & Humanitarian Law, Washington); Steinerte E, Murray R & Laing J, Monitoring those deprived of their liberty in psychiatric and social care institutions and national practice in the UK (2012) 16(6) *International Journal of Human Rights* 865-882. [↑](#footnote-ref-5)
6. [*P v Cheshire West and Chester Council and another; P and Q v Surrey County Council* [2014] UKSC 19.](https://www.bailii.org/uk/cases/UKSC/2014/19.html) [↑](#footnote-ref-6)
7. For example, in recent ethnographic research on the care of people with dementia in hospital, it was observed that almost all patients with dementia were objecting to or resisting some aspects of their care: Featherstone K and Northcott A, *Wandering the Wards: An Ethnography of Hospital Care and its Consequences for People Living with Dementia* (Routledge 2021); Featherstone K, Northcott A and Bridges J, ‘Routines of resistance: An ethnography of the care of people living with dementia in acute hospital wards and its consequences’, (2019) 96 International Journal of Nursing Studies 53. [↑](#footnote-ref-7)
8. This is the population of England and Wales, not the entire UK. [↑](#footnote-ref-8)
9. Department of Health and Social Care, *Impact assessment of the Mental Capacity (Amendment) Act 2019* (Published 28 January 2021, 2021). [↑](#footnote-ref-9)
10. NHS Digital, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2020-21* (2021) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2020-21> See demographic data tables. [↑](#footnote-ref-10)
11. Lucy outlines some of the problems in the following publications: Series L, ‘On detaining 300,000 people: The Liberty Protection Safeguards’, (2019) 25 International Journal of Mental Health and Capacity Law 2, <https://www.northumbriajournals.co.uk/index.php/ijmhcl/article/view/952>; Series L, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022). [↑](#footnote-ref-11)
12. House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (HL Paper 139, 2014); Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017). [↑](#footnote-ref-12)
13. Ibid. [↑](#footnote-ref-13)
14. Jepson M and others, *The Deprivation of Liberty Safeguards: their impact on care practice* (National Institute for Health Research 2014); Series L, ‘The Mental Capacity Act 2005 and the Institutional Domination of People with Learning Disabilities’ (University of Exeter 2013). [↑](#footnote-ref-14)
15. Earlier reports have a more detailed focus on the DoLS than more recent reports: Care Quality Commission, *Monitoring the deprivation of liberty safeguards in 2014-15* (2015); CQC *Monitoring the Deprivation of Liberty Safeguards in 2014/15* (2015). [↑](#footnote-ref-15)
16. John's Campaign, *The Holding Pen: 14 Days Enforced Isolation for People Living in Care Homes* (Golden Duck 2021). [↑](#footnote-ref-16)
17. NHS Digital, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards - 2020-21* (2021). [↑](#footnote-ref-17)
18. Doyle Guilloud S, ‘The right to liberty of persons with psychosocial disabilities at the United Nations: A tale of two interpretations’, (2019) 66 *International Journal of Law and Psychiatry* 101497. [↑](#footnote-ref-18)
19. Series L, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022). [↑](#footnote-ref-19)
20. CQC, *Monitoring the Mental Health Act in 2020-21* (February 2022) p. 45. [↑](#footnote-ref-20)
21. *Out of Sight – who cares?* (October 2020) available at <https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf> [↑](#footnote-ref-21)
22. *As if Expendable: The UK Government’s failure to protect older people in care homes during the Covid-19 pandemic* (2020) available at <https://www.amnesty.org.uk/files/2020-10/Care%20Homes%20Report.pdf?VersionId=kd5Z8eWzj8Q6ryzHkcaUnxfCtqe5Ddg6> [↑](#footnote-ref-22)