

# Inclusion London information paper on abuse and deaths in state institutions

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## Introduction

### Inclusion London

Inclusion London is a London-wide user-led organisation which promotes equality for London’s Deaf and Disabled people and provides capacity-building support for over 70 Deaf and Disabled People’s Organisations (DDPOs) in London and through these organisations our reach extends to over 70,000 Disabled Londoners.

### Disabled people

* In 2012/13 there were approximately 12.2 millionDisabled adults and children in the UK, a rise from 10.8 million in 2002/03. The estimated percentage of the population who were Disabled remained relatively constant over time at around 19 per cent.[[1]](#footnote-1)
* There are approximately 1.2 million Disabled people living in London.[[2]](#footnote-2)

This information paper looks at the abuse, restraint and deaths of Disabled people in state institutions primarily focusing on people with learning difficulties and people with mental health support needs.

## Inappropriate institutional care

People with mental health support needs and people with learning difficulties or on the autistic spectrum are losing their liberty inappropriately and being placed in hospital units or in residential care, not from choice or need but because of a lack of care in the community.[[3]](#footnote-3) The homes or hospital units are often many miles[[4]](#footnote-4) from family or community where there is a heightened risk or abuse.

[In 2015/16](http://www.content.digital.nhs.uk/catalogue/PUB21934), local authorities were funding:

* 30,240 adults with learning disabilities in residential care services
* 1,815 adults with learning disabilities in nursing homes.[[5]](#footnote-5)
* 3,000 people with learning difficulties in specialist inpatient units in September 2015.[[6]](#footnote-6)

Many patients are ‘sectioned’ inappropriately, purely because local authorities and CCG commissioners fail to agree funding for appropriate housing and support.[[7]](#footnote-7)

Regarding the 3,000 people with learning difficulties were in specialist inpatient units in September 2015:[[8]](#footnote-8)

* 30% of people have been in ATUs for more than 5 years. [[9]](#footnote-9)
* 24% of patients self-harmed in 2015.[[10]](#footnote-10)
* 26 per cent of patients experienced at least one adverse experience, such as accidents, physical assault and self-harm, as well as at least one restrictive measuresuch as restraint or seclusion.[[11]](#footnote-11)
* 72 per cent of patients (2,155) received antipsychotic medication regularly.[[12]](#footnote-12) There are concerns about over medication of patients.[[13]](#footnote-13)

## Violence and abuse

Violence or abuse in care settings or from ‘care’ providers, particularly segregated institutions has been a problem for many years[[14]](#footnote-14) through to recent times as the book ‘Longcare Survivors’ published in 2011[[15]](#footnote-15) and the abuse at Winterbourne View Private Hospital[[16]](#footnote-16) revealed. Following the uncovering of the abuse at Winterbourne view the Government committed to discharging inpatients with learning difficulties and those on the autistic spectrum back to their homes and communities, ‘where appropriate’. The ‘Transforming Care’ Programme was established to ‘enable more people to live in the community, with the right support, and close to home.’[[17]](#footnote-17) However, the Public Accounts Commons Select Committee report found that during the four years since the abuse was uncovered ‘…children and adults have continued to go into mental health hospitals, and to stay there unnecessarily, because of the lack of community alternatives’.[[18]](#footnote-18) The Committee found that, ‘Discharges from hospital are being delayed because funding does not follow the individual when they are discharged into the community.’[[19]](#footnote-19)

There is a severe shortage of affordable housing in community and proposed changes to the funding of supported housing makes current provision unsustainable and has slowed new build. The shortage of housing together with severe cuts to care and support in the community[[20]](#footnote-20) poses huge difficulties in moving Disabled people back into the community. Both these problems need to urgently addressed - Inclusion London recommends that social care and support is funded through general taxation, funding is provided to build more social housing and that the proposed changes to funding of supported housing do not go ahead.

## People with a learning difficulty – death by indifference

The ‘Death by indifference’ a report published in 2012 highlighted the deaths of 74 people with a learning disability in NHS care over the last ten years, which could have been avoided and were a ‘direct result of institutional discrimination’.[[21]](#footnote-21) This report follows up a previous Death by indifference report published in 2007.

It is tragic that the death of Connor Sparrowhawk[[22]](#footnote-22) took place after the publication of these reports and that research published in 2013 revealed that 1,200 people with a learning disability die needlessly every year in NHS care.[[23]](#footnote-23)

Connor was admitted to Slade Treatment Unit run by Southern Health NHS Foundation in March 2013. He drowned in a bath in July 2013. The inquest found that ‘Connor Sparrowhawk died by drowning following an epileptic seizure while in the bath, contributed to by neglect’.[[24]](#footnote-24) Southern Health statement says that ‘Connor’s preventable death was a result of multiple and individual failures by the Trust…’[[25]](#footnote-25)

## Laughing Boy Bill (LBBill)

Connor Sparrowhawk had the online name of ‘Laughing boy’ (LB). A campaign aiming to achieve ‘JusticeforLB’ through changing the law via ‘the Laughing Boy Bill’ (LBBill) is ongoing.[[26]](#footnote-26) Clause 1 of the second draft of the Bill would see the ‘Implementation of Article 19 of the Convention on the Rights of Persons with Disabilities’[[27]](#footnote-27) to ‘ensure that all disabled people can live in their community, with choices equal to others and the support necessary to ensure their full inclusion and participation in the community.’[[28]](#footnote-28)

Unfortunately the Bill has not progressed. Also It is disappointing that no government proposals followed the ‘No Voice unheard no right ignored’ consultation with people with learning difficulties, autism and mental health conditions’[[29]](#footnote-29) initiated by Norman Lamb, while he was Minister of Care in the wake of the Winterbourne view scandal.[[30]](#footnote-30) Inclusion London’s response to the consultation[[31]](#footnote-31) highlighted the LBBill and the urgent need for Article 19 UN CRDP to be committed into domestic law.

We believe the need to incorporate Article 19 UNCRDP into domestic law is even more urgent for a number of reasons but particularly because the Care Quality Commission’s review of the way NHS trusts review and investigate deaths people with learning difficulties or mental health ‘problems’ published in 2016 has found the deaths were not given adequate attention and that opportunities to learn from patient deaths are being missed.[[32]](#footnote-32)

Also, according to an inquiry which reviewed the deaths of 247 people with learning difficulties, 37% of the deaths of people with a learning difficulty were considered avoidable.[[33]](#footnote-33) Based on the findings of the inquiry it was estimated that 1,238 children and adults die across England every year because they are not getting the right health care.[[34]](#footnote-34)

## Deaths of patients ‘detained’ under Mental Health Act

According to the CQC in 2014/2015 there were 227 deaths of patients detained under the Mental Health Act, of which 34, where due to ‘Unnatural causes,’ 11 were ‘Undetermined’ and 182 due to ‘natural causes’.

However, INQUEST[[35]](#footnote-35) raised concerns regarding data collection, saying, ‘There is currently no single, complete and coherent set of data on the number of deaths in mental health settings in England and Wales, with differing sets of statistics focussing on different groups of patients.’ [[36]](#footnote-36) This lack of a single comprehensive data set could seriously impede the monitoring of services. We call on the government to insure that there is a single data set in the future.

## Unexpected deaths of patients under NHS care

Unexpected deaths include death by suicide, neglect and misadventure. There is concern that ‘unexpected deaths’ of patients under NHS care are not being investigated:

* An independent report on the deaths of people ‘with a learning ‘disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015, which was commissioned following Connor Sparrowhawk’s death published in 2015 revealed that just 272 of 722 ‘unexpected’ deaths were investigated under the Southern Health NHS Foundation Trust[[37]](#footnote-37), which serves four counties in the south of England.[[38]](#footnote-38)
* Hospitals in England investigated just 222 out of 1,638 deaths of patients with learning difficulties since 2011 and only 137 (35%) of the 397 the ‘unexpected deaths’ were investigated according to Freedom of Information request by the Guardian newspaper.[[39]](#footnote-39)
* Freedom of Information data obtained by the Liberal Democrats found that there were 1,714 unexpected deaths in 2014-15 across the 58 mental health trusts in England, an underlying increase of 20%. These death figures include 751 suicides - up 22% from 2012-13.[[40]](#footnote-40)
* According to Freedom of Information requests by the BBC the number of unexpected patient deaths reported by England's mental health trusts has risen by almost 50% in three years, figures suggest. [[41]](#footnote-41) The Department of Health said the increase was "expected" because of changes to the way deaths were recorded and investigated.[[42]](#footnote-42)

## Deaths & physical injury due to ‘restraint’ of patients in NHS care

* There were at least 13 restraint-related deaths of people detained under the Mental Health Act 1983. Eight of these occurred in a single year (2011).[[43]](#footnote-43)
* In 2012 restraint was used over 3,000 times resulting in almost 1,000 incidents of physical injury.[[44]](#footnote-44)

The use of ‘restraint’ resulted in the death in 1998 of David ‘Rocky’ Bennett a 38 year old African Caribbean, followed an incident involving the use of restraint in a NHS medium secure unit, in Norwich.[[45]](#footnote-45) The lack of restraint training and staff knowledge was a contributory factor according to the inquests held in 2008 into the deaths of Kurt Howard who died in 2002 and Azrar Ayub and Geoffrey Hodgkin who both died in 2004.[[46]](#footnote-46) These deaths occurred after the recommendations from the Rocky Bennett inquiry were made public.[[47]](#footnote-47)

## Cause of death unknown

The Independent Advisory Panel (IAP) into deaths in custody figures show that there were:

* 42 deaths of detained patients where the cause of death was “unknown” deaths of detained patients in 2013, 37 in 2012, 55 in 2011, 36 in 2010.[[48]](#footnote-48)

## Lack of information provided by services

According to INQUEST, ‘there are a significant number of deaths in mental health detention where details of the cause of death are not forthcoming at an early stage, which could alert authorities to any trends emerging and enable preventative measures to be taken’.[[49]](#footnote-49)

INQUEST finds that there is ‘a glaring disparity between the manner in which deaths in mental health detention are investigated pre-inquest compared to those in other forms of state custody; Unlike deaths in police, prison or immigration detention or following contact with state agents – where the coroner’s inquest is based on the independent investigation of the Independent Police Complaints Commission (IPCC) or the Prisons and Probation Ombudsman (PPO) – no such equivalent investigative mechanism exists to scrutinise deaths in mental health settings. Instead, the inquest is reliant pre-inquest on the internal reviews and investigations conducted by the same trust responsible for the patient’s care.’ [[50]](#footnote-50) The lack of independent investigation prior to inquest regarding the death of detained patients appears to be a discriminatory practice, which we call on the government to address.

INQUEST goes on to say, ‘Except by way of targeted FOI requests, there is currently no system for coroners or families to access information and statistics to check the number or nature of deaths that have occurred in specific settings (unlike other custodial deaths where this information is published). This means that patterns of deaths in individual hospitals or units which merit closer examination may escape public scrutiny’.[[51]](#footnote-51)

Also the Care Quality Commission (CQC) report raised concerns regarding late reporting of detained patients: ‘We are particularly concerned that providers are failing to notify us of the death of a detained patient in the expected timescales in nearly half (45%) of all cases. This does not meet our expectations for incident reporting or effective governance systems in well-led services.’[[52]](#footnote-52)

## Change in the law

The information above indicates that there can be a lack of detailed information provided by services following the death of a patient, there is not an independent investigation prior to an inquest regarding deaths of patients in mental health settings and the CQC are not being informed about ‘detained’ patients by the expected timescales.

Therefore we are very concerned about a change in the law, which removes deprivation of liberty inquests duty so Coroners are no longer required to hold an inquest if a person dies while subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. The Chief Coroner has said that the previous requirement for all DoLS deaths to go to inquest had distressed bereaved families and created unnecessary pressure on services.[[53]](#footnote-53) However, we believe that bereaved families have a right to know the full details surrounding the death of a family member should they wish to and a lack of information can cause further distress. We find it lamentable that the government seems to be moving in the wrong direction regarding openness and transparency regarding the deaths of patients subject to DoLS through this change in the law.

## Inappropriate use of anti-psychotic drugs and other medication

Evidence demonstrates that anti-psychotic and anti-depressant drugs are being routinely and inappropriately prescribed to persons with learning disabilities. A 2015 study found that in England on any given day:

* 17% of persons with learning disabilities were routinely being prescribed anti-psychotic drugs, despite only 4% exhibiting psychosis;
* 17% were being prescribed anti-depressants while only 7% have depression, and 16% were prescribed one or other drug while having neither psychosis nor depression.[[54]](#footnote-54)
* 72 per cent of inpatients with a learning disability (2,155) received antipsychotic medication either regularly or 'as and when needed' in the 28 days prior to the Learning Disability Census in 2015.[[55]](#footnote-55)

## Mental health services in crisis

Mental Health (MH) services in the UK have seen years of underfunding and services are now in crisis. The MPs health committee has said the scale of suicides is unacceptable.[[56]](#footnote-56) [[57]](#footnote-57)

* “4,820 people are recorded as having died by suicide during 2015 in England last year, but the true figure is likely to be higher.”
* A British Medical Association report found that there has been a 44% decrease in the number of mental health beds since 2000/01, with 726 mental health patients being given out of area placements each month between March and October last year.[[58]](#footnote-58)
* A Commons select committee found, “Many psychiatric wards are over capacity and there is huge pressure on beds, nevertheless, we were shocked to learn that there is evidence that patients who need hospital treatment are being sectioned unnecessarily in order to access a bed.”[[59]](#footnote-59)

## BAME mental health

There is over-representation of black people in mental health settings:[[60]](#footnote-60)

* 22% per cent of people are subject to the Mental Health Act are from BAME communities, even though we make up only 8% of the general population.[[61]](#footnote-61)
* Black Caribbean and white/black Caribbean mixed groups, stay, on average, in hospital for longer. Seclusion rates are higher among the other white and mixed white/black Caribbean groups.[[62]](#footnote-62)

## Mental Health Act

There are concerns that the Mental Health Acts are not protecting people with mental health support needs as they should, see more information in Appendix 1.

## Criminal justice system

There are concerns regarding the disproportionate percentage of people with learning difficulties, people mental health support needs and black people in prison:

* 72% of male and 70% of female sentenced prisoners have two or more mental health support needs,[[63]](#footnote-63) 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.
* The percentage of people with learning difficulties in the criminal justice system is about 30%[[64]](#footnote-64). 20–30% of offenders have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system.[[65]](#footnote-65)
* According to the Equality and Human Rights Commission, there is now greater disproportionality in the number of black people in prisons in the UK than in the United States. Out of the British national prison population, 10% are black and 6% are Asian, while black Britons represent just 2.8% of the general population.[[66]](#footnote-66)

We are concerned that reasonable adjustments[[67]](#footnote-67) are not being made so Disabled people do not have access to justice on an equal basis to others. Once inside prison people with learning difficulties or who are on the autistic spectrum continue to be disadvantaged with inspectors finding[[68]](#footnote-68) that “little thought was given to the need to adapt regimes…"[[69]](#footnote-69)

## Deaths and restraint in prison

A report published in October 2011 ‘highlighted that certain groups were more vulnerable to risks associated with restraint – both intrinsically, and because they are more likely to be restrained.’ These groups included people with serious mental support needs, or learning disabilities or those from BME communities.[[70]](#footnote-70)

A report by the Independent Advisory Panel on deaths in custody where restraint was either a direct cause or a contributory factor[[71]](#footnote-71) found 28 male deaths and one female death. In 12 of the deaths the individuals had mental health support needs at the time of their death. Five people had been diagnosed as suffering from schizophrenia and two with paranoid schizophrenia. Five people had been restrained whilst being detained by the police under Section 136 of the Mental Health Act (MHA)3.[[72]](#footnote-72) There was a lack of records regarding whether an individuals had a learning difficulty.

People with learning disabilities are five times as likely as other prisoners to have been subjected to control and restraint techniques and three times more likely to have spent time in segregation.[[73]](#footnote-73)

The deaths of three black men in Broadmoor prison, Michael Martin (1984), Joseph Watts (1988) and Orville Blackwood (1991) followed the use of restraint and the forcible injection of tranquillising medication on patients detained under the Mental Health Act.[[74]](#footnote-74)

## Children

Use of restraint on children in custody is alarmingly high, with an average of 360 restraint incidents a month. ‘In the year to March 2016, there were 28 incidents of restraint per 100 children in custody, up from 18 in 2010. It is shocking that ‘87 incidents required medical treatment as a result of restraint in 2016—three of these required a child to be sent to hospital.’[[75]](#footnote-75)

In June 2016, the Committee on the Rights of the Child expressed concern about the use of restraint on children in custodial settings in England and Wales, young offenders institutions and on children with ‘psychosocial disabilities’ including autism in schools.[[76]](#footnote-76)

## Self-inflicted deaths in custody

Until 2011 there was a welcome decline in self-inflicted deaths. However, this decline has been reversed and as rates are now near record levels. 344 people died in the year to March 2017, of these deaths a third (113) were self-inflicted. 199 people died of Natural Causes in the year to December 2016, a surprising rise of 21% on the previous year.[[77]](#footnote-77)

## Conclusion

There are a shockingly high number of deaths in state institutions. It is equally shocking that a high percentage of these deaths are not properly investigated. The deaths of detained patients in hospitals are not independently investigated prior to inquest while deaths in custody are. This lack of investigation is compounded by a change in the law, which has removed the deprivation of liberty inquests duty so Coroners are no longer required to hold an inquest if a person dies while subject to a Deprivation of Liberty Safeguards (DoLS) authorisation.

There is no single comprehensive data set on deaths in mental health settings in England and Wales to facilitate the monitoring of services. Instead coroners or families have to use FOI requests to access information and statistics on the number or nature of deaths, which have occurred in specific settings. As INQUEST highlights this prevents the patterns of deaths in individual hospitals or units to be revealed and also to escape public scrutiny. [[78]](#footnote-78) We call on the government to insure that there is a single data set in the future.

There are serious concerns that anti-psychotic and anti-depressant drugs are being routinely and inappropriately prescribed to persons with learning disabilities. The use of restraint on people with learning difficulties and mental health support needs is high with deaths or injuries occurring. The number of suicides is rising and many people in state institutions self- harm. Abuse has taken place in hospital units and neglect has been occurring for years. State institutions are seriously failing Disabled people.

We believe the failure of the state to investigate and prevent violence, neglect and deaths of Disabled people in institutions and segregated residential settings amounts to a systematic violation of the UN Convention on the Rights of Persons with Disabilities (UN CRPD) over an extended period of time. We call on the government to urgently address the abuse, use of restraint and deaths of Disabled people in state institutions.

#

# Appendix 1

## Concern regarding the Mental Health Act 2005

The Mental Health Act 2005 (as amended)[[79]](#footnote-79) permits the Deprivation of Liberty of a person on the basis of ‘disability of the mind’. ROFA raised concerns that this breaches Breach of the Article 14 UN CRDP.[[80]](#footnote-80)

There are significant problems with the implementation of the ‘safeguards’ in the Mental Capacity Act 2005 (MCA)[[81]](#footnote-81) A Lords report found[[82]](#footnote-82) that the Deprivation of Liberty Safeguards (DoLS), inserted into the Mental Capacity Act in 2007 are ‘not fit for purpose’[[83]](#footnote-83) and recommended that DoLS be replaced. The report found that “…. far from being used to protect individuals and their rights, they are sometimes used to oppress individuals…..”[[84]](#footnote-84)

The health select committee of MPs also raised concerns regarding DoLS, the chair said, "Mental health legislation is designed to protect extremely vulnerable patients but our review has found that many vital safeguards are not working effectively”. The Chair went onto say, “The provisions for DOLS are not working well. We found that it is commonplace for DOLS to be ignored leaving many people at heightened risk of abuse.”[[85]](#footnote-85)

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1. Family Resources survey United Kingdom 2012/13: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325491/family-resources-survey-statistics-2012-2013.pdf> (page 61) [↑](#footnote-ref-1)
2. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325491/family-resources-survey-statistics-2012-2013.pdf> (page 64) See also ‘Disability data tables’ at: <https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201516> [↑](#footnote-ref-2)
3. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/508909/ld-census-further-sep15-rep.pdf> [↑](#footnote-ref-3)
4. The proportion of inpatients receiving care more than 100km away from their home and community in 2015 was 23%, an increase from 19% in 2014: <http://content.digital.nhs.uk/article/6874/Learning-Disability-Census-2015-almost-half-of-inpatients-with-learning-disabilities-common-to-each-census-since-2013> [↑](#footnote-ref-4)
5. <http://www.content.digital.nhs.uk/catalogue/PUB21934/comm-care-stat-act-eng-2015-16-rep.pdf> [↑](#footnote-ref-5)
6. <http://content.digital.nhs.uk/article/6874/Learning-Disability-Census-2015-almost-half-of-inpatients-with-learning-disabilities-common-to-each-census-since-2013> [↑](#footnote-ref-6)
7. <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-08-14-mha2007cs/>

7 Days of Action Campaign Group <https://theatuscandal.wordpress.com/> [↑](#footnote-ref-7)
8. <http://content.digital.nhs.uk/article/6874/Learning-Disability-Census-2015-almost-half-of-inpatients-with-learning-disabilities-common-to-each-census-since-2013> [↑](#footnote-ref-8)
9. 7 Days of Action Campaign Group <https://theatuscandal.wordpress.com/> [↑](#footnote-ref-9)
10. <http://content.digital.nhs.uk/article/6874/Learning-Disability-Census-2015-almost-half-of-inpatients-with-learning-disabilities-common-to-each-census-since-2013> [↑](#footnote-ref-10)
11. <http://content.digital.nhs.uk/article/6874/Learning-Disability-Census-2015-almost-half-of-inpatients-with-learning-disabilities-common-to-each-census-since-2013> [↑](#footnote-ref-11)
12. <http://content.digital.nhs.uk/article/6874/Learning-Disability-Census-2015-almost-half-of-inpatients-with-learning-disabilities-common-to-each-census-since-2013> [↑](#footnote-ref-12)
13. <https://theatuscandal.wordpress.com/> [↑](#footnote-ref-13)
14. Hoong Sin, C., Hedges, A., Cook, C. Mguni, N., Comber, N. (2009) Office for Public Management. *Disabled people’s experiences of targeted violence and hostility*. Research Report 21. [↑](#footnote-ref-14)
15. <https://www.disabilitynewsservice.com/longcare-survivors-the-biography-of-a-care-scandal/> [↑](#footnote-ref-15)
16. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf>

<http://hosted.southglos.gov.uk/wv/report.pdf> The Abuse was revealed by the BBC Panorama programme in May 2011, which used hidden cameras to film the abuse. [↑](#footnote-ref-16)
17. <https://www.england.nhs.uk/learning-disabilities/care/> [↑](#footnote-ref-17)
18. <https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-caring-for-people-with-learning-disabilities/> [↑](#footnote-ref-18)
19. <https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-caring-for-people-with-learning-disabilities/> [↑](#footnote-ref-19)
20. By 2015 4.6 billion had been cut from social care budgets over 5 years <https://www.adass.org.uk/full-report-adass-budget-survey-2015> [↑](#footnote-ref-20)
21. <https://www.mencap.org.uk/press-release/mencap-report-finds-nhs-still-unsafe-people-learning-disability> [↑](#footnote-ref-21)
22. <https://lbbill.wordpress.com/who-is-lb/> [↑](#footnote-ref-22)
23. <https://www.mencap.org.uk/press-release/mencap-research-scandal-avoidable-death-1200-people-learning-disability-die> [↑](#footnote-ref-23)
24. <https://www.judiciary.gov.uk/wp-content/uploads/2015/12/Sparrowhawk-2015-0445.pdf> [↑](#footnote-ref-24)
25. <http://www.southernhealth.nhs.uk/news-archive/2016/trust-statement-regarding-connor-sparrowhawks-death/> [↑](#footnote-ref-25)
26. <https://lbbill.wordpress.com/what-is-lbs-bill/> [↑](#footnote-ref-26)
27. Article 19 - Living independently and being included in the community

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

	1. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;<http://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx#19> [↑](#footnote-ref-27)
28. <https://lbbill.files.wordpress.com/2014/11/explanatory-notes-lbbill-draft-2.pdf> [↑](#footnote-ref-28)
29. <https://www.gov.uk/government/consultations/strengthening-rights-for-people-with-learning-disabilities> [↑](#footnote-ref-29)
30. <https://www.inclusionlondon.org.uk/campaigns-and-policy/facts-and-information/independent-living-social-care-and-health/rights-social-care-support/> [↑](#footnote-ref-30)
31. <https://www.inclusionlondon.org.uk/campaigns-and-policy/facts-and-information/independent-living-social-care-and-health/inclusion-london-response-to-the-no-voice-unheard-no-right-ignored-consultation/> [↑](#footnote-ref-31)
32. <http://www.cqc.org.uk/news/stories/deaths-people-learning-disabilities-or-mental-health-problems-not-always-given-adequate> [↑](#footnote-ref-32)
33. <http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf> [↑](#footnote-ref-33)
34. <http://www.bris.ac.uk/cipold/> [↑](#footnote-ref-34)
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