**Health Legal Update**

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Introduction

“Welcome to Spring” was a headline in the press last week. It is a time of renewal and revival and having read through the contributions for this edition of the HLU, it is a time for reports and advice on how to change or improve existing practices. I had that in mind as I reflected on the approaching end of the NHS financial year and the suggestion of exploring new financial models, made by Amyas Morse, the Comptroller and Auditor General of the National Audit Office following its review of publicly funded projects; especially the current Treasury model for PFI. On the issue of new models there is mention inside of the consultancy report of EC Harris and their conclusions that up to £1 billion might be saved by the NHS by the adoption of improved practices for the procurement for and disposal of estates.

As always we invite you to look at the healthcare resource centre, health broadcast centre, health commissioning portal, procurement portal, and our seminar programme. These are just some of the resources we have on offer to support you. You might also be interested to read our briefing on the recently handed down judgment on the latest DOLS case, Rabone v Pennine Care NHS Trust.

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NHS management: clinical commissioning groups

Commissioning outcomes framework: the benchmark for clinical commissioning group performance

As readers will be aware, as part of the Government's plans to reform, the NHS clinical commissioning groups (CCGs) will take over responsibility for commissioning the majority of NHS services in England subject to the passage of the Health and Social Care Bill. All GP practices in England will be required to join one of the CCGs, which will begin to assume their new statutory responsibilities from 2013/14.

On 31 January 2012, the National Institute for Clinical Excellence (NICE) launched its consultation on the indicators for the proposed 2013/14 commissioning outcomes framework (COF). Comments are invited on 120 indicators, which cover a broad range of topics including mental health, cancer and asthma.

The National Commissioning Board will use the COF to hold clinical commissioning groups to account for the quality and outcomes of the services they commission. NICE will play a central role in this process by developing an annual list of indicators.

Now that the consultation has closed, the COF advisory committee at NICE will recommend a set of indicators and publish this advice on its website. The NHS Commissioning Board will decide on the final set of indicators for the 2013/14 COF in the autumn of 2012.

For further information or advice please contact Philip Grey on 01223 222463.

NHS management: PFI

National Audit Office report: Equity investment in privately financed projects

In a report, Equity investment in privately financed projects, the National Audit Office (NAO) urged public authorities to make sure that they have clear evidence they are paying a fair price for private sector funding and risk equity in particular.

The watchdog report acknowledged the role equity investors had played in helping deliver infrastructure projects through PFI. However, NAO said investors should be rewarded for taking risks. Typically these are the costs of bidding, that their contractors fail to perform or that other project costs the investors bear the risk for are higher than envisaged.

However, the NAO pointed out that investors can limit their risk by passing it on to contractors. It also highlighted how “the Government is a very safe credit risk and many projects such as hospitals and schools are repeat projects”.

The report said that the Treasury and Whitehall departments had failed to gather systematic information to prove the pricing of equity is optimal.

The NAO pointed to three potential inefficiencies in the pricing of equity:

- the time and costs of bidding;
- minimum rates set by investors, “which sometimes do not reflect the actual risks the project will face”; and
Public authorities have not had the skills and information to challenge investors’ proposed returns, according to the NAO report.

In three projects reviewed by the NAO, they said around 1.5 to 2.2 per cent of the annual service payments were “difficult to explain in terms of the main risks investors said they were bearing”. The report also highlighted how investors selling shares in successful projects early had made high annual returns: typically between 15 to 30 per cent. It recommended that the Treasury explore alternative investment models as part of its current review of PFI.

Following its examination of the cost of debt in PFI projects, the NAO turned its attention to equity investment. Its report, based on the “limited” publicly available information, warns that public sector bodies are often not equipped to challenge the returns equity investors take.

Bank and bondholders provide around 90 per cent of the funding for PFI projects on the understanding that the rest is supplied by the investors as risk capital and equity. This would be lost if the projects got into difficulty.

NAO head, Amyas Morse, said: “PFI projects benefit from secure cash flow from the public sector. Public sector authorities should have clear evidence they are paying a fair price for private sector funding, and risk equity in particular, considering the stable environment that the PFI generally provides. Morse said “the Treasury should use its PFI review to scrutinise the returns investors are getting from PFI projects”.

The NAO also calls for public bodies to conduct further analysis during the bidding process to allow them to assess the reasonableness of investor returns.

For further information or advice please contact Tania Richards on 01223 222476.

NHS management: Care Quality Commission

Medicines security audit must be undertaken and sent to Care Quality Commission by 31 March

A recent DH “Dear Colleague” letter requires all acute trusts (and any foundation trusts who wish to do so), to undertake an audit on medicines security and send a summary of the completed audit to the Care Quality Commission (CQC) by 31 March.

Recent evidence, including a Sky News report, has suggested that some trusts may not be complying with appropriate standards for the safe and secure handling of medicines. These standards are set out in The Safe and Secure Handling of Medicines: A Team Approach.

In response to the alleged breaches, the DH sent the Dear Colleague letter on 9 February. It emphasises the need for all hospital trusts to have a robust policy for the safe and secure handling of medicines. It also reminds trusts that the CQC will require evidence of compliance with the standards when carrying out inspections. Most urgently, the letter requires all NHS acute hospital trusts to undertake a comprehensive audit of the safe and secure handling of medicines. The audit is voluntary for foundation trusts.

The policy must:
be signed off by the trust board;

- include a programme of regular audit, including unannounced visits to clinical areas by senior nursing and pharmacy staff and mechanisms to promptly agree and implement any remedial action;

- be familiar to all staff prescribing, dispensing and dealing with the administration of medicines as well as managers involved in clinical areas.

The audit must:

- be undertaken by 31 March;

- have a summary of the audit signed off by the chief executive and chief pharmacist;

- the summary must be sent off to the CQC and a copy sent to the relevant strategic health authority (SHA) pharmacy lead;

- if the trust has already undertaken a comprehensive audit since July 2011, a summary of the results from that audit and any “robust, detailed, remedial action plan” should be sent to the CQC and relevant SHA pharmacy lead.

For further information or advice please contact Philip Grey on 01223 222463.

Performance and capability review: Care Quality Commission
The DH has just published the Performance and Capability Review of the Care Quality Commission (CQC) in the same week that CQC chief executive Cynthia Bower resigned.

The review acknowledges that the CQC has made considerable achievements since being established in 2009 as the new watchdog for health and social care services in England. By bringing together three different organisations it has created the largest organisation of its kind in the world, setting up a system of joint regulation of the health and social care sectors. The review states that the CQC has delivered a challenging programme of work registering more than 21,000 providers since April 2010 and there are now an increasing the number of inspections taking place.

However, the review also found that the scale of the CQC’s task had been underestimated and more could have been done to manage the risks during the early years, where it was acknowledged that there were performance shortcomings. It was found that the role of the CQC has not been as clear as it needs to be to health and care providers, patients and the public.

The performance and capability review recognises that over the last nine months, the CQC has made significant improvements. They have increased inspection staffing and are focusing more on the core duties of registering and inspecting healthcare providers.

The recommendations are designed to support the CQC’s continuing improvement and build further on what has already been learnt. In total there are 23 recommendations which include the following:

- the CQC must become more strategic and set out more clearly what success looks like;
the board should be strengthened with the appointment of additional members and there should be clearer arrangements between the board and the executive, to ensure that the board is holding the operation of the CQC to account;

the CQC should build an evidence base for its regulatory model to demonstrate and ensure confidence in its effectiveness;

the CQC needs to be more proactive and systematic in understanding stakeholder expectations;

frontline inspectors should have greater access to individuals with professional experience, such as doctors, nurses or social care experts;

there should also be more consistency in how inspections are carried out and there should be enough inspectors to meet future demand.

The review recognises that the DH needs to do more to support the CQC, ensuring it is held to account for its role in regulating health and social care. The department has confirmed it will be working with the CQC to recruit additional non-executive members to the board with the recruitment process starting imminently. The department has also confirmed that they are committed to keeping the regulations under review with an initial review of the regulations already in their final stages, with the laying the new regulations expected before Easter.

For further information or advice please contact Tania Richards on 01223 222476 or Katrina McCrory on 0121 456 8451.

GP practices getting ready for Care Quality Commission (CQC) registration in April 2013

The Royal College of General Practitioners (RCGP) has announced that 150 GP practices have signed up to its accreditation scheme since its launch in 2011.

GP practices should now be considering how and if they will be able to declare compliance against the CQC’s essential standards in order to achieve registration with the regulator by 1 April 2013. The RCGP considers that accreditation to its scheme will evidence maintenance of robust and safe systems and procedures for patients and the CQC alike.

In a joint press release with the RCGP, the CQC has stated that at the point of registration, a GP practice will not usually be required to submit evidence to the CQC regarding compliance with the essential standards. Instead, practices will need to use information in order to determine themselves, whether they are compliant or not. The CQC reports that evidence such as, but not limited to, accreditation with the RCGP scheme could be an example of the type of evidence GP practices could use to assure themselves of compliance.

Once GPs are registered, the CQC will monitor the risks within a service, as they do for the NHS and social care providers currently. The CQC will use evidence such as accreditation as one source of information, amongst many others, to assess risk.

The CQC and the RCGP have stated that they will work together to determine how to share information so that it can be effectively used within regulation in the future.

The CQC does not require a GP practice to have accreditation with the RCGP’s accreditation scheme, but it is clear that there is open support by the regulator for such a scheme.

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Real Estate

**Is NHS estate efficiency improving?**
The NHS could save £1 billion through improved procurement for estates and efficiencies gained through land disposal, according to a report by built asset consultancy EC Harris.

According to the report, the health service is missing out on £2 billion of savings by wasting the space available in its estate. In addition to the £1 billion saved through better procurement, a further £1 billion could be saved by selling off 50 per cent of this unused space. The report added that neighbouring NHS trusts should work together to maximise economies of scale and make better use of its estate.

In its third annual report into the efficiency of the NHS estate *Shaped for the future - Reforming the NHS Estate*, EC Harris said the NHS had cut the amount of space underused by 210,000 metres squared in 2010-11 compared to 2009-10, the equivalent of 264 football pitches. However, 1.9 million metres squared remains poorly utilised.

The report also highlights the need for local collaboration by foundation trusts in order to achieve further significant savings. “The majority of remaining unused space is owned by foundation trusts and is therefore, not accessible to the Treasury to dispose of or seek savings through leveraging procurement scale,” said Conor Ellis, the report’s author and a partner at EC Harris.

The NHS has to save £20 billion by 2014-15. The DH has said it had identified the potential for £1.2 billion savings as part of the Quality, Innovation, Productivity and Prevention (QUIPP) initiative and is launching a procurement strategy in April to help the NHS deliver this target. According to the DH, the NHS decides locally on the estate they need to deliver high quality services. This includes deciding which estate, not needed by the NHS, can be used more efficiently.

The DH is establishing the company NHS Property Services, which will manage properties owned by primary care trusts, when they are abolished at the end of March. The company (owned by the department) will release savings from properties that are surplus to requirements, but NHS foundation trusts will remain responsible for their own estate.

For further information or advice please contact **Tania Richards** on 01223 222476

Information governance

**Comments requested for the ICO Plan 2012**
Set to be finalised on 1 April 2012, the ICO Plan 2012–2015 aims to combine the business and corporate plans of the organisation in a single-focused document. It will be reviewed annually.

Ahead of finalising the plan, the ICO is now engaged on a four-week consultation process running from 22 February 2012 to 20 March 2012. Organisations and individuals are asked to comment on:

- the practical steps the ICO intends to take in order to achieve its strategic outcomes (as found in the ICO information rights strategy); and
the new format of the plan.

Comments will be considered and incorporated into the final version if appropriate. The document will then be published on the ICO’s website. A summary of comments received as part of the consultation will also be made available shortly after the plan is published.

For further information or advice please contact Lorna Shastri-Hurst on 0121 456 8400 or Stuart Knowles on 0121 456 8461.

Healthcare assistant pleads guilty to unlawfully obtaining patient details

A former healthcare assistant who worked in the outpatients department at the Royal Liverpool University Hospital has been convicted under section 55 of the Data Protection Act and fined £500. The maximum penalty for the offence is up to £5000 in the magistrates’ court or an unlimited fine in the Crown Court.

She accessed the medical records of five members of her ex-husband’s family in order to obtain their new phone numbers. An investigation had been launched by the hospital when the defendant’s father-in-law contacted them after he had received nuisance phone calls, which he suspected came from the defendant.

It emerged that none of the patients whose details had been compromised were, at any time, under the medical care of the defendant and she had no work-related reasons for accessing these records.

For further information or advice please contact Jacqueline Haines on 0121 456 8453.

Regulatory matters

Subject to safeguards, the General Dental Council (GDC) can use patient records without consent and without a court order

In the matter of General Dental Council v Savery and Others, the GDC sought a declaration that they may disclose, internally, confidential clinical records (already in their possession) of 14 patients without their consent.

They also sought clarification about such use of records in future fitness to practise proceedings. The GDC had received records from an insurer who had raised complaints about Dr Al Naher (AN) to the GDC. They wished, in accordance with their fitness to practise procedures, to disclose records to various GDC committees, legal teams and experts, and use them at any public hearing duly anonymised.

It was submitted for AN that the GDC should always apply to court for permission to disclose such records in this way, that in this case it would be unlawful so to do, and also that these records had been obtained unlawfully.

S33B of the Dentists Act provides a power for the GDC to obtain information or documents. It was submitted that the judgment in A Health Authority v X required a court order before patient records could be used as proposed. However, this was rejected on the grounds that that case only required application to the court where disclosure was required other than for the purposes of investigation by “official regulatory bodies”.

Mr Justice Sales reviewed the common law duty of confidentiality, the Data Protection Act 1998, the Human Rights Act 1998 and the European Convention on Human Rights. None of these schemes disallowed the proposed use of the records and specifically a court order was not required despite the absence of patient consent MS v Sweden (1999) 28 EHRR 313 applied.
NHS management: governance

‘Never Events’ list published for 2012/2013

After substantially revising of the “Never Events” list in 2011, the list for 2012/2013 has now been published by the DH. The new list retains the previously published 25 Never Events and no new events are added to the list. The new list does, however, make two amendments to the previous list that providers should be aware of.

The first relates to Never Event number 18. This concerns transplantation of ABO incompatible (incompatible blood types) organs. A reference to Human Leukocyte Antigen has been removed as feedback was received about how preventable this type of incident was.

The second Never Event to be amended is number 23. This relates to misidentification of wristband identification. It is now been acknowledged by the DH that some services, mostly mental health services, would not use wristbands for safety reasons. It is accepted for those services that this type of Never Event would not apply.

The policy framework for Never Events is still in place and the definition has not been changed. To be a Never Event there must be evidence that:

- the incident has the potential for or has caused severe harm/death;
- the incident has occurred previously;
- there are existing national guidance and/or national safety recommendations on how the risk can be prevented;
- the event is largely preventable; or
- the occurrence can be easily defined and identified and continually measured.

Although the previous list has not been amended significantly, it is clear that the DH accepts feedback relating to the list and so any suggestions for future improvement should be sent to them.

For further information or advice please contact Katrina McCrory on 0121 456 8451.

The Council for Healthcare Regulatory Excellence (CHRE) consults on draft standards for members of NHS boards and governing bodies in England

The CHRE is the body which regulates the healthcare regulators, such as the GMC and NMC. It was asked by Sir David Nicholson in July 2011 to develop "a set of high-level standards for executive and non-executive NHS board members in England." The CHRE website states that the standards are "intended to apply to members of boards and governing bodies in the NHS, meaning chief executives; chairs; non-executive and executive directors; and members of the governing bodies of Clinical Commissioning Groups."

The consultation is open until 10 April 2012. Contributions are invited from all clinicians and NHS staff and any individuals or organisations with an interest or expertise in leadership and management, in the NHS or other comparable environments.

For further information or advice please contact Philip Grey on 01223 222463.
NHS management: NHS litigation authority

NHS Litigation Authority Industry Review published
As part of the wider review of arms length bodies, the DH commissioned Marsh, the insurance broker and risk adviser, to undertake an industry review of the NHS Litigation Authority (NHSLA). On 26 January 2012, the DH published the report of the *NHS Litigation Authority (NHSLA) Industry Review* and the department's response.

The objective of the review was to establish:

- whether the NHSLA achieves optimum performance in delivery of its risk pooling functions;
- whether any sub-optimal performance by the NHSLA is responsible for upward trend in scheme liabilities that has been experienced in recent years; and
- whether there may be opportunities to introduce greater commercial management and practice to improve the efficiency of the services.

Overall, the NHSLA have good reason to be pleased with the outcome of the review. The report highlights the positive role of the NHSLA and the effective contribution it has made since its establishment in 1995. The department broadly accepts the report, its conclusions and recommendations.

The report recommended that the Government explores the possibility of giving NHS bodies more leeway to obtain clinical negligence cover from private insurers. It said that it did not envisage wholesale commercial involvement in such work “at the moment”, but recommended that insurers be consulted on what they would need to participate.

Marsh was enthusiastic about the potential for the private sector to handle non-clinical negligence claims against the NHS.

A process of engagement will now begin with stakeholders by the NHSLA and the department to look at how particular recommendations will be implemented, or where further policy development needs to be undertaken.

For further information or advice please contact Tania Richards on 01223 222476 or Stephen King on 01603 693257.

Employment

Compulsory retirement selection criteria and age discrimination
Is it indirectly discriminatory to only accept applications for compulsory early retirement from employees under the age of 50? The Employment Appeal Tribunal (EAT) has found that such a policy is not unlawful age discrimination, but is a proportionate means of achieving a legitimate aim.

In the case of *HM Land Registry v Benson and others UKEAT/0197/11*, four employees of HM Land Registry, all aged between 50 and 54 years of age, brought a claim of age discrimination because their applications for compulsory early retirement had been rejected on the basis that the costs of providing their early retirement benefits would be more expensive than applications brought by younger employees. The employer argued that there was a finite budget of £12 million in respect of the compulsory early retirement scheme and it also needed to ensure sufficient numbers of experienced employees were retained.
An employment tribunal found in favour of the employees and that the selection criteria were discriminatory.

However, this was overturned in the EAT which accepted that the employer's decision as to the allocation of financial resources was genuine and served a legitimate aim. This was the case even where the employer could have afforded to make a different allocation with a lesser impact on the older employees. The EAT found that whilst the selection criteria for the retirement scheme had been disproportionately unfavourable to employees over 50, the tribunal's key finding had been that the employer had no real alternative to using these criteria. As a result, use of the criteria was inevitably justified and lawful.

However, employers should be hesitant about relying on this decision. While it is helpful authority for the proposition that the allocation of financial resources can constitute a legitimate need, if any other non-discriminatory selection criteria could have been used, the decision may have been different.

For further information or advice please contact Fiona Hargreaves on 0121 456 8466.

Redundancy selection: pool of one employee can be unfair
In the recent judgment of *Capita Hartshead Ltd v Byard*, the Employment Appeal Tribunal (EAT) has set out the principles in relation to the employment tribunal’s authority to challenge the process by which employers select their redundancy pools.

The claimant was one of four actuaries employed by the respondent. The claimant no longer had enough work to sustain her role full-time as a number of pension schemes she worked on had been wound up. The employer said that pension schemes could not be swapped between actuaries and therefore, the claimant was the only employee in the redundancy pool.

The tribunal found that the employer's decision to limit the size of the pool to comprise solely of the claimant was unfair as there were other actuaries who could have been included. The tribunal rejected the employer's claim that there was a risk the employer would lose business if the actuaries and pension schemes were re-organised, as such steps had been taken before.

One of the employer’s grounds of appeal was that the tribunal was not permitted to determine that an employer’s selected pool for redundancy, could be unsound and lead to a finding of unfair dismissal.

The EAT rejected the appeal and found that tribunals are permitted to question how an employer defines their redundancy pool. It was found that the tribunal is duty-bound to scrutinise an employer’s reasoning behind selection to determine if they have genuinely applied their mind, when considering those employees to select for the redundancy pool.

This case underlines the importance of selecting redundancy pools appropriately and not narrowly confining them in an unfair or indefensible manner.

For further information or advice please contact Jog Hundle on 0121 456 8206, Martin Brewer on 0121 456 8357 or Stuart Craig on 01223 222280.

Government publishes draft legislation to increase unfair dismissal qualifying period
The Government has published draft legislation detailing the increase in the qualifying period for unfair dismissal from one year to two. The changes mean that the qualifying period for unfair dismissal increases to two years for employees employed on or after 6 April 2012.
However, the change will not be retrospective which means that employees who joined an employer prior to 6 April 2012 will still be subject to a one-year qualifying period.

The draft regulations also increase the qualifying period that applies to the right to receive a written statement of reasons for dismissal on request. The current one-year qualifying period (which applies in most cases) will increase to two years for employees who start work with their employer on or after 6 April 2012.

The increase in the qualifying period was originally proposed by the Government in its public consultation on wider reforms on resolving workplace disputes. Another potential reform proposed was the introduction of fees in the employment tribunal. This is currently subject to a separate consultation which is due to close on 6 March 2012.

For further information or advice please contact Fiona Hargreaves on 0121 456 8466.

Caution urged in involving the police in disciplinary proceedings

In the recent case of A Crawford & Anor v Suffolk Mental Health Partnership NHS Trust (2012), the claimant had been dismissed on the grounds of gross misconduct in restraining an elderly dementia patient who had exhibited aggressive behaviour. He admitted tying a chair, in which the patient was sat, to a table, which was an unauthorised form of restraint. However, he denied tying the patient to the chair using a sheet. In investigating the matter, the NHS trust carried out an experiment to test whether the patient could have become accidentally restrained through a sheet being placed on him and concluded that he could not and the patient had been deliberately tied to the chair.

An employment tribunal found that the trust had insufficient evidence based on an inadequate investigation to ground its belief that the patient was improperly restrained. The matter was appealed to the Employment Appeal Tribunal and the Court of Appeal, which upheld the finding of the tribunal that the decision to dismiss was unfair due to procedural errors with the investigation.

However, the decision is interesting for remarks made by the court about employers finding themselves in this situation. In particular, the court noted that it was important that employers had to be seen to be acting transparently and not concealing wrong-doing; but they also owed duties to their long serving staff and defensive management responses which focused solely on their own interests did them little credit.

The court also said that the threat of possible criminal proceedings was a heavy burden for an employee to face and employers should not subject employees to that burden without the most careful consideration and a genuine and reasonable belief that the case, if established, might justify the epithet "criminal" being applied to the employee's conduct. The court said that that requirement was not satisfied in the instant case. No one had suggested that the claimant was acting other than in the best interests of the particular patient. The alleged restriction was not essentially different to the physical restraint which had been carried out on the patient before. There was obvious justification for restraining the patient in question, even if the appropriate procedures for doing so were not employed, and the police should never have been involved.

For further information or advice please contact Fiona Hargreaves on 0121 456 8466.

Vicarious liability: giving employers a fighting chance

You would probably be safe in thinking that unless employed as a heavyweight boxer, acts of physical violence by employees are relatively rare. However, they do happen occasionally and employers beware, they could be on the hook.
Vicarious liability in this context was considered by the Court of Appeal in two cases heard together, *Weddall v Barchester Healthcare Limited* and *Wallbank v Wallbank Fox Designs Limited*.

In *Weddall*, M was a senior healthcare assistant at a care home. He was off duty and had been drinking heavily when he received a call from his manager (W) asking if he could cover a shift. M refused but felt mocked by W during the call and so decided to cycle to the care home where, upon arrival, he physically assaulted W.

The Court of Appeal held there was no vicarious liability. The only connection between M’s employment and the assault was that it happened at his place of work. This was an independent venture by M so the act and employment were not sufficiently connected.

This is in contrast to *Wallbank*, where B was employed to spray bed frames and load them onto a conveyor belt. It was more efficient to load a large number of frames at a time and one day B’s manager (JW) noticed B had only loaded a few. JW questioned this and gestured for B to help load some more. B followed JW and threw him into a table.

The Court of Appeal decided there was vicarious liability. It is part of employment to react to instructions, usually lawfully and by carrying them out. It was a spontaneous and immediate reaction by B whilst doing his job therefore, there was sufficient connection to render the employer liable for B’s act.

The key is to ask whether the act was committed in the course of employment, if so how closely connected are the wrongful act and the employment.

For further information or advice please contact Jog Hundle on 0121 456 8206, Martin Brewer on 0121 456 8357 or Stuart Craig on 01223 222280.

**Age discrimination: Home Office postpones ban on age discrimination**

The Home Office has announced that provisions in the *Equality Act 2010*, designed to ban age discrimination in the provision of goods and services, will not come into force in April 2012 as had been anticipated.

A consultation, which ran from March to May last year, sought comment on the proposed exceptions to the ban, which would permit differential treatment on the basis of age where this was deemed to be beneficial. For example, holidays for specific age groups or sports tournaments for under 21s.

The DH had already announced that it would not be seeking any specific exception to the ban on age discrimination in the provision of health or social care, with the result that any such age-based practices (ie, IVF provision up to the age of 40) would need to be objectively justifiable, in the event of challenge.

The measures are not expected to become law now before October 2012 at the earliest, but charities for the elderly are already campaigning against what they see as the proposed ditching of the plans; in light of the anticipated condemnation by Robert Francis QC of the conditions in which the elderly were left at Mid Staffs and the recent call for a dignity code to ensure that elderly patients are treated with respect.

For further information or advice please contact Jane Williams on 0121 456 8421.

**GMC guidance warns against contracts with confidentiality clauses**

In our *February’s Health Legal Update*, we reported on David Nicholson’s Dear Colleague letter *Compromise agreements and the Public Interest Disclosure Act 1998* of 11 January 2012. This highlights that although compromise agreements are likely to include some form of confidentiality clause, the spirit of the guidance issued
by the DH to NHS organisations in Health Services Circular 1999/198, which provides that “NHS trusts should prohibit the use of gagging clauses in contracts of employment and compromise agreements, which seek to prevent the disclosure of information in the public interest”; must not be contravened.

Following the publication of that Dear Colleague letter, the General Medical Council (GMC) has now published new guidance, Raising and acting on concerns about patient safety, which offers advice to doctors on what to do when concerns arise about patient safety.

In particular, the guidance sets out that doctors’ duties in relation to patient safety should prevent them from entering into contracts that prevent or restrict their ability to raise concerns about patient safety. It also states that such contracts are void if they aim to stop an employee from making a “protected disclosure”. A disclosure that shows that someone’s health or safety is endangered is described as a protected disclosure (or “blowing the whistle”) and cannot be prohibited by a confidentiality clause.

Niall Dickson, Chief Executive of the GMC, has criticised such contracts stating:

“These clauses are totally unacceptable. Doctors who sign such contracts are breaking their professional obligations and are putting patients, and their careers, at risk.”

The guidance provides that doctors with a management role or responsibility must make sure that they do not prevent employees or former employees raising concerns about patient safety. For example, you must not propose or condone contracts or agreements that seek to restrict or remove the contractor’s freedom to disclose information relevant to their concerns.

Separate GMC guidance for doctors with leadership or management roles has also been published. This guidance, Leadership and management for all doctors, imposes an overriding duty to follow the guidance in both sets of guidance, come into effect on 12 March 2012.

For further information or advice please contact Philip Grey on 01223 222463.

Patient matters: children

Children and Young People's Outcomes Strategy to be unveiled later this year

Health Secretary, Andrew Lansley, announced last month that there will be a new focus on improving care for children and young people, which will be unveiled later this year. The Children's and Young People’s Outcomes Strategy will focus the health service on improving health results for children, including those needing primary, hospital and urgent care and children with long-term conditions. It will identify health issues that matter most to children and young people; as well as how a modern NHS will meet their needs.

The strategy will be informed by an independent group of experts, the Children’s and Young People’s Forum, which will be made up of a group of experts from local Government, the NHS and charities and will be jointly chaired by Professor Ian Lewis, Medical Director at the Alder Hey Children’s NHS Foundation Trust and Christine Lenehan, Director at the Council for Disabled Children. The Forum will hear views from children, parents, carers and wider families, as well as health professionals.

The Children’s and Young People’s Forum, which is designed on the NHS Future Forum model, will carry out a three month period of engagement with appropriate stakeholders before submitting its recommendations to the Government later in the year.
The forum will build on work already planned through the Health and Wellbeing Board learning network. The strategy also ties in with the special educational needs (SEN) and disability pathfinder programme which is currently being run further to the Department for Education’s *Support and aspiration: A new approach to special educational needs and disability consultation*, which closed on 30 June 2011. The new proposals are aimed at improving services across health, education and social care for children and young people with SEN or disability. Watch this space for a briefing on the implications of the proposed changes contained within the green paper for the NHS, which will be followed by updates as and when the proposals become law.

For further information or advice please contact Alison Maw on 0121 456 8454.

**Guidance for commissioners of mental health services for young people making the transition from child and adolescent and adult services**

This guidance, produced by the Joint Commissioning Panel for Mental Health (JCP-MH), describes good practice for a modern mental health service based on scientific evidence, patient and carer experience and innovative service evaluations.

In particular, it highlights the gap between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS) whereby young people with mental health problems whose needs have been met primarily by paediatric services, education or social care may find that there is no equivalent service for adults.

Service models, according to the guidance, should not be limited to strict age boundaries, but should “operate in response to need and to provide continuity”.

It is suggested that formal joint working arrangements should address structural and procedural difficulties arising from the interface of CAMHS and AMHS and the differences in approach arising from cultural differences between the two services. It is hoped that this will lead to less young people being "lost" to services at a critical time and reduced periods of untreated illness.

Finally, the guidance states that commissioners must work with their public health colleagues to ensure that the needs of young people with mental health problems, including those young people whose needs are primarily met within education; social care and non-statutory agencies; and young people in contact with the criminal justice system, are identified in the Joint Strategic Needs Assessment (JSNA).

For further information or advice please contact Charlotte Mawdesley on 0121 456 8402.

**Patient matters: adult social care**

**Health and adult social care: integration?**

If you had read The Guardian’s recent headline “David Cameron orders merging of health and social care” you might be forgiven for thinking that there would be radical change afoot.

In fact, the article was referring to the Government’s response to a new report on integrating care by the King’s Fund and Nuffield Trust health think tanks, whose chief executives both advise Downing Street. The paper suggests that the Prime Minister has given the report his backing. However, the report falls short of suggesting that the two parallel duties be merged and given to a single body, but instead focuses on working together to deliver real benefits for patients. The report concludes that it is not actually necessary to formally integrate organisations to deliver effective integrated care.
The main thrust of the document is that for integration to be achieved, services need to commission and evaluate as a whole with new payment incentives and new local currencies. The report wants the DH and the NHS Commissioning Board to introduce "a clear, ambitious and measurable goal that is linked to patients, users, and carers’ experience of integrated care and that must be delivered by a defined date." This must become a priority.

The Care Services Minister, Paul Burstow, is quoted as saying: "Integrated care should be the norm. That's why we asked the NHS Future Forum to specifically work on the issue. Our ambition for the NHS and social care is a simple one – to achieve better results for people and carers. So our priority is to orientate the whole system around patients, service users and carers through our Outcomes Framework."

For further information or advice please contact Duncan Astill on 01223 222477

Patient matters: assisted suicide

GMC consultation on guidance in allegations of assisted suicide

The General Medical Council (GMC) is consulting on guidance for investigators to use when faced with allegations about doctors relating to cases of allegedly assisting in a patient’s suicide.

GMC Chief Executive Niall Dickson stated: “The consultation states that the intention behind producing guidance is to ensure GMC staff are fair and consistent in their approach to investigating such cases and in the decisions that they take on how to deal with each case”. The guidance will set out:

- the law on assisting suicide and ethical principles underpinning the guidance;
- a test to be applied by the decision makers when considering an allegation that a doctor has assisted a suicide; and
- types of cases and factors which should be considered that may be relevant to their consideration.

It will also provide guidance on whether the case should be referred to a Fitness to Practise hearing and will allow both doctors and those seeking the assistance of doctors in such circumstances, to understand the implications for the doctor of doing so.

The deadline for responses is 4 May 2012.

For further information or advice please contact Philip Grey on 01223 222463.

Patient matters: fertility issues

Change in the law a bar to ovarian tissue replacement?

A young woman, Miss Oliver, whose ovarian tissue was removed and cryopreserved before she began chemotherapy for Ewing’s sarcoma as a teenager, has discovered that a change in the law in the intervening period may prevent Leeds Teaching Hospitals NHS Trust from replanting the tissue to overcome the fact that she was left infertile by the treatment for cancer.

The European Union Tissue and Cells Directives (EUTCD) comprise the parent Directive (2004/23/EC), which provides the framework legislation, and two technical directives (2006/17/EC and 2006/86/EC) which provide the detail. Their aim was to establish a harmonised approach to the regulation of tissues and cells across the EU,
setting a benchmark for the standards that should be met when carrying out any activity involving tissues and cells for human application.

The Human Tissue Authority, as one of the competent authorities in the UK under the EUTCD, has responsibility for regulating tissues and cells for human application (other than gametes and embryos, which are regulated by the Human Fertilisation and Embryology Authority).

The directives were fully implemented in UK law on 5 July 2007, via the Human Tissue (Quality and Safety for Human Application) Regulations 2007.

The trust is reported as having said that, like other trusts across the country, they do not have the facilities to meet the requirements set out in the regulations. Across the world, a mere 23 babies are believed to have been born after women have had ovaries replanted or ovarian tissue grafted back on; none of these in the UK.

Hot on the heels of Miss Oliver’s story comes a somewhat futuristic sounding American research discovery which may well one day be commonplace. Researchers have announced that it may be possible to find stem cells in adult women which spontaneously produce new eggs under laboratory conditions.

It has always been assumed that while men produce an ever renewing supply of gametes, women are born with all the eggs they will ever have. This study seems to suggest that may not be strictly correct. Two British IVF experts, Dr Allan Pacey and Mr Stuart Lavery, while acknowledging that the new technology still had some considerable way to go, both welcomed the scientific potential offered, not least for the preservation of fertility of women undergoing treatment for cancer.

This latest news on the onward march of technology serves as a useful reminder to trusts of the critical importance of familiarity with the relevant legislation governing tissue and cell storage.

For further information or advice please contact Jane Williams on 0121 456 8421.

Patient matters: drug safety

Changes in the future for safe management and use of controlled drugs
The National Prescribing Centre (NPC) has recently published three reports relating to safe management and use of controlled drugs in the ambulance service (including paramedics), prisons and the private sector.

Ambulance service (including paramedics)
The ambulance service report covers the NHS and private sectors. Potential problems are highlighted including that legislation covering the use of controlled drugs in primary legislation (such as the Misuse of Drugs Act 1971 etc) does not mention the use of controlled drugs in the ambulance service arena. Although secondary legislation does cover the service and there is guidance available, it was found that interpretation can differ which could lead to risk in patient care.

The report makes nine recommendations for the future which include recommending that:

- the Home Office should clarify the guidance and consider amendment of the regulations:
- the DH and NHS Business Service Authority prescription service should consider implementing a recommendation from the Shipman Inquiry that each prescriber has a unique code:
further awareness needs to be raised of professional responsibility:

- commissioners should ensure funding is available to enable controlled drugs responsibility to be fulfilled. 

Ambulance trust accountable officers should ensure:

- that there are appropriate standard operating procedures in place and that they are being complied with;
- that there is training for all healthcare professionals, including private practitioners within an ambulance trust’s remit; and
- ambulance trusts should ensure that a reporting system is in place when things go wrong and that there is continual monitoring of practice possibly through a committee.

It is acknowledged that as the ambulance trusts work within a wide geographical area, there are significant challenges with respect to consistency. However, this also means that it is essential for there to be good communication and sharing of intelligence.

Prisons

The prisons report highlighted similar issues as with the ambulance service. For example, that the legislation does not specifically refer to prisons.

As a result of the complex commissioning models for prison health, the report states a pharmacy assessment need for each prison is required. As with the ambulance service, some personnel do not have adequate knowledge and a controlled drugs governance lead could provide a point of contact between the prison and the primary care trust (PCT) controlled drugs accountable officer.

There are three recommendations:

- the DH Pharmacist should write to PCTs to reinforce that pharmacy expertise is integral to effective commissioning of pharmacy services for prisons and that this links into recommendation 16 of Care Quality Commission’s essential standards;
- PCTs are reminded that their controlled drugs accountable officers should discharge their duties in accordance with the regulations; and
- further training for professionals is required.

Private sector

The final report dealing with the private sector acknowledges that the vast majority of practitioners work within a robust and effective governance framework but that there were a minority of practitioners that worked in an unsafe manner. The current system of monitoring could be strengthened. As a result nine recommendations were made including that practitioners had a unique identification number (as recommended for the ambulance service). There was also a recommendation that there should be reconsideration of the controlled drugs requisition form and there should be a strengthened role in support of PCTs executive officers of the controlled drugs accountable officer to discharge their responsibility effectively.

Conclusion

These reports certainly give an indication that there may be changes in the legislation in the future in this area. It is also interesting to note that the recommendations made are far reaching and touch the professionals involved,
their professional bodies, the DH, the providers of services and the commissioners. Everyone is involved and responsible for getting this right.

For further information or advice please contact Katrina McCrory on 0121 456 8451.

Patient matters: Mental Capacity Act

Court of Appeal clarifies approach to be taken in best interests cases
The recent Court of Appeal decision in K v LBX, L and M [2012] EWCA Civ 79, considered the correct approach to be taken by decision makers (including NHS bodies) in determining the best interests of adults who lack mental capacity to take decisions in relation to their own care, residence and treatment.

L was a 28 year old man diagnosed as having “a mild mental retardation”. He lived with his father and brother but did not have capacity to determine where he should live.

The judge at first instance determined that it would be in L’s best interests to live in supported accommodation for a trial period. L’s father argued that the judge’s approach in determining L’s best interests was incorrect and appealed to the Court of Appeal. He argued that a judge should start off by considering whether the measures proposed would amount to a violation of the incapacitated person’s right to a private and family life under Article 8 ECHR. The court – and also those making best interests decisions – should start off by presuming that it would be best for an adult to remain in their family home.

The Court of Appeal disagreed. It held that the correct approach to taking a best interests decision was that set out in section 4 of the Mental Capacity Act 2005, ie, to use the “best interests checklist” that requires decision makers to consider all relevant factors.

This ruling underlines that, when taking a best interests decision, all relevant factors must be given appropriate weight, depending on the particular circumstances. No one individual factor carries more weight than another. For PCTs facing objections to decisions to move continuing health care patients into a nursing home, this ruling may be helpful in underlining that there is no presumption that patients must be cared for in their own home.

For further information or advice please contact Philip Grey on 01223 222463.

Patient matters: mental health

Patients detained under the Mental Health Act can pay privately for treatment provided the responsible clinician or detaining authority direct the placement or treatment
In the recent case of Timothy Coombs v Dorset NHS Primary Care Trust (1) & Nottinghamshire Healthcare NHS Trust (2), the High Court was asked to determine whether a patient detained under the Mental Health Act could lawfully fund private treatment for his mental disorder.

The claimant in this case was detained under Section 3 of the Mental Health Act. The proceedings arose following a serious head injury sustained whilst he was an inpatient.

It was argued by the defendants that to allow the claimant to fund his own placement and treatment would be contrary to the Mental Health Act and public policy because a patient could not choose where and how to be treated for mental disorder.
The court accepted that a patient detained under the Mental Health Act could not choose his/her placement or treatment but that this did not prevent a patient paying privately for a placement or treatment provided the responsible clinician had deemed the placement and/or treatment appropriate.

For further information or advice please contact Laura Jolley on 01223 222448.

**Mencap alleges NHS still guilty of institutional discrimination**

In its recently published report, *Death by indifference: 74 deaths and counting*, Mencap calls for the Government to make changes to ensure that people with learning disabilities receive safe NHS care. The report details the experiences of the families of 74 people with learning disabilities who died as a result of perceived NHS failures. The report follows up Mencap’s 2007 report, *Death by indifference*, which dealt with six earlier deaths in similar circumstances. The 2007 report sparked an investigation by the Parliamentary and Health Service Ombudsman and an independent inquiry which led to the recommendations in the report *Healthcare for all*. In response to *Healthcare for all*, the DH adopted a three-year strategy for people with learning disabilities *Valuing People Now*. Mencap concludes that although some progress has been made since the 2007 report, healthcare professionals are still, in some instances, failing to provide basic care and institutional discrimination within the NHS persists.

Some of the criticisms mirror those of the Care Quality Commission regarding the quality of care provided to the elderly and Mencap has explicitly drawn on that link in the report, doubtless hoping to tap into current public concerns about patients not being treated with dignity and respect.

Particular issues identified in the report include:

- a lack of compliance with the *Equality Act* and with the *Mental Capacity Act 2005*, underpins the failures identified by the families;
- do not resuscitate orders were used inappropriately; and
- the NHS complaints process is not fit for purpose.

The report makes a number of recommendations, including the following:

- mandatory training for all healthcare professionals that will challenge the assumptions made about people with learning disabilities and the discrimination against them;
- the nationwide implementation of a system for identifying people with learning disabilities and keeping record of the care they receive;
- standard hospital passports to be made available to all people with a learning disability;
- all hospitals sign up to Mencap’s *Getting it right charter* and put in place practice known to save lives;
- the employment of acute learning disability liaison nurses by every acute service; such nurses should be linked to senior leadership, who have a strategic role in supporting ward staff to make reasonable adjustments;
- a lead for learning disability within all acute trusts and primary care trusts, accountable to trust boards; and
a complete overhaul of the NHS complaints system to ensure that complaints are dealt with quickly and effectively.

The report argues that successfully tackling the issues of discrimination against those with learning disabilities will lead to “getting it right” for other vulnerable groups including the elderly.

For further information or advice please contact Philip Grey on 01223 222463.

**New guides to improve mental health commissioning**

The Joint Commissioning Panel for Mental Health (JCP-MH) has produced four helpful and practical guides in relation to mental health commissioning.

The short guides focus on primary mental health care services, child and adolescent mental health service transitions, dementia services and acute liaison services.

They bring together scientific research, patient and carer experience and examples of best practice to describe what good quality, modern mental health services should look like.

A further 10 guides are currently in production covering: addiction services, acute mental health care, child and adolescent mental health services, community mental health services, eating disorder services, forensic services, peri-natal services, public mental health interventions, rehabilitation services, and services for older people.

For further information or advice please contact Charlotte Mawdesley on 0121 456 8402.

**Inquest**

**Honesty of hospital which admitted mistake praised by family at inquest**

A patient underwent keyhole surgery to have a cancerous kidney removed at the Royal Gwent Hospital but instead the surgeon tried to remove her liver. She suffered a loss of blood and a fatal heart attack.

Under the supervision of an experienced surgeon, a trainee surgeon put her hand in to try and remove the kidney but became unsure and the surgeon took over. He felt what he believed to be her kidney and pulled down sharply which is normal procedure for organ removal. However, the anaesthetist reported a fall in the patient’s blood pressure and the surgeon immediately realised her had pulled on the liver, tearing it.

Attempts were made to save the patient but were unsuccessful.

As a result of the death, the operating procedure had been modified slightly and the new method communicated worldwide.

It is reported that a full internal investigation was undertaken which explained very detail of every action taken prior to and during the surgery.

The coroner returned a narrative verdict and the patient’s son is reported by the BBC to have said “I think that it was the honesty that saved the hospital. If we thought that they had not answered our questions it would have been different. This was an honest mistake.”
The coroner’s verdict, the family’s comments and the way the case was reported are all excellent reasons to ensure that when catastrophic mistakes are made, the circumstances are thoroughly investigated, changes made where necessary and that those findings are fully shared with the family and the coroner.

For further information or advice please contact Jacqueline Haines on 0121 456 8453.