

Health legal update

Introduction	2
NHS MANAGEMENT – ARM’S LENGTH BODIES	3
Arm’s length bodies review	3
NHS MANAGEMENT – PUBLIC HEALTH	4
Andrew Lansley sets out his vision for a new public health service body	4
NHS MANAGEMENT – MONITOR	4
Monitor publishes amendments for those applying for NHS FT status.....	4
REGULATION – PHARMACISTS	5
The balance between prosecution and reporting of dispensing errors.....	5
INFORMATION GOVERNANCE	5
Information Commissioner’s Office (ICO) updates guidance on breach notification	5
Identical FOIA requests sent to large number of trusts in England	6
Information Commissioner’s Office (ICO) publishes details of the loss of children’s personal sensitive information	7
PATIENT MATTERS – IMPROVING CARE	8
Hospitals to face financial penalties for readmissions within 30 days.....	8
NICE launches quality standards for the NHS.....	8
Eggcellent news for older women – could test to predict menopause mean IVF for "forties females" on the NHS?	9
NICE seeks to improve donor identification and consent rate	9
Secretary of State announces a review into palliative care funding	10
Review of the adult social care: a progress report	10
PATIENT MATTERS – THE MENTAL HEALTH ACT	11
Guide to the age appropriate amendments to the Mental Health Act 1983	11
PATIENT MATTERS – INQUESTS	11
Court underlines the circumstances in which coroners have a duty to hold an inquest	11
PATIENT MATTERS – DEPRIVATION OF LIBERTY SAFEGUARDS	12
Court gives guidance on Deprivation of Liberty Safeguards (DOLS)	12
Court holds that deprivation of liberty safeguards (DOLS) are compliant with Article 5 of the European Convention on Human Rights	13
PATIENT MATTERS – THE COURT OF PROTECTION	13
Court of Protection decides on the test for capacity to consent to contraception	13
PATIENT MATTERS – MENTAL HEALTH ACT	14
Court clarifies scope of section 117 "after care" duty.....	14
PATIENT MATTERS – END OF LIFE CARE	15
GMC produces new guidance on end of life care	15
PATIENT MATTERS – ASSISTED SUICIDE	15
Director of Public Prosecutions (DPP) won’t prosecute assisting GP	15
Director of Public Prosecutions (DPP) asked to rule on murder proceedings	16
PATIENT MATTERS – CHILDREN	16
Court decides whether or not to provide surgery to children.....	16
Pledge to children with life threatening conditions	17
Court gives guidance on emergency protection orders under the Children Act 1989.....	17
EMPLOYMENT	18
Court of Appeal opens way to full pay-out for Gibb	18

briefing continued

Introduction

Many of us will probably be heading off on our summer holidays this year with some unusual holiday reading material. So much information has been coming out of the Department of Health following the publication of the White Paper *Equity and excellence: Liberating the NHS* that the challenge for many will be keeping up with all the important issues and proposed changes. I hope you received our special edition *Health Legal Update* which focused on the White Paper if you missed it, then you can access this by clicking [here](#).

The White Paper consultations announced so far are set out below for your ease of reference. We will of course continue to provide commentary on these in subsequent editions of our update or in separate briefings.

The NHS Commissioning Board will be responsible for delivering better health outcomes through a national NHS Outcomes Framework. Click [here](#) for the consultation document *Transparency in outcomes – a framework for the NHS*.

We know that GP consortia will be put in charge of commissioning local services to best meet the needs of local individuals. Following this announcement in the White Paper, two key consultation documents have been published:

- *Liberating the NHS: commissioning for patients – consultation on proposals*; and
- *Liberating the NHS: increasing democratic legitimacy in health*.

Views are sought on how the NHS Commissioning Board and GP consortia can:

- involve patients in improving the quality of health services;
- work closely with secondary care, community partners and others in providing a joined up service; and
- make effective and efficient commissioning decisions.

Our own briefing *GP commissioning: 12 legal issues* is accessible [here](#).

With a larger role for local authorities, we are asked to comment on the local authorities' enhanced roles in supporting patient choice, in taking on local public health improvement functions and in promoting more effective commissioning arrangements for NHS, social care and public health.

Most recently there has been *Liberating the NHS: regulating healthcare providers*. This consultation document outlines proposals with respect to foundation trusts and the establishment of Monitor as an independent economic regulator of health and adult social care. This consultation document can be accessed [here](#). Our own briefing *Liberating the NHS: regulating healthcare providers* can be accessed [here](#).

As I stated at the outset, this will be a busy summer with consultations on the above closing on 11 October 2010, and then there will be the Health Bill in the autumn. Expect to see more in your inbox from us, as we set out our views on these and other documents, and the opportunities for engagement by all in the NHS and wider community.

This month's update deals with information governance issues and the need for staff to be properly trained in the handling of sensitive information, and the consultation document from NICE as they seek to improve donor identification and consent rates for donation. The Secretary of State has also announced a review into palliative care funding, with the findings of the review expected by summer 2011. We have also produced an interesting round-up of cases covering DOLS issues, the test for capacity to consent to contraception, the scope of section 117 "after care" duty, and the use of emergency protection orders, to select a few.

briefing continued

I hope you find this edition useful and interesting.

Have a great summer.



Dawn Brathwaite

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NHS MANAGEMENT – ARM’S LENGTH BODIES

Arm’s length bodies review

The Department of Health’s review on arm’s length bodies (ALBs) has been published and proposes to demolish, merge or transfer the functions of 12 out of 18 bodies, with only six assured of a “clear future”, namely:

- Monitor;
- the Care Quality Commission;
- the National Institute for Health and Clinical Excellence;
- the Medicines and Healthcare Products Regulatory Agency;
- the Health and Care Information Centre; and
- NHS Blood and Transplant.

The Human Fertilisation and Embryology Authority and the Human Tissue Authority will remain ALBs for the time being but their functions will be transferred to other organisations by the end of the current Parliament.

The Health Protection Agency and the National Treatment Agency will be abolished although their functions will be transferred to the new public health service.

The Alcohol Education Research Council, the Appointments Commission, the National Patient Safety Agency and NHS Institute for Innovation and Improvement will be abolished.

The Council for Healthcare Regulatory Excellence will be "moved out of the sector".

The General Social Care Council will have its functions transferred to an existing professional regulator and the NHS Litigation Authority and NHS Business Services Authority will be the subject of a commercial review to decide their future.

The review can be accessed [here](#).

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8453.

briefing continued

NHS MANAGEMENT – PUBLIC HEALTH

Andrew Lansley sets out his vision for a new public health service body

The White Paper promises that later in the year we will see the publication of a further White Paper which will set out the Government's vision for a new public health service which we now know will not include the Health Protection Agency which will be one of the health watchdogs to be abolished as confirmed in the Government's [Arm's-length bodies review report](#) and as discussed above – but in the meantime, speaking at the UK Faculty of Public Health's annual conference, Mr Lansley outlined what the framework required to deliver more effective public health might look like.

The framework of empowerment includes:

- a new responsibility deal between Government and business built on shared social responsibility and not state regulation;
- a new ring-fenced public health budget;
- a new "Health Premium" to target public health resources towards the areas with the poorest health;
- clear outcomes and measures to judge progress alongside NHS and social care outcomes;
- an enhanced role for public health directors so they have the resources and authority to improve the health of their communities;
- a new Cabinet Sub-Committee on Public Health, chaired by the Health Secretary, to tackle the drivers of demand on the NHS; and
- a White Paper, to be published later this year, will set out in more detail how the public health service will work.

For further information or advice please contact [Tania Richards](#) on 01223 222476.

NHS MANAGEMENT – MONITOR

Monitor publishes amendments for those applying for NHS FT status

[Amendments to applying for NHS FT status: a guide to applicants](#) provides updates to Chapters 5 and 6 and Monitor's appendices and supersedes the relevant chapters in the November 2008 Guide for Applicants.

The content in the document will be incorporated into a full update to the Guide for Applicants in the summer and at that time the revised Guide for Applicants will also take account of updates required by the Department of Health which are presently under consideration. Of course the guidance will need to be substantially rewritten if the Government's White Paper proposals are implemented.

Key changes are highlighted below:

- amendments to section 5.1 to incorporate the quality governance and performance criteria for authorisation;
- a new section 5.3.2.4 to provide details of the quality governance proposals;
- amendments to section 5.3.2.3 to provide detail to the quality performance threshold and to align the governance rating to the 2010/11 Compliance Framework, (the quality performance threshold is effective from 1 April 2010);
- clarification to current guidance as follows:
 - providing details on Monitor's approach to assessing applicants undergoing transactions, ie, to clarify that if an applicant has recently undergone a material transaction, Monitor will need 12 months of

briefing continued

combined track record before assessing the transaction (six months in exceptional circumstances) in section 5.9;

- o providing details on how Monitor will work with the Care Quality Commission in section 5.7.5;
- o providing details on the letter of assurance that Monitor received from the Department of Health in section 5.7.6;
- o indication that the timeframe for assessment could increase in light of the additional work on quality governance (3-4 months in total) in section 5.7.2;
- o amendments to appendix B12 to align the self-certification to the *2010/11 Compliance Framework*;
- o new appendix B13 covering quality governance board statement and board memorandum; and
- o new appendix B14 covering good practice guidance on quality governance.

For further information or advice please contact [Tim Winn](#) on 0121 456 8355 or [Tania Richards](#) on 01223 222476.

REGULATION – PHARMACISTS

The balance between prosecution and reporting of dispensing errors

The [Legal Guidance note](#) published by the Crown Prosecution Service (CPS) on 21 June 2010 highlights areas where pharmacists, pharmacy technicians and other persons handling medicines are liable to prosecution under the Medicines Act 1968 (the Act). These include the incorrect supply of medicines and the incorrect labelling of medicines.

Unlike most criminal offences, offences under the Act do not distinguish between negligent, reckless or intentional acts. However, the sentencing range (from a fine up to two years imprisonment) is broad enough to allow the court to take this into account.

The main issue is that pharmacists are required, under the Act, to record and notify incidents and this effectively amounts to a confession. Obviously, the main aim of reporting incidents is to allow for improvements to be made to systems so that these incidents can be avoided in the future.

However, if it was routine for pharmacists to be prosecuted for simple dispensing errors, it would have the effect of discouraging the recording and reporting of these errors. Therefore, a balance needs to be struck between prosecution and incident reporting. Therefore investigations by the Medicines and Healthcare Products Regulatory Agency (MHRA) and prosecutions by the Department of Health are rare.

For this reason it is important to have clear, up to date and relevant standard operating procedures that all staff are aware of and follow. By following these procedures, pharmacists may have a defence by demonstrating that they could not reasonably have done anything more to prevent the error occurring and the error was due to the act or default of another person.

For further information or advice please contact [Jill Mason](#) on 0121 456 8367.

INFORMATION GOVERNANCE

Information Commissioner's Office (ICO) updates guidance on breach notification

The UK's ICO has recently updated its [guidance](#) for organisations, on when to notify it of data breaches.

briefing continued

Although there are no current legal obligations for organisations to report breaches of security which result in loss, release or corruption of personal data, the Information Commissioner (IC) recommends that “serious breaches” should be reported.

“Serious breaches” are not defined, but the guidance does provide examples of when breach of data security should be reported, including:

- **Where there is a potential harm to data subjects:** examples include ways in which harm can incur, including significant actual harm or potential harm. But if there is minimal risk that individuals will suffer significant harm, because a stolen laptop is encrypted, there is no need to report.
- **The volume of personal data lost, released or corrupted:** the guidance states that every case is to be considered on its merits, but generally, a collection of around 1,000 individuals is a reasonable figure to report.
- **The sensitivity of the data lost, released or unlawfully corrupted:** The guidance comments that there should be a presumption to report to the ICO, where smaller amounts of sensitive personal data is released if there is significant risk of individuals suffering substantial harm.

Crucially, the guidance explicitly states that the IC does not have the power to impose a fine or a penalty as a punishment for a breach, but can impose obligations as to future conduct.

For more information or advice please contact [Arzu Ozel](#) on 0121 456 8356.

Identical FOIA requests sent to large number of trusts in England

We have recently provided advice to an NHS foundation trust on a Freedom of Information Act 2000 (FOIA) request received from a university department for journalism.

The requester asked for the following information:

- copies of all compromise agreements entered into between the trust and doctors of any grade during the last ten years; and
- a list of exploratory or illustratory issues covered by the compromise agreements, ie, the reasons why they were entered into.

As our clients are aware, there is a general obligation under the FOIA for a public authority to disclose all relevant recorded information it holds relating to a request unless:

- a) any information is exempt from disclosure;
- b) the cost to locate and retrieve the relevant information would exceed the relevant cost limit; or
- c) the request is vexatious or has already been dealt with by the public authority.

We understand that the requester has sent/is in the process of sending, identical FOIA requests to trusts throughout England. Whilst our advice will depend on the circumstances in each individual case, as it seems this may be a commonly received request, we are in a position to provide advice to any of our clients as to what information they need to disclose, if they have received such a request.

For further information or advice please contact [Lucy Johnston](#) on 01223 222366 or [Emma Tully](#) on 01223 222485.

briefing continued

Information Commissioner's Office (ICO) publishes details of the loss of children's personal sensitive information

The ICO has published details of the action it has taken against three local authorities and an NHS trust following breaches of the Data Protection Act 1998 in relation to children's medical records. The breaches were primarily caused by a lack of staff training on how to handle personal information and the findings serve as a useful reminder in relation to document storage for colleagues who work with children (as well as adults).

The ICO's press releases can be accessed [here](#).

The data breaches were as follows:

- theft from an employee's home which led to the loss of unencrypted, non-password protected USB sticks and CDs containing personal information of over 9,000 children and their family members – the employee did not have authorisation to download the data;
- theft of an unencrypted laptop stolen from an employee's home which contained children's personal information;
- loss at Heathrow Airport of documents containing sensitive information relating to two children; and
- two unencrypted laptops containing patients' personal data, stolen from a day centre at a hospital.

The ICO has concluded that the losses were caused by a "systemic lack of training on how to handle personal information".

Each organisation has given an undertaking to ensure it complies with the requirements to protect personal sensitive data aimed at ensuring preventative safeguards are in place when transferring or storing children's personal information.

The undertakings given vary but include the following terms which need to be adhered to by all organisations that hold personal sensitive data:

- portable and mobile devices including laptops and other portable media used to store and transmit personal data, the loss of which could cause damage or distress to individuals, should be encrypted using encryption software which meets the current standard;
- all staff with access to personal data need to be made aware of the data controller's policies for storage and use of personal data and need to be appropriately trained how to follow those policies;
- compliance with the data controller's policies on personal data and IT security issues should be appropriately and regularly monitored; and
- procedures should be implemented to ensure that a proper risk assessment is carried out prior to removal from the office environment of documents containing personal sensitive data and appropriate security measures put in place to protect such data in transit.

Whilst the breaches in question related specifically to personal sensitive data relating to children, obviously it also applies generally to all health care and local authority practitioners.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Stuart Knowles](#) on 0121 456 8461.

briefing continued

PATIENT MATTERS – IMPROVING CARE

Hospitals to face financial penalties for readmissions within 30 days

On 8 June 2010, Andrew Lansley, the new Health Secretary, unveiled a new scheme where NHS hospitals in England will face financial penalties if patients are readmitted as an emergency within 30 days of being discharged. Hospitals will essentially have the responsibility of looking after patients' health and wellbeing for up to a month after they are discharged but if a patient is readmitted within 30 days, with a related problem, the hospital will not receive any additional payment for the additional treatment.

There are concerns that this new scheme will have a negative knock-on effect and rather than avoiding readmissions patients could be kept in hospital for longer than necessary.

Nigel Edwards, Policy Director of the NHS Confederation, has commented that where patients have multiple conditions it may be difficult to work out which of the conditions has brought the patient back to hospital.

The move towards this scheme has been as a result of increased numbers of readmissions which have increased by 50 per cent in the last 10 years. However, it is not clear if the increased number has been considered against the increasing number of hospital admissions in the same period.

This scheme was unveiled before the White Paper and we will have to wait and see how this develops in the emerging health landscape! Trusts will need to devise clear policies regarding readmissions, if and when the scheme is rolled out.

For further information or advice please contact [Katrina McCrory](#) on 0121 456 8451.

NICE launches quality standards for the NHS

The National Institute for Health and Clinical Excellence (NICE) has launched the first set of quality standards, setting the benchmark for high quality treatment and care in the NHS for stroke, dementia and the prevention of venous-thromboembolism.

Within five years around 150 clinical areas will have their own set of standards, which were first intimated in Lord Darzi's 2008 *Next Stage review*. The new Government has adopted the idea and tells us in the White Paper that the standards will be developed for the Commissioning Board by NICE and will span both health and social care. Each standard will be a set of five to ten specific, concise quality statements and associated measures which will act as markers of high quality, cost effective patient care which will be developed independently by NICE in collaboration with NHS and social care professionals, their partners and service users.

The White Paper also tells us that commissioners will draw from the "NICE library" of standards as they commission care with GP consortia and providers, agreeing local priorities for implementation each year taking account of the NHS Outcomes Framework. We are told that the NICE quality standards will be reflected in commissioning contracts and financial incentives.

NICE's press release can be accessed [here](#).

For further information or advice please contact [Jane Williams](#) on 0121 456 8421.

briefing continued

Eggcellent news for older women – could test to predict menopause mean IVF for "forties females" on the NHS?

Hot on the heels of the announcement of a new test to predict the anticipated age of the menopause, based on the number of eggs remaining in a woman's ovaries (ovarian reserve), comes the flip-side, news that the National Institute for Health and Clinical Excellence (NICE) may dispense with the guideline upper age limit for eligibility for NHS IVF where a woman still has viable eggs.

Over the past few months, NICE has been consulting on the scope for revisions to its 2004 fertility treatment guideline CG11. The guideline, indicative of best practice but not binding on commissioners in the same way as technology appraisal guidance, currently recommends that women between the ages of 23 and 39 should be offered three cycles of IVF on the NHS if the treatment is otherwise appropriate.

Although the final scope has yet to be published on the NICE website, the idea has already been seized upon by some as the solution to the present postcode lottery for IVF treatment. Ethics groups however, have condemned the move to invest NHS money in the over-forties, a group with a high percentage of birth abnormalities due to age-related degradation of egg quality.

Perhaps most interestingly however, an article in the current edition of *Current Opinion in Obstetrics & Gynaecology* (August 2010 – Volume 22 – Issue 4 – p 271–276), entitled *Tests for ovarian reserve: reliability and utility*, by Domingues, Thaís; Rocha, André and Serafini, concludes that none of the currently employed tests of ovarian reserve can reliably predict pregnancy after assisted conception. Further, it states ovarian reserve tests cannot predict the onset of reproductive and hormonal menopause.

A storm in an egg cup? Keep an eye on the NICE website at: [Fertility \(update\)](#).

For further information or advice please contact [Jane Williams](#) on 0121 456 8421.

NICE seeks to improve donor identification and consent rate

The National Institute for Health and Clinical Excellence (NICE) has published for consultation a draft scope clinical practice guideline on cadaveric organ donation for use in the NHS in England, Wales and Northern Ireland. The draft scope defines what aspects of care the guideline will cover and to whom it will apply. The intention, ultimately, is to improve identification of donors and consent rates for donation, so increasing the availability of organs for transplant.

Currently more than 10,000 people in the UK are waiting for an organ transplant as a result of primary organ disease or the secondary effects of diabetes or cystic fibrosis. This figure is rising by approximately 8 per cent per annum, yet even this does not reflect the true extent of needs because many clinicians are loathe to list more patients than are realistically likely to receive organs. It is believed that the real need is at least 50 per cent more than currently available and is increasing rapidly with changing UK demographics – principally an ageing population and a surge in the incidence of type II diabetes.

The UK has one of the lowest donation rates in Europe (13 donors per million of population – compared, for example, to Spain at 35 donors per million). Each year more than 1,000 people die before an organ becomes available. Of the 86 per cent of potential post-brain stem death donors referred to donor co-ordinators, families refused permission for 38 per cent of those possible donations (data from UK Transplant). Only 3 per cent of deceased kidney donors are of Asian or Afro-Caribbean descent, even though these groups form 25 per cent of the kidney transplant waiting list because they are three to four times more likely than white Caucasians to develop end-stage renal failure.

briefing continued

The guideline will focus exclusively on identifying potential donors and obtaining consent for organ donation under current legislation (although interestingly, the Welsh Assembly has pledged to introduce legislation presuming consent for organ donation after death, obliging individuals to opt out of the system rather than opt in, as is currently the position). Development of the guideline recommendations post-consultation will begin in September 2010.

Information about the consultation can be accessed [here](#).

For further information or advice please contact [Jane Williams](#) on 0121 456 8421.

Secretary of State announces a review into palliative care funding

The review, which will cover both children and adults, will be chaired by Tom Hughes-Hallett, Chief Executive of Marie Curie Cancer Care, and will focus on how the Government can make sure that the money intended to help look after people who are approaching the end of life is spent properly.

The issue of patient choice will also be a key element. An aim of the review is to include an element of choice in end of life care and the review will make recommendations in relation to how a system can be funded which encourages more community-based care (allowing a patient to stay in their own home) whilst retaining transparency for all organisations involved in palliative care.

We regularly advise and provide talks to clients on all aspects of end of life care – including palliative care – and would be happy to discuss any issues you may be experiencing.

The findings of the review are expected by summer 2011.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Lee Parkhill](#) on 0121 456 8420.

Review of the adult social care: a progress report

The consultation into this review is now closed and the responses are being collated.

At a recent social care conference, Frances Patterson (who is chairing the review), confirmed that the proposal for the future is likely to be that there will be regulations to establish the eligibility framework for social care and that there will be a duty on local authorities to decide upon eligibility based on specific criteria. Once eligibility needs have been established, there will be an enforceable duty to meet those needs. There will also be a statutory code of practice that will be developed.

The review also touches upon safeguarding issues and Ms Patterson confirmed that there would be a statutory definition of an adult at risk, the phrase of vulnerable adult will no longer be used.

Finally, Ms Patterson confirmed that the review of the social care legislation would tie in with the Government's proposals to review social care funding which has been outlined in the new White Paper.

Currently there has been no indication how continuing healthcare will be affected but as the connection between social care and health is widening this may be an area to watch.

The new Social Care statute should be available by 2012.

briefing continued

For further information or advice please contact [Katrina McCrory](#) on 0121 456 8451.

PATIENT MATTERS – THE MENTAL HEALTH ACT

Guide to the age appropriate amendments to the Mental Health Act 1983

Since 1 April 2010 mental health trusts and PCTs have been under a duty (by virtue of section 131 MHA) to ensure that the environment on a mental health ward is suitable to the child's age subject to their needs, ie, they have to provide age appropriate accommodation for under 18's.

YoungMinds, the voice for young people's mental health and wellbeing, has produced a practical briefing which sets out some key factors to make adult wards safe and appropriate for young people:

- wards need established links with one CAMHS team and CAMHS professionals to support under 18s admitted;
- joint working between CAMHS and the adult ward staff should be established;
- staff should be CRB checked;
- staff need to have the necessary skills to ensure young people receive appropriate assessments, care and treatment;
- all admissions of under 18s should be monitored to assess compliance with the new duty to provide age appropriate care;
- staff should liaise with educational services to ensure continued learning when required; and
- wards need to have robust transfer protocols to support transitions to other services.

The practical briefing can be accessed [here](#).

For further information or advice please contact [Ruth Creed](#) on 0121 456 8323 or [Charlotte Mawdesley](#) on 0121 456 8402.

PATIENT MATTERS – INQUESTS

Court underlines the circumstances in which coroners have a duty to hold an inquest

A recent Divisional Court case, *Jack Connah v Plymouth Hospitals NHS Trust and others*, highlights that the families of deceased patients do not have the right to require that an inquest is held into the death of their loved one. Mr Connah, whose wife died in 1998 of a brain tumour, for which she had received hospital treatment that he alleged was negligent, applied to the court for an order under section 13 of the Coroners Act 1988 (the Act), to force a coroner to hold an inquest. The court can make such an order if the coroner has refused to hold an inquest in circumstances where one "ought to be held" (section 13(1)(a) of the Act).

The deceased's husband was convinced that his wife had wrongly been given treatment intended for a different patient. He believed that this alleged negligence had been covered up in a conspiracy that included the judiciary and the Attorney General. While expressing sympathy with the claimant's grief, and the hope that he finds relief from the "terrible fantasy" of his views about his wife's death, the court underlined that the Act sets out in terms the situations where an inquest "ought to be held", namely where there is *reasonable cause* (our italics) to suspect that the deceased died:

- a violent or unnatural death;

briefing continued

- a sudden death of which the cause is unknown;
- in a prison or at a location; or
- in circumstances where an inquest is required by other legislation.

The strength of feeling on the part of Mr Connah that an inquest should be held was not a material factor for the coroner to take into account – the relatives of a deceased cannot demand that an inquest is held because they feel that the care of their loved one should be investigated. If the death does not fall within one of the factors listed above, an inquest will not be held.

For further information or advice please contact [Philip Grey](#) on 01223 222463.

PATIENT MATTERS – DEPRIVATION OF LIBERTY SAFEGUARDS

Court gives guidance on Deprivation of Liberty Safeguards (DOLS)

[Re A \(child\)](#) and [Re C \(adult\)](#) were two cases heard together by Justice Munby (now Lord Justice Munby).

A and C suffered from Smith Magenis syndrome, a genetic condition characterised by learning disabilities, behavioural problems and disturbed sleep patterns. A and C were cared for at home by their respective families. During the night both were locked in their bedrooms to prevent them from wandering around the house and injuring themselves. Neither were concerned about having the bedroom door locked. Locking the doors was considered to be the only option as having carers nearby would be likely to disturb their sleep further.

Three issues were considered by the court:

The application of Article 5 of the European Convention on Human Rights (right to liberty and security of the person)

The court considered how Article 5 is engaged where the person responsible for the alleged deprivation of liberty is a private person not a public body. The court found that the state (here the local authority) owes positive obligations under Article 5 to protect individuals from arbitrary interferences with their right to liberty. This means that local authorities must take reasonable steps to prevent (or seek court authorisation for) a deprivation of liberty which they are aware of, or which they ought to be aware of. However, it held that the positive duty of the state to investigate and refer the matter to court only applies where the local authority has direct responsibility for the alleged deprivation of liberty. Article 5 is only engaged where the local authority has sufficient control over the private individual.

The question of what amounts to deprivation of liberty

The purpose of the restrictions imposed on a person was held by the court to be relevant in ascertaining whether there is a deprivation of liberty, although this is not in itself determinative. On the facts of the case it was held that there was a restriction of liberty only. A and C were being locked in their bedrooms for their own safety. This restriction was only at night time when they otherwise would have been asleep but for the effects of their condition. They were checked by their families and were happy with their care. The fact that they had no say over where they lived and how they were cared for, was outweighed by these considerations.

The guidance for local authorities when dealing with incapacitated adults

Justice Munby criticised local authority practice that assumed that individuals under the control of the local authority have to comply with local authority decisions regarding their care. Where objections to a DOLS are made/there is not specific consent, local authorities must seek the assistance of the court before a DOLS take place, unless there is a genuine emergency.

briefing continued

For further information or advice please contact [Lorna Shastri-Hurst](#) on 0121 456 8400 or [Helen Burnell](#) on 020 7648 9237.

Court holds that deprivation of liberty safeguards (DOLS) are compliant with Article 5 of the European Convention on Human Rights

The Court of Appeal has recently handed down an important deprivation of liberty (DOLS) decision which represents the first confirmation from the Court that the DOLS regime has, to use the words of the court, "plugged" the *Bournewood* gap in a lawful manner.

The focus of the arguments in the case of [G v E](#) were around Article 5 of the European Convention on Human Rights (ECHR).

Article 5 relates to an individual's right to liberty and security. The question before the Court of Appeal was whether Article 5 meant that threshold conditions had to be satisfied before a best interests assessment under DOLS could be carried out.

E suffered from a rare and complex genetic condition which had left him with severe learning difficulties. He had been in foster care but had then been moved to a residential unit.

G was E's sister who had applied for declarations/orders concerning his past, present and future care.

The High Court had found that E had been deprived of his liberty without authority in the residential home but that it was in his best interests to remain there.

G had relied on European case law relating to the detention of mentally ill patients in a psychiatric hospital. The Court of Appeal emphasised that in a case like E's to require psychiatric evidence of the necessity of a deprivation would be "simply unreal" and in some cases "irrelevant" under the DOLS regime. However, the court indicated that it would require credible expert evidence that an individual lacks capacity upon which the court could rely. Article 5 provided a safeguard against arbitrary detention and the DOLS Code was compliant with that. The court contrasted this with those patients who fall under the Mental Health Act 1983.

This judgment will confirm the existing practice of many of our clients but it serves as a useful reminder in relation to the need for a thorough assessment of capacity to be undertaken when consideration is being given as to whether a patient might fall under the DOLS scheme.

For further information contact [Helen Burnell](#) on 0207 648 9237 or [Jill Mason](#) on 0121 456 8367.

PATIENT MATTERS – THE COURT OF PROTECTION

Court of Protection decides on the test for capacity to consent to contraception

This was the central issue in the case of *A Local Authority v Mr A and Mrs A* [2010]. The background to the case was that Mr and Mrs A both had learning disabilities. Mrs A had previously had two children removed into care. There was evidence of domestic violence within the relationship and that Mr A was very controlling and prevented Mrs A from having contact with social services and seeking contraception.

briefing continued

The local authority submitted that the test for capacity to consent to contraception involved understanding and weighing the reasonably foreseeable consequences of not using contraception. It argued that this included understanding what would be involved in having a child and caring for it.

The Official Solicitor (on behalf of Mrs A) said that this set the bar too high. The court agreed with this. Mr Justice Bodey set out the issues which a woman would need to understand and weigh up in order to demonstrate capacity to consent to contraception:

- the reason for contraception and what it does;
- the types available and how each is used;
- the advantages and disadvantages of each type;
- the possible side-effects and how they can be dealt with;
- how easily each type can be changed; and
- the generally accepted effectiveness of each.

In the case of Mrs A, it was felt that she did have capacity to understand the relevant medical issues but that she was unable to weigh them because of the influence that her husband had over her.

It is worth noting that these considerations include an assessment of capacity in accordance with the Mental Capacity Act 2005.

Readers are referred to our [Health Resource Centre](#) for further information on the test for capacity. The checklist above provides a useful guide when considering the specific issue of contraception.

We have experience of providing advice in relation to capacity and contraception and would be happy to discuss these issues further if required.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Ruth Creed](#) on 0121 456 8323.

PATIENT MATTERS – MENTAL HEALTH ACT

Court clarifies scope of section 117 “after care” duty

In the recently decided case of *R (Mwanza) v London Borough of Greenwich and London Borough of Bromley [2010]*, the High Court considered the scope of local authority duties under section 117 Mental Health Act 1983 (the Act) under which people detained under section 3 of the Act (and 37, 45A, 47 and 48) are, when discharged, entitled to after care services from both the relevant primary care trust and the relevant local authority.

In this case, the court had to consider whether local authorities are obliged, under section 117, to provide “simple” accommodation to a previously detained patient. The patient sought “simple” accommodation because, due to his immigration status, he was not able to work and unable to claim benefits. He was therefore homeless, which would cause a deterioration in his mental health condition.

The court decided that section 117 does not create a duty to provide a service just because it will, or may, prevent a deterioration in the patient’s mental condition. The court said the duty is only to provide services which are needed as a

briefing continued

result of the patient's mental illness. The court stated: "an after-care service must be a service that is necessary to meet a need arising from a person's mental disorder ..."

The court accepted that the lack of accommodation, or employment, may contribute to a deterioration in a person's mental health. However, the need for accommodation, or employment, are basic needs which do not arise from a mental disorder. Accordingly, the court said, such needs do not call to be met under section 117.

This indication that basic needs, such as a need for simple accommodation, are not eligible needs under section 117 is particularly important in relation to local authority duties as no charge can be made for section 117 services. If section 117 included a duty to provide simple accommodation per se without being connected to a patient's mental illness, local authorities would be obliged to provide free accommodation to everyone previously detained under section 3. Also, because someone's need for accommodation never ends, if there were a duty as above the duty would not end even if the patient fully recovered from their mental illness.

This judgment is also relevant to NHS bodies discharging section 117 functions. The court's decision that the section 117 duty only extends to meeting needs which arise from a mental illness should also guide NHS bodies in determining which NHS services should be supplied under section 117 and which should be supplied via other mechanisms, for example, continuing healthcare.

For further information or advice please contact [Lee Parkhill](#) on 0121 456 8420 or [Jill Mason](#) on 0121 456 8367.

PATIENT MATTERS – END OF LIFE CARE

GMC produces new guidance on end of life care

The General Medical Council (GMC) has recently updated its [Good Medical Practice in Action](#) (GMPIA) website, with a brand new set of scenarios targeting the ethical dilemmas that doctors find most difficult to deal with.

GMPIA originally launched in 2008 with just 12 scenarios and has now grown to accommodate 60 scenarios, receiving over 40,000 visits from doctors, medical students and members of the public.

The recently added case studies contain scenarios which aim to help doctors and patients understand better the new [GMC Guidance on end of life care](#), which came into effect on 1 July 2010 and replaces [Withholding and withdrawing guidance for doctors](#).

The new case studies focus on difficult issues such as talking to a dying patient about whether to attempt cardio pulmonary resuscitation; what to do when there is a dispute between relatives regarding the care their loved one should receive; and the steps to take if a doctor has a conscientious objection to withdrawing treatment.

For further information or advice please contact [Sarah Berry](#) on 0121 456 8370.

PATIENT MATTERS – ASSISTED SUICIDE

Director of Public Prosecutions (DPP) won't prosecute assisting GP

The DPP has decided that Dr Michael Irwin, a former GP and right to die campaigner, will not be prosecuted despite claiming to have taken three terminally ill people to Dignitas, the euthanasia organisation in Switzerland, where they subsequently committed suicide. The DPP has decided that although there is enough evidence to prosecute Dr Irwin for assisting suicide, it would not be in the public interest to do so.

briefing continued

This decision is yet another indication that the legislation will only be invoked in exceptional circumstances, perhaps if there is any doubt about the patient's intentions.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8453.

Director of Public Prosecutions (DPP) asked to rule on murder proceedings

Mr Nicklinson suffers from "locked-in syndrome" following a stroke in 2005. As a result his only movement is in his eyelids which is also his only method of communication. He has indicated that he wants to end his own life but he would not be able to administer his own lethal dose of drugs which his wife or someone else, would have to administer it for him. This would amount to the offence of murder rather than assisted suicide which most of the previously reported cases have been, including that of Dr Irwin referred to above.

Mr Nicklinson has issued legal proceedings claiming that the current murder legislation infringes his right to respect for his private life under Article 8 of the European Convention on Human Rights and asking whether or not the DPP would authorise proceedings against Mrs Nicklinson were she to follow her husband's wishes and help him to end his life.

We will of course keep you informed of the progress of this interesting case.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8453.

PATIENT MATTERS – CHILDREN

Court decides whether or not to provide surgery to children

The case of [LA v SB and AB and MB](#) provides a useful reminder of the accepted practice of the court in establishing the correct parties to child protection issues involving a medical issue and it gives useful guidance to practitioners involved in complex care issues involving families and local authorities.

M is one of five siblings. He suffers from a rare but progressive brain disease, Rasmussen's encephalitis, that causes him to suffer from very frequent epileptic seizures, global developmental delay and partial sightedness. He also suffered from precocious puberty.

The local authority had commenced care proceedings in respect of M as two medical reports had outlined the life threatening nature of his conditions. The clinicians had also been concerned that M's parents were not being fully co-operative in investigation of treatment options. Both non surgical and surgical options were open for investigation, with the surgical option being preferred by the clinicians.

The local authority did not seek a care order allowing them to remove M from his mother and father's care but did ask the court to determine the question of surgery.

Importantly, the hospital concerned did not wish to intervene in the proceedings. It did however provide the court with a position statement outlining that surgery was the preferred treatment.

The court held that the issue of surgery was a matter to be decided between the family and the clinicians and neither were asking the court to make a decision with regard to surgery. Given that they were the decision makers there was no dispute for the court to decide as neither had asked the court to make a decision – the proceedings had been brought by the local authority.

briefing continued

The children's health team has recent experience of representing a client in similar proceedings and would be happy to offer advice to any other clients facing similar issues.

For further information or advice please contact [Helen Burnell](#) on 0207 648 9237 or [Ruth Creed](#) on 0121 456 8323.

Pledge to children with life threatening conditions

The Health Secretary, Andrew Lansley, has made a renewed commitment to help children with life threatening or life limiting conditions.

Up to £30 million is being made available this year to help children's hospices, networks and other providers to develop local children's palliative care projects. Eligible organisations, which includes NHS bodies who provide palliative care to children can apply for funding, as long as they meet the criteria which have been set out in a publication that has been issued by the Department of Health this month and can be accessed [here](#).

The Department of Health has provided organisations with two bidding rounds to make their applications. The first round closed on 30 July 2010. The second round closes on 30 September 2010.

The purpose of the funding is to provide a more nationally equitable provision of children's palliative care services which is sustainable and takes into account the needs of children and their families.

In the future, Mr Lansley wishes to introduce a "per patient" funding system for all hospices and other providers of palliative care so that proper support for sick children and adults can be developed.

The Department of Health press release can be accessed [here](#).

For further information or advice please contact [Sonal Lala](#) on 0121 456 8248 or [Charlotte Mawdesley](#) on 0121 456 8402.

Court gives guidance on emergency protection orders under the Children Act 1989

The case of [A v \(1\) East Sussex County Council \(2\) Chief Constable of Sussex \[2010\]](#) concerned a mother who called emergency services when her child stopped breathing who was subsequently admitted to hospital. He was later assessed as being fit for discharge but the consultant was concerned that this may have been a fictitious illness. He notified the local authority and police. The child was removed under section 46 Children Act 1989 and placed in foster care. Care proceedings were commenced and the mother agreed to go into a mother and baby unit, following an assessment by the judge that it was not safe for the child to return to the mother's care unsupervised. The outcome of the assessment was positive for the mother and the care proceedings were discharged.

The mother sought damages under the Human Rights Act 1998 from the local authority following the temporary removal of her baby from her care. The court at first instance had ruled that the hospital could not have let the matter wait until a hearing (ie, that the doctor had to act and inform the local authority and the police). The mother argued that the incident happened in the afternoon and that an urgent hearing could have been heard. The mother appealed.

The Court of Appeal reiterated the principle that an application for an emergency protection order rather than the exercise of powers under section 46 should be used, where reasonably practical to do so. Where practicable, a court order should be sought in preference to the use of section 46 powers. However, in this case the expert evidence was that it was not safe for the child to go home but given that the mother was entitled to take him home unless lawful

briefing continued

authority was provided for the child to remain, immediate action had been required and that precluded an application for an emergency protection order.

The court made a point of reiterating that, even in an emergency, it was desirable to work in partnership with parents.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Charlotte Mawdesley](#) on 0121 456 8402.

EMPLOYMENT

Court of Appeal opens way to full pay-out for Gibb

The [Court of Appeal](#) has overturned last year's High Court decision about the £250,000 termination package agreed by Maidstone and Tunbridge Wells NHS Trust with its outgoing chief executive Rose Gibb. All but £75,000 of the payment had been blocked since the intervention of the Department of Health in October 2007. It argued that it was beyond the powers of the trust to agree such a generous termination package just before the publication of a report which was seriously critical of the standards of hygiene and patient care at the trust's hospitals. This argument convinced the high court judge, who thought that the payment was "irrationally generous", but not the Court of Appeal.

The Court of Appeal reiterated the limited grounds on which the courts are prepared to strike down financial decisions of public bodies if they act within their ostensible powers. NHS trusts enjoy a fair degree of independence when making decisions about the remuneration of their staff, and it was not the court's role to second-guess their decisions or act as auditors. Furthermore the high court judge had been wrong to say the remuneration committee had not been entitled to take into account Ms Gibb's many years of good service and the difficulty she would face in finding new employment.

This decision marks a return to legal orthodoxy after a period of considerable uncertainty. However it should not be seen as signalling a green light to a return to the, some would say, generous termination packages in the NHS. There remains a requirement to get termination payments approved by the Remuneration Committee, the SHA/Monitor and to obtain Treasury approval prior to agreeing to the payment.

For further information or advice please contact [Anna Youngs](#) on 0121 456 8359 or [Martin Brewer](#) on 0121 456 8357.



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