

# Verification Before Detention

## Neurodivergent Screening, the Duty to Check the Account, and the Dual Reading of Suicidal Ideation in Mental Health Act Assessments

Eli Goldsobel, doctoral researcher

### Introduction

In an earlier essay, I argued for compulsory neurodivergent screening when Pre-Sentence Reports are prepared.<sup>1</sup> Its central claim was that the criminal justice system too often discovers a defendant's autism or ADHD only after conviction. The Equality Act 2010's anticipatory duty, I argued, requires institutions to look for such needs before the damage is done.

This essay moves that argument earlier in the process. For many people, the first coercive contact with the state is not a court. It is a police officer acting under section 136 of the Mental Health Act 1983, a warrant under section 135, or an assessment leading to detention under section 2. The misreading that the earlier essay traced to sentencing often begins here.

The earlier essay asked a single question: is this person neurodivergent? Asked alone, that question is incomplete. A person brought in under these powers may say they want to die and describe being persecuted. To assess them fairly, services must ask two questions in parallel: is the account true, and is the way it is being told being misread?

The presentation that most needs both questions is one in which a person wants to die and believes that others want them dead. These two statements are often recorded as a single

---

<sup>1</sup> E. Goldsobel, "Enhancing Safeguards for Vulnerable Defendants: The Case for Compulsory Neurodivergent Screening in Pre-Sentence Reports", Chambers Law Essay Competition entry on the theme "Prioritising Reform: Identifying a Critical Area in the Criminal Justice System" (2024). Corrections to that essay: (a) It presented *R v Sossongo* [2021] EWCA Crim 1777 and *R v PS* [2019] EWCA Crim 2286 as separate cases. They concern the same appellant. PS was convicted in June 2017 of murder and related offences committed on 18 November 2016, when he was 14. Diagnoses of ASD and ADHD made in 2018 and 2019 were admitted on appeal against sentence in 2019, and his minimum term was reduced from 14 to 10 years. The Criminal Cases Review Commission then referred the conviction back to the Court of Appeal. In 2021 the court held that the post-conviction diagnosis was fresh evidence that could have affected the jury's decision, and the conviction was quashed. He was acquitted at the retrial. (b) *R v PS* was a joint judgment on three unconnected appeals, and is authority on sentencing offenders with autism or other mental health conditions. (c) "Connors" should read "Conners". (d) The Sentencing Council guideline is *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments*, in force from 1 October 2020. (e) Criminal Justice Act 2003 s 143(1) has been replaced by Sentencing Act 2020 s 63. (f) Article 6 ECHR is better framed as the right to effective participation in a fair trial (*T v UK*; *V v UK* (1999); *SC v UK* (2004)). (g) The Autism Spectrum Quotient is unsuitable as a stand-alone tool in clinical populations; see note 6.

finding, suicidal ideation with persecutory beliefs. They can in fact be true together. The core proposal of this essay is therefore modest: a record that can say both things, in the person's own words, and that shows whether anyone has checked the account. A wider set of checking and candour duties is offered as a direction of travel, not as something the law already requires.

## Part I: The Point of First Contact

Consider this presentation. A person is brought to a place of safety. They say they want to die. They describe being persecuted by an institution, a landlord, a community or the state. On a conventional reading, this is psychosis with risk to self. That reading may be right.

But a finding of persecutory delusion rests on a condition that is easily overlooked: the belief must be false, or held without adequate grounds. Where the belief concerns specific acts of institutional mistreatment, whether those acts happened is a question of fact. It can sometimes be checked against tenancy files, benefits correspondence, complaint records and safeguarding history.

The error this essay identifies is the substitution of a judgment about how plausible an account sounds for a finding that it is false.<sup>2</sup> If it occurs, it leaves no trace in the notes: "persecutory beliefs about the local authority" reads the same whether or not anyone looked at the housing file.

At present this is a theory of error, not a demonstrated pattern. No audit has yet counted how often section 136 or section 2 papers record an account of institutional mistreatment as delusion without any check of the record. Such an audit, of the assessment templates in use and of a sample of approved mental health professional reports, is the first empirical step this essay recommends.

Two factors can lower the credibility of a true account:

- **Autistic communication.** Dense detail, idiosyncratic vocabulary, a circumstantial style and flat affect can raise the listener's sense that something is wrong. These features overlap with the markers clinicians use to identify psychotic speech. The communicative failure is mutual rather than located in the autistic speaker, which Milton calls the double empathy problem.<sup>3</sup>
- **Social position.** A person without resources, representation or standing is less likely to be believed. Fricker's account of testimonial injustice, where a speaker is given less credibility than they deserve because of who they are, names this mechanism.<sup>4</sup>

---

<sup>2</sup> This is the author's own synthesis, extending Fricker's framework (note 4) to a clinical determination she does not address. The adjacent literature is H. Carel and I.J. Kidd, "Epistemic Injustice in Healthcare: A Philosophical Analysis" (2014) 17 *Medicine, Health Care and Philosophy* 529; I.J. Kidd and H. Carel, "Epistemic Injustice and Illness" (2017) 34 *Journal of Applied Philosophy* 172; and, closest to this essay, P. Crichton, H. Carel and I.J. Kidd, "Epistemic Injustice in Psychiatry" (2017) 41 *BJPsych Bulletin* 65. The narrower point claimed here is the substitution of a plausibility judgment for the falsity condition of a delusion at the moment of a detention decision.

<sup>3</sup> D. Milton, "On the Ontological Status of Autism: The 'Double Empathy Problem'" (2012) 27 *Disability & Society* 883.

## Part II: The Symmetry Requirement

Any proposal of this kind must take the opposite error seriously. Autism can be mistaken for psychosis, but psychosis can also be missed in autistic people, overshadowed by features that have been present all their lives. A 2022 meta-analysis of 53 studies put the pooled prevalence of psychosis among autistic adults at 9.4%, far above the general-population rate.<sup>5</sup> A reform that pushed assessors toward “it’s autism, not psychosis” would simply move the harm in the other direction.

Nor is checking the account decisive. Many false beliefs are detailed, internally consistent and aimed at real institutions, and a complaint on file shows that a complaint was made, not that it was justified. A check can at most establish whether particular alleged events happened. If they did, a finding that the belief about those events is delusional cannot stand. But it does not follow that the person has no psychiatric disorder: psychosis can attach to a real grievance and add an intent the record does not show. The more reliable way to distinguish autism from later-onset psychosis is developmental history, not a same-day file review.

Screening tools do not resolve the question either. The Autism Spectrum Quotient, which my earlier essay proposed, separates autistic adults from the general population well but does poorly within a clinical sample. One study found no significant difference in scores between autistic participants and those with psychosis.<sup>6</sup> Neither the presentation, nor a screening score, nor a check of the record can settle the question alone. They are inputs to an assessment, and genuine psychiatric need must be treated throughout.

## Part III: The Dual Presentation

Suicidal ideation is commonly recorded as a single risk marker, and in the literature relied on above it is treated as a feature shared by autism and psychosis. Cassidy and colleagues reported lifetime suicidal ideation in 66% of adults diagnosed with Asperger syndrome in adulthood, against 59% in a psychosis comparison drawn from other sources.<sup>7</sup> Those figures

---

<sup>4</sup> M. Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (OUP 2007).

<sup>5</sup> K.J. Varcin and others, “Occurrence of psychosis and bipolar disorder in adults with autism: A systematic review and meta-analysis” (2022) 134 *Neuroscience and Biobehavioral Reviews* 104543 (53 studies; pooled prevalence of psychosis 9.4%, N = 63,657, 95% CI 7.52–11.72).

<sup>6</sup> L. Fusar-Poli and others, “Self-Reported Autistic Traits Using the AQ: A Comparison between Individuals with ASD, Psychosis, and Non-Clinical Controls” (2020) 10 *Brain Sciences* 291. The AQ was given to 35 autistic adults, 64 adults with schizophrenia spectrum disorders and 198 non-clinical controls. It separated autistic adults from controls well (AUC 0.84) but poorly within the clinical sample (AUC 0.63), and did not correlate with clinician-rated ADOS-2 scores.

<sup>7</sup> S. Cassidy, P. Bradley, J. Robinson, C. Allison, M. McHugh and S. Baron-Cohen, “Suicidal ideation and suicide plans or attempts in adults with Asperger’s syndrome attending a specialist diagnostic clinic: a clinical cohort study” (2014) 1 *Lancet Psychiatry* 142. The study surveyed 374 adults diagnosed in adulthood at a specialist clinic. The comparison figures of 17% (general population) and 59% (psychosis) were drawn from other samples.

are lifetime self-report counts. They do not establish that the ideation reported was a primary wish to die, separable from the circumstances in which it arose.

The single category conflates at least three distinct propositions:

- **A wish to be dead.** A statement that the person cannot see a tolerable future under present conditions, for example after sustained housing, benefits or complaint disputes. The statement may be accurate as to the conditions and still indicate real risk.
- **A belief that others intend the person's death.** This is a different proposition. It may be figurative, an inference of intent from indifference, an autistic or trauma-shaped way of describing institutional harm, or a persecutory belief. Which it is depends in part on facts that can be examined.
- **Active suicidal intent.** A plan or intention to end one's life. This calls for an immediate clinical response, whatever its context.

The case that matters for this essay is the combination of the first two. A person may wish to die because they have concluded that a landlord, a trust, a benefits authority or a community is trying to remove them. The two propositions are not competing diagnoses; they may describe one set of circumstances. A record that captures only suicidal ideation omits the second proposition. A record that captures only persecutory delusion omits the first, and treats as settled a factual question that has not been examined.

The two questions set out in the Introduction therefore need to be asked together. An assessment that asks only about suicidality produces a risk finding and, often, a route to detention. An assessment that asks only whether the alleged persecution occurred produces a complaint, with no finding on immediate risk. Asked together, the factual allegations can be examined while the wish to die is treated as a present clinical fact.

This does not reduce the assessed risk. Population data show suicide to be a major contributor to premature mortality among autistic people, particularly those without intellectual disability,<sup>8</sup> and adversity increases that risk. The point is narrower: the combination of real hostility and a real wish to die is the case in which the documentary record and the developmental history are most relevant, not least. Nor does the combination count against detention. A belief that others intend one's death is not evidence that detention is unjustified, and a co-occurring depressive or psychotic illness may be present. Under the 2025 Act the consequence is specific: if this presentation is recorded as psychosis with risk on the section 2 papers, the section 3 protection for autistic people will not be engaged (see Part V).

## Part IV: The Double Misreading

For people from faith communities, and from Black and minoritised ethnic communities, cultural misreading adds a second layer. Religious language about exile, divine judgment or

---

<sup>8</sup> T. Hirvikoski and others, "Premature mortality in autism spectrum disorder" (2016) 208 *British Journal of Psychiatry* 232. In this Swedish population cohort (27,122 autistic people), all-cause mortality was elevated (OR 2.56). Among autistic people with intellectual disability, the leading cause of excess death was epilepsy and other neurological conditions; among those without intellectual disability, suicide carried the highest excess risk (OR 9.40).

spiritual danger can be heard as grandiose or delusional by a clinician who does not share the frame. Behaviour considered ordinary inside a close-knit religious community can look withdrawn or bizarre from outside it.

The disparities are stark. In 2024–25, the detention rate for Black or Black British people was 262.4 per 100,000, nearly four times the White rate of 65.8.<sup>9</sup> Black people were more than eight and a half times as likely as White people to be placed on a community treatment order.<sup>10</sup> Deprivation matters too: people in the most deprived areas were more than three and a half times as likely to be detained as those in the least deprived.<sup>11</sup>

These figures are context, not proof. A three-region study by Singh and colleagues of 4,423 assessments found that, among people already being assessed under the Act, ethnicity was not an independent predictor of detention once diagnosis, risk and recorded social support were controlled for.<sup>12</sup>

This essay adds a hypothesis about measurement, which those studies do not test. “Social support” is not observed directly; it is whatever the assessment records. If the form has no field for faith-community support, a person held within a dense congregation may be recorded as isolated, and recorded isolation predicts detention. If so, the form partly produces the predictor. Both papers used a household measure of living status. In the Birmingham cohort, social support entered the analysis as whether the person lived alone, with others, or had no fixed abode, recorded from the approved mental health professional’s forms (see note 12). In the three-region study, the categories were living with friends or family, living alone, homeless, or in supported accommodation; supported accommodation, not living alone, predicted detention. Neither measure can register congregational support.

A faith field also cuts both ways. Congregations can be sources of support, but also of coercion, honour-based abuse, or shared belief that sustains an account.<sup>13</sup> When a

---

<sup>9</sup> NHS England, *Mental Health Act Statistics, Annual Figures 2024–25*: detention rates.

<sup>10</sup> NHS England, *Mental Health Act Statistics, Annual Figures 2024–25*: community treatment orders.

<sup>11</sup> Mind, response to the 2024–25 annual figures (18 September 2025).

<sup>12</sup> S.P. Singh, T. Burns, P. Tyrer, Z. Islam, H. Parsons and M.J. Crawford, “Ethnicity as a predictor of detention under the Mental Health Act” (2014) 44 *Psychological Medicine* 997 (published online 2013): 4,423 assessments in Birmingham, West London and Oxfordshire, 2008–2011. Living status entered the model as living with friends or family, living alone, homeless, or supported accommodation; supported accommodation predicted detention (OR 1.8). A separate Birmingham cohort (1,115 assessments, 2009–10) is reported in R. Gajwani, H. Parsons, M. Birchwood and S.P. Singh, “Ethnicity and detention: are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007?” (2016) 51 *Social Psychiatry and Psychiatric Epidemiology* 703. In that study, social support entered the regression model as living status (alone, with others, or no fixed abode), recorded from AMHP assessment forms; the authors acknowledge that bias operating before the assessment would not be detected. The 2014 finding was contested: S.P. Sashidharan, K. Bhui and J. Duffy, “‘Ethnicity as a predictor of detention under the Mental Health Act’: a response to Singh et al.” (2014) 44 *Psychological Medicine* 893.

<sup>13</sup> The same research programme found that Asian service users and carers were the group most likely to attribute symptoms to faith-based or supernatural explanations and to seek

community corroborates an account that sounds implausible, that corroboration is information, not proof. The assessor should record who corroborates and on what basis. Where the account concerns the community itself, its corroboration should be treated with the same caution as any other interested source.

My doctoral research develops these questions through three comparative types: a Hasidic Jewish person in London, a person of Afro-Caribbean and Sudanese heritage in London, and a person of Sudanese heritage who came to Bristol via Germany. The design holds neurodivergence constant while race, religion and migration vary.<sup>14</sup> Until the empirical work is done, the types illustrate the question; they do not answer it.

## Part V: Legal Framework

No single existing duty requires what this essay proposes. The relevant duties are fragmented across different statutes and bodies. The argument is that the revised Code of Practice should join them at the point of first contact.

### The Mental Health Act 2025

The Mental Health Act 2025 received Royal Assent on 18 December 2025, but most of its provisions are not yet in force.<sup>15</sup> Once commenced, it will prevent autistic people from being detained for treatment under section 3 unless they have a co-occurring psychiatric disorder. Its new “serious harm” test for detention under sections 2, 3 and 5(4) is not yet in force either.<sup>16</sup>

The reform leaves section 2 open to autistic people, and the section 2 period can be used to assess whether a co-occurring psychiatric disorder exists.<sup>17</sup> That makes section 2 the gateway. If autistic communication is recorded there as psychosis, the new section 3 protection is bypassed before it can operate. A revised Code of Practice is still to be drafted and consulted on, likely taking at least a year.<sup>18</sup> That Code is the natural home for the core proposal below.

---

help from faith organisations. That help offered comfort and meaning; it also sometimes delayed access to medical care and, in some cases, involved financial exploitation: S.P. Singh, Z. Islam, L.A. Brown and others, *Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study* (2013) 1(3) NIHR Programme Grants for Applied Research. A later analysis of first-episode pathway data found that Black and Asian patients were both more likely than White patients to consult faith-based institutions, but found no ethnic difference in the duration of untreated psychosis: S.P. Singh and others, “Ethnicity and pathways to care during first episode psychosis: the role of cultural illness attributions” (2015) 15 *BMC Psychiatry* 287.

<sup>14</sup> These are research types, not findings about named individuals.

<sup>15</sup> Mental Health Act 2025, c 33.

<sup>16</sup> Mental Health Law Online, “New detention criteria for s2, s3 and s5(4)” (status: not yet in force).

<sup>17</sup> Hill Dickinson, “The Mental Health Bill: what changes are going to happen to those with learning disabilities and/or autism?” (2025).

## The duty to inquire

Under *Tameside*, a public decision-maker must take reasonable steps to acquaint itself with the information needed to answer the question before it.<sup>19</sup> The current Code of Practice goes further than is often recognised. It requires those taking decisions under the Act to recognise and respect each patient's diverse needs, values and circumstances, including religion or belief and culture. It warns against diagnosing, or failing to diagnose, mental disorder on the basis of preconceptions or a failure to appreciate cultural and social differences. It provides that no one may be considered mentally disordered solely because of their political, religious or cultural beliefs, values or opinions, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind. And it gives, as an example of a reasonable adjustment, assessment for detention by professionals with the specialist skills needed where the person is autistic. Under *Munjaz*, the Code must be followed unless there is a cogent reason not to.<sup>20</sup>

What is reasonable depends on context. At two in the morning in a section 136 suite, with a 24-hour limit and no housing officer on call, reasonable steps may go no further than recording the account accurately and marking it as unchecked. That is the core of this essay's proposal. Further checking belongs later in the section 2 period, where time allows.

## Equality Act 2010

The primary route is the anticipatory duty to make reasonable adjustments, under sections 20 and 21, applied to services and public functions by section 29 and Schedule 2. Autism engages that duty as a disability. The duty is owed to disabled people generally, needs no comparator, and asks only whether the adjustment is reasonable. A field on a form and a prompt cost almost nothing. A specialist developmental assessment within 28 days does not, and adult autism diagnostic capacity is the binding constraint. The anticipatory duty supports the first far more readily than the second.

The secondary route is indirect discrimination under section 19, on grounds of religion or ethnicity. It needs a comparator who shares the person's circumstances, including their socio-economic position, since that is not a protected characteristic in England. Following *Essop*, the claimant does not have to explain why the practice produces the disadvantage.<sup>21</sup> The public sector equality duty in section 149 runs alongside both routes.

## Articles 3 and 5 ECHR

*Winterwerp* requires that a person detained as being "of unsound mind" has a true mental disorder, reliably shown by objective medical expertise.<sup>22</sup> English courts have not read this

---

<sup>18</sup> NHS Confederation, "The Mental Health Act 2025: what you need to know".

<sup>19</sup> *Secretary of State for Education and Science v Tameside MBC* [1977] AC 1014 (HL).

<sup>20</sup> Department of Health, *Mental Health Act 1983: Code of Practice* (TSO 2015) paras 1.14, 2.7–2.8 and 3.13 (figure 3); Introduction, para V (departures must be recorded and will be scrutinised); *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148.

<sup>21</sup> *Essop v Home Office (UK Border Agency)* [2017] UKSC 27.

<sup>22</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387. This essay relies on the first *Winterwerp* criterion. The author's Thesis I relies only on the persistence criterion. The difference is

as a duty to verify every alleged fact before a section 2 application. The narrower point is this: where a finding of delusion is central to the case for detention, and the belief concerns facts that could be checked, the record should show whether they were.

DSD held that serious failures by the police in investigating grave offences breached Article 3.<sup>23</sup> That is a duty on the police in respect of serious crime. It does not make an approved mental health professional an investigator. It does mean that where a person detained under section 136 discloses serious ill-treatment, their being in crisis does not displace the police's own obligation.

## Crime recording and safeguarding

Under the Home Office Counting Rules, a crime against an identified victim must be recorded if, on the balance of probability, the circumstances amount to a crime and there is no credible evidence to the contrary.<sup>24</sup> This is a recording rule, designed to stop under-recording of offences such as rape. Recording is not investigating, and a recorded crime is not a finding that the account is true. A crime reference in a clinical file should never be read as corroboration. What the rule establishes is narrower: mental illness alone is not a reason to disregard a disclosure.

Under section 42 of the Care Act 2014, a local authority must make enquiries where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or at risk of, abuse or neglect, and cannot protect themselves. Section 1 of the same Act makes the person's wellbeing, including their participation and their own views, the organising principle of care.

## Candour

Candour in English law has developed along three lines. None yet reliably reaches the checking step this essay proposes.

The first is the common law duty of candour in judicial review: public authorities must set out the relevant facts and reasoning fully and fairly, not merely defend their decision.<sup>25</sup> But the duty applies only once a claim has been issued, long after the account has been recorded.

The second is the statutory duty of candour in healthcare, introduced after the Francis Report into Mid Staffordshire and set out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<sup>26</sup> It is triggered only by a notifiable safety

---

deliberate: this essay concerns the moment of assessment, not continued detention.

<sup>23</sup> *Commissioner of Police of the Metropolis v DSD* [2018] UKSC 11.

<sup>24</sup> Home Office Counting Rules, General Rules; National Crime Recording Standard. See HMICFRS, "Crime recording process".

<sup>25</sup> *R v Lancashire County Council, ex p Huddleston* [1986] 2 All ER 941 (CA) 945 (Sir John Donaldson MR); *Tweed v Parades Commission for Northern Ireland* [2006] UKHL 53, [2007] 1 AC 650.

<sup>26</sup> SI 2014/2936, reg 20; Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (HC 947, 2013).

incident, and it is owed to the patient and their family. Most accounts of institutional mistreatment will fall outside it.

The third is the Public Office (Accountability) Bill, known as the Hillsborough Law. It would require public authorities and officials at all times to act with candour, transparency and frankness in their dealings with inquiries and investigations. That includes notifying the person leading an inquiry or investigation of relevant information, providing it, drawing attention to anything of particular significance, and correcting errors or omissions in information already given.<sup>27</sup>

As introduced, the Bill applied to statutory and non-statutory inquiries and coroners' investigations, with powers to extend it to other investigations by regulations.<sup>28</sup> At second reading, the minister committed to amendments extending the duty to ombudsman and local authority investigations.<sup>29</sup> The government has also said that public servants will be placed under a professional duty of candour, set out in each organisation's mandatory code of ethics.<sup>30</sup> The Bill completed its Commons stages on 14 July 2026 and was scheduled for second reading in the Lords on 1 September 2026.<sup>31</sup> It is not yet law. Even when enacted, a duty owed to inquiries and investigations is not a duty on a housing department to open a file during a Mental Health Act assessment.

The Bill is therefore a direction of travel, and a target for the consultation on the revised Code, rather than a duty that already reaches the checking step. Three proposals follow. They are proposals for future law and a future Code, not descriptions of current duties:

- The Bill, once enacted, should be read or extended so that it expressly covers section 42 enquiries, and any check of a detained person's account of institutional mistreatment.
- Codes of ethical conduct for NHS bodies and local authorities should state that candour applies to records relied on in Mental Health Act assessments.
- The revised Mental Health Act Code of Practice should require any body holding relevant records to disclose them fully to whoever is checking the account, and to correct errors in them.

## Part VI: Proposal

The proposal has two tiers. The core reform can be written into the revised Code of Practice without waiting for diagnostic capacity, candour legislation or an independent checker. The wider checking duties are a direction of travel.

---

<sup>27</sup> Public Office (Accountability) Bill (Bill 306, 2024–26, as introduced), cl 2(1)–(4).

<sup>28</sup> Public Office (Accountability) Bill, Explanatory Notes (Bill 306–EN), para 4.

<sup>29</sup> House of Commons Library, *Public Office (Accountability) Bill 2024–26: Progress of the bill* (CBP-10424). Whether the amended text covers section 42 enquiries is not yet clear.

<sup>30</sup> HC Deb 27 April 2026, vol 784 (Public Office (Accountability) Bill (Carry-over)).

<sup>31</sup> House of Lords Library, *Public Office (Accountability) Bill: HL Bill 42 of 2026–27* (26 August 2026).

## The core reform

- 1. Record the words.** At handover and in the section 2 papers, the person's statements should be recorded in their own words. They should not be coded as "suicidal ideation" or "persecutory beliefs" at first pass.
- 2. Ask the questions separately.** Does the person want to die? Do they believe others intend their death? What, specifically, do they say those others have done?
- 3. Split the status field.** The account of what others have done should be marked as verified, refuted, unverified, or not yet checked. The wish to die is a separate clinical finding. One being true does not cancel the other. The status must be recorded before any section 3 application or Tribunal hearing.
- 4. Record faith and community.** The person's faith identity, religious obligations and community should be recorded in their own words, both as a source of support and, where it arises, as a source of pressure, with any corroborating source identified.
- 5. Screen as a trigger, not a diagnosis.** A neurodivergent screen should trigger a specialist assessment grounded in developmental history, gathered from family, school records or the person's community. The screen itself is never a finding.
- 6. Limit the purpose.** Neither a screening flag nor an account marked "not yet checked" should become a risk-register entry, or a quiet marker that the person is "litigious" or "non-compliant". Both exist to prevent a mistaken finding, not to add a new one.

## The direction of travel

Beyond the core reform, the account should, where practicable, be sent to the body able to check it:

- Alleged crimes go to the police. Allegations about the police themselves go to the Independent Office for Police Conduct, not the force concerned.
- Alleged abuse or neglect goes to a section 42 enquiry.
- Alleged NHS failings go through the Patient Safety Incident Response Framework.
- Everything else goes to a check of the documentary record: tenancy files, benefits correspondence, complaint files and correspondence.

The check concerns the record, not the person's character or credibility. These routes cannot all be started as of right within the first 28 days, and the proposal does not require that. It requires that where a route has been started, its status is recorded, and that where it has not, the record says so. Where the allegation concerns the body that would carry out the check, someone independent should do it, and the body holding the record should owe a duty of candour to the person checking it.

Alongside both tiers, the audit described in Part I should be carried out, so that the extent of the error this essay identifies can be measured rather than assumed.

## Part VII: Addressing Challenges

**Delay to treatment.** Recording and checking run alongside treatment, not ahead of it. A person with a genuine psychosis, or active suicidal intent, is treated throughout. The proposal changes what is recorded and what the Tribunal sees, not whether care is given.

**Time.** Section 136 and many section 2 assessments cannot wait for tenancy files or referrals. This is why the core reform is a recording reform: an accurate record with an honest status can be made at two in the morning. Checking follows where time allows.

**Police involvement.** Since 2023, the Right Care, Right Person approach has reduced police involvement in mental health calls, and the government has committed to consulting on whether people other than police officers could carry out removals under sections 135 and 136.<sup>32</sup> The proposal fits that direction. It asks for accurate recording at handover, not a larger police presence.

**Consent and safety.** Some people will not want the police involved, particularly where trust in the police is low or the account concerns family or congregation. A recorded crime can itself put a person at risk within their family or community. Any further step should follow the person's wishes unless others are at risk, and section 42 enquiries should likewise be led by the person.

**Independence and candour.** The local authority runs both section 42 enquiries and the approved mental health professional service, and the trust holds the clinical record. Where an account alleges failings by those bodies, independent checking is right but institutionally hard, and candour from the body holding the file is the part most likely to be resisted or delayed. That is why candour is presented here as a design requirement for future law, not as current law.

**Misuse.** "Not yet checked" can be read by the next clinician as "still possibly true", or as a sign of a difficult patient. The purpose limitation in the Code would need to be unusually sharp.

**Resources.** Recording is nearly costless. Checking a documentary record is cheap where a record exists. Specialist adult autism assessment is scarce and expensive, and this essay does not claim to have costed it. A phased approach, starting with section 2 admissions where the account alleges institutional mistreatment, would direct that capacity to where the legal consequences are greatest.

## Conclusion

The case of Philippe Sossongo shows what happens when a child's autism is identified years too late. Mental health services face an earlier and graver version of that risk: detention on the strength of a finding nobody checked, recorded in words that cannot show whether anyone did.

The existing duties are real but fragmented: the police must not disregard a disclosure because of mental illness, local authorities must enquire into suspected abuse, decision-makers must take reasonable steps to acquaint themselves with the facts, and Parliament is

---

<sup>32</sup> National Partnership Agreement: Right Care, Right Person (Home Office and Department of Health and Social Care, July 2023); NHS Confederation (note 18).

building a duty of candour on the lesson of Hillsborough. The revised Code of Practice is the place to join them at the moment a person is brought in.

The smallest version of that reform is also the most important. A person who wants to die, and who believes others want them dead, should be recorded as saying both things, in their own words, with the factual account marked as checked or not. Checking the account and assessing the person, side by side, does not presume the person is right, or that they are autistic, or that they are safe. It requires only that someone looks, that the wish to die is not used as a reason to stop looking, and that those holding the record tell the truth about it.