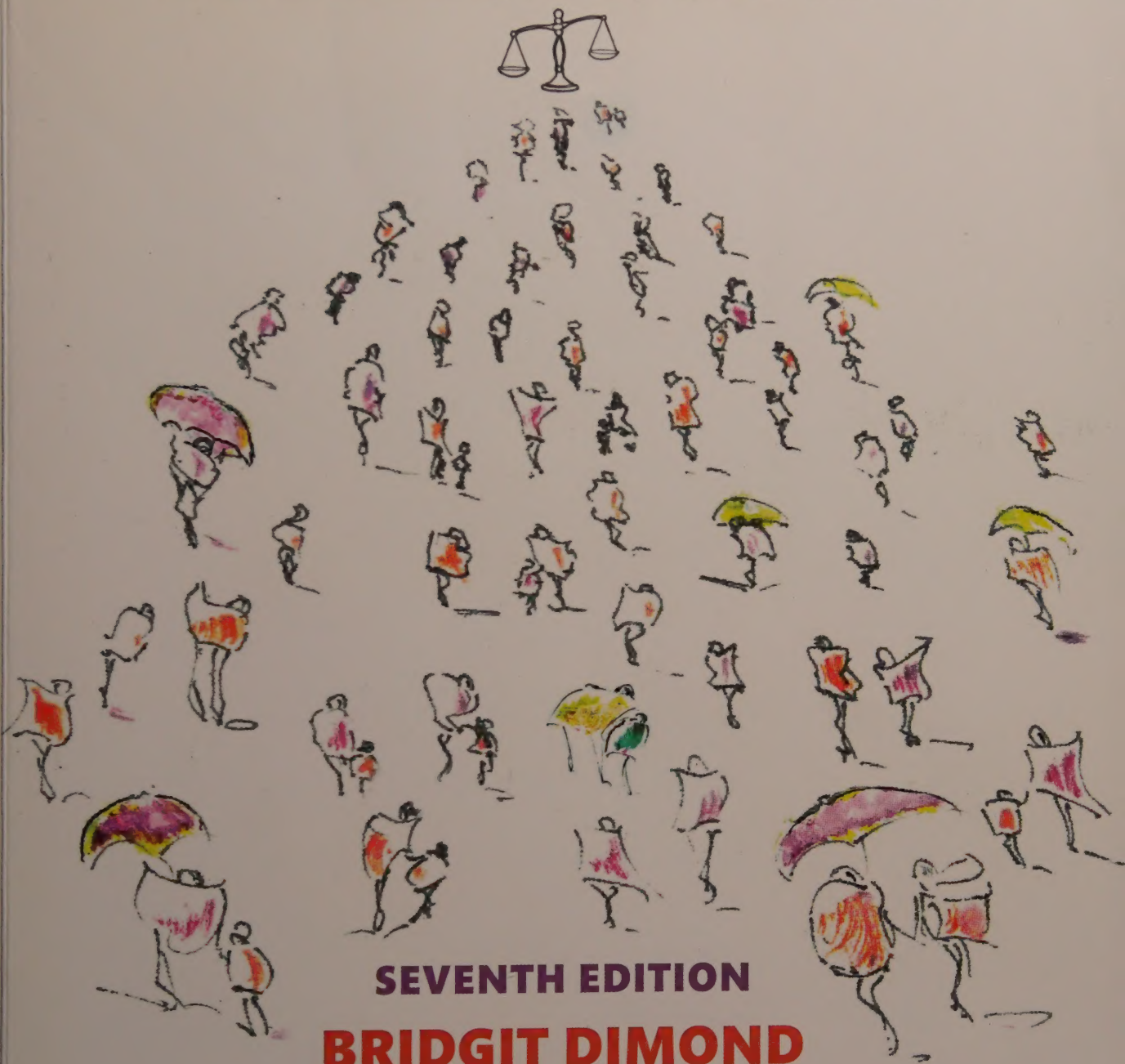
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Legal Aspects of Nursing

Seventh Edition



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Barrister-at-Law

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Contents

Guided tour xii
Table of cases xiv
Table of statutes xxvi
Abbreviations xxxii
Foreword to first edition xxxv
Foreword to seventh edition xxxvi
Preface to first edition xxxvii
Preface to seventh edition xxxix
Acknowledgements xl

Part I
General principles affecting all nurses 1

1 Introduction: four arenas of accountability, the legal system and human rights 3

Accountability 4
Criminal liability 6
Professional liability 7
Civil liability 8
Accountability to employer 9
Relationship between the four arenas of accountability 10
Sources of law 10
Differences between civil and criminal law 11
Civil actions 12
Judicial review 12
Legal personnel and legal complaints 13
Legal language 14
Human Rights Act 1998 14
Freedom of Information Act 2000 19
Devolved law-making powers 19
Conclusions 20
Reflection questions 20
Further exercises 20
References 21

2 Actions in the criminal courts and defences to criminal charges 23

Initial stages of arrest and prosecution 24
Magistrates' courts 27
Plea and Case Management Hearing 28
Crown Court proceedings 29
Elements of a crime 32
Case of Dr Nigel Cox 33
Case of Dr Adomako 33
Case of Dr Shipman 35
Case of Beverley Allitt 35
Case of Kevin Cobb 35
Administration of drug by epidural instead of intravenous injection 36
Offence of ill-treatment or wilful neglect 36
Defences 36
Criminal injuries compensation 40
Conclusions 42
Reflection questions 42
Further exercises 42
References 43

3 Liability in a civil court case for negligence 45

Duty of care 46
Standard of care 50
Causation 56
Liable for what? 60
Harm 61
Conclusions 64
Reflection questions 64
Further exercises 65
References 65

4 Specific problem areas in civil liability: personal liability of the nurse, vicarious liability of the employer and managerial issues 68

Negligence in communication 69
Inexperience 69
Team liability and apportionment of responsibility 71
Taking instructions: refusal to obey 73
Nurse as manager 75
Pressure on the manager 75
Vicarious liability of employer 77
In the course of employment 78
Liability for negligence of volunteers 82
Duty of care liability for independent contractors 82

Direct liability of employer 83
Indemnity from the employee at fault 84
Pressure from inadequate resources 86
Public Interest Disclosure Act 1998 and whistleblowing 89
Conclusions 94
Reflection questions 94
Further exercises 95
References 95

5 Statutory functions and management of the NHS 97

National Health Service 98
White Paper *Equity and Excellence: Liberating the NHS* 98
Enforcement of statutory duties 102
The National Health Service Commissioning Board (NHS England) 106
Clinical commissioning groups 108
The Mandate 110
NHS foundation trusts 111
Monitor 111
National Health Service Trust Development Authority 114
Clinical governance 114
Duty of quality 115
The Care Quality Commission 116
National Institute for Health and Care Excellence (NICE) 119
National Service Frameworks (NSFs) 121
NHS 111 and walk-in clinics 122
NHS inquiries 123
Mid Staffordshire NHS Foundation Trust Inquiry 124
The NHS Constitution 126
The Healthy NHS Board 128
Nursing initiatives 128
NHS and the private sector 128
Conclusions 129
Reflection questions 129
Further exercises 130
References 130

6 Progress of a civil claim: defences and compensation 133

Civil proceedings 134
Compensation in civil proceedings for negligence 139
Defences to a civil action 142
Clinical Negligence Scheme for Trusts (CNST) and the NHS Litigation Authority (NHSLA) 151
NHS Redress Act 2006 151
Reforms to civil litigation 152
Conclusions 152
Reflection questions 153
Further exercises 153
References 153

7 Consent to treatment and informing the patient 156

Basic principles 157
Requirements of a valid consent 157
How should consent be given? 157
Right to refuse treatment 160
Taking one's own discharge 164
Definition of mental capacity under the Mental Capacity Act 2005 164
Hunger strikes 166
Amputation of healthy limbs 167
Defences to an action for trespass to the person 167
Mental Capacity Act 2005 168
Mental Health Act 1983 173
Giving information to a patient prior to consent being obtained 173
Non-therapeutic procedures 177
Giving information to the terminally ill patient 178
Notifying the patient of negligence by a colleague 179
No decision about me, without me 180
Conclusions 181
Reflection questions 181
Further exercises 181
References 182

8 Data protection: confidentiality and access 184

Data Protection Act 1998 185
Data protection principles 187
First data protection principle 188
Duty of confidentiality 189
Caldicott Guardians 206
Health and Social Care Information Centre (HSCIC) 207
Freedom of Information Act 2000 208
DNA databases 210
Access to personal health records 211
Access to Medical Reports Act 1988 213
Conclusions 213
Reflection questions 214
Further exercises 214
References 214

9 Record keeping, statements and evidence in court 219

Record keeping 219
Statements 225

Evidence in court 230
Defamation 233
Internet 234
Conclusions 235
Reflection questions 235
Further exercises 235
References 235

10 The nurse and employment law 237

Human rights 238
Contract of employment 239
Statutory provisions covering employment 244
Unfair dismissal 255
Trade union rights 259
Public and private employees 260
Discrimination: The Equality and Human Rights Commission 261
Equality Act 2010 261
Agenda for Change 271
Conclusions 271
Reflection questions 271
Further exercises 271
References 271

11 The nurse as a registered professional 275

Background to the establishment of the Nursing and Midwifery Council 276
Nursing and Midwifery Council 276
Registration and removal 278
Professional standards and codes of practice 288
Education and training 288
Post-registration education and practice (PREP) 289
Fitness to Practise Annual Report 2012–2013 290
Professional Standards Authority for Health and Social Care (Council for Healthcare Regulatory Excellence (CHRE)) 291
NHS Improving Quality (formerly NHS Institute for Innovation and Improvement) 292
Framework for assessing national competence standards 293
Health and Care Professions Council 293
Conclusions 293
Reflection questions 294
Further exercises 294
References 295

12 Health and safety and the nurse 297

Statutory provisions 298
Corporate manslaughter and corporate homicide 318
Common law duties: employer's duty 318
Remedies available to an injured employee 320
Special areas 322
The future 338
Conclusions 339
Reflection questions 340
Further exercises 340
References 340

Part II
Specialist areas 345

13 Children and young persons 347

Consent to treatment 348
Child protection 358
Parental care and the nurse 367
Disciplining a child 369
Education of children in hospital 370
Children's trusts 371
National Service Frameworks (NSFs) 371
Adolescents 373
Teenage sexuality 373
Court proceedings and the child or young person 374
Conclusions 375
Reflection questions 376
Further exercises 376
References 376

14 Midwifery 381

Midwifery Committee 382
Midwives' rules and code of practice 382
Law relating to consent in midwifery care 384
Liability of the mother for harm caused to the baby 389
Taking the newly born into care 391
Midwifery practice and standard of care 392
Breastfeeding 395
Cord blood collection 396
Medicines and the midwife 396
Congenital Disabilities (Civil Liability) Act 1976 397
Nurseries within midwifery departments 400
Special care baby units 401
Cot deaths 405
Registration of births and stillbirths 405
Use of fetal tissue and placenta 406
Record keeping and midwifery 406
AIDS and the midwife 407
National Institute for Health and Clinical Excellence (NICE) 407
National guidelines on midwifery practice 407
Project 2020 410

Human Rights and birth 411
Morecambe Bay NHS Trust 411
Independent midwifery 411
The future 412
Conclusions 412
Reflection questions 412
Further exercises 412
References 413

15 The nurse on the gynaecology ward 417

Abortion 417
Sterilisation 430
Female circumcision 435
Conclusions 437
Reflection questions 437
Further exercises 437
References 438

16 Acute care 440

Civil liability procedures and practices in theatre 441
The theatre nurse and the scope of professional practice 443
Accidents in the theatre 444
Consent in the theatre 445
Recovery room nursing 447
Transfusions and blood contamination 448
Organ transplantation 449
Intensive care units: resource pressures 455
Review of critical care services 456
Conclusions 457
Reflection questions 457
Further exercises 458
References 458

17 Learning disabilities 461

Acting in the best interests of a mentally incapacitated adult 462
Deprivation of Liberty Safeguards (DoLS) (Bournewood) 465
Carers 468
Court of Protection and Code of Practice 470
White Paper *Valuing People* 473
Safeguarding vulnerable adults 475
Sexual relations and related issues 476
Property 478
Direct payments 478
Registration and inspections 482
Conclusions 482
Reflection questions 483
Further exercises 483
References 483

18 Nurse educator and researcher 487

NMC and standards in education 488
Record keeping by teachers 489
Liability for instructing others 490
Hearing about unsound practices 490
Employment law 491
Legal aspects of research 492
Health Research Authority 496
Confidentiality 497
Consent 497
Health Education England 501
Conclusions 502
Reflection questions 503
Further exercises 503
References 503

19 Legal aspects of the care of older people 505

Rights to care 506
National Service Framework for Older People 507
Intermediate care 509
Consent to treatment 510
Force, restraint and assault 511
Medication and the confused older patient 514
Dementia 515
Standard of care 519
Risk management 521
Abuse of older people 522
Mental Capacity Act 2005 and decision making for the mentally incapacitated adult 525
Conclusions 526
Reflection questions 526
Further exercises 527
References 527

20 Nursing the mentally disordered 530

Informal patients 531
Patients detained under mental health legislation 532
Holding power of the nurse 533
Compulsory detention of an informal inpatient 535
Compulsory admission 535
Definition and role of nearest relative 539
Role of the approved mental health professional 539
Informing the patient and relatives 541
Consent to treatment provisions 542
Community provisions 547
National Service Frameworks 555
Mental health strategy and priorities 556
Conclusions 557

Reflection questions 558
Further exercises 558
References 558

21 Accident and emergency, outpatients, genito-urinary departments and day surgery 561

Accident and emergency department 561
Outpatients department 569
Genito-urinary medicine 571
Day surgery 573
Conclusions 574
Reflection questions 574
Further exercises 575
References 575

22 Human fertility and genetics 577

Artificial insemination 579
Human Fertilisation and Embryology Act 1990 as amended by 2008 Act 581
In vitro fertilisation (IVF) 585
Embryos 587
Confidentiality 591
Surrogacy 591
Conscientious objection 594
Genetics 595
Gene therapy and genetic diagnosis 596
Gender selection 597
Genetic screening and testing 598
Cloning 600
Conclusions 602
Reflection questions 602
Further exercises 602
References 602

23 Community and primary care nursing 607

NHS and social services provision 608
Funding of long-term care 612
Care Act 2014 615
Human rights and care homes 625
Delayed discharges 627
Carers 629
Negligence 630
Safety of the community professional 633
Consent to treatment 636
Protection of property 638
Disclosure of information 638
Criminal suspicion 638
Standards: care homes 639
Community matrons 640
The specialist community public health nurse 641
The school nurse 641
The clinic nurse 643
The practice nurse 645
Developments in technology and structure 646
Conclusions 647
Reflection questions 647
Further exercises 647
References 648

24 Scope of professional practice, clinical nurse specialist and consultant nurse 651

Scope of professional practice 652
Delegation and supervision 654
Nurse consultants 655
Clinical nurse specialists and specialist nurses 656
Concerns about developments in scope of professional practice 657
Scope of professional practice in primary care 658
Scope of professional practice in theatre nursing 659
Scope of professional practice in emergency nursing 660
Scope of professional practice and X-rays 660
NHS 111 (formerly NHS Direct) and walk-in clinics 660
Modern matrons 661
Clinical supervision 662
Agency nurses 663
Healthcare support workers 663
Conclusions 664
Reflection questions 665
Further exercises 665
References 665

Part III General areas 669

25 Legal aspects of property 671

Principles of liability 672
Administrative failures 673
Exclusion of liability 673
Property of the mentally incompetent 674
Mental Capacity Act 2005 675
Day-to-day care of money 676
Power of attorney 677
Court of Protection 678

Protecting patients from relatives 679
Returning the patient's property 679
Staff property 680
Gifts 681
Conclusions 682
Reflection questions 682
Further exercises 682
References 683

26 Legal aspects of public health 684

Public health legislation 685
Notifiable diseases 686
Cross-infection control 688
Health and Social Care Act 2008 690
Health Protection Agency (now Public Health England) 691
Public Health England 692
Tuberculosis (TB) 692
Hepatitis 693
HIV-infected persons and AIDS patients 693
Vaccination 696
Blood donors 699
Confidentiality 699
Conclusions 700
Reflection questions 701
Further exercises 701
References 701

27 Handling complaints 704

Methods of complaining 705
Handling complaints 707
Hospital Complaints Procedure Act 1985 and the Wilson Report 708
Complaints procedure 2004 709
Complaints procedure 2004 and 2006 710
Complaints procedure 2009 710
The Health Service and Parliamentary Ombudsman (HSC) 714
The House of Commons Select Committee 715
Healthwatch England 716
Local Healthwatch (formerly LINKS) 716
Independent Complaints Advocacy Service (ICAS) 717
Patient Advice and Liaison Services (PALS) 717
Other quality assurance methods 718
Complaints relating to detained patients 719
Secretary of State inquiries 719
The NHS Constitution 720
Review of NHS complaints system 720
Conclusions 721
Reflection questions 722
Further exercises 722
References 722

28 Legal aspects of medicines 724

General principles 725
Controlled drugs 727
Problems in the administration of medicine 729
Management of errors or incidents in the administration of medicines 731
Self-administration by patients 736
Covert administration of medicines 737
Medicines and the operating department practitioner (ODP) 737
Nurse as prescriber 738
Group protocols or patient group directions 739
Nurse prescribing: independent and dependent (subsequently known as supplementary) prescribers 740
Role of the pharmacist 743
Safety of medicines 743
Product liability and drugs 744
Misuse of drugs 745
The future: personalised medicine 746
National Prescribing Centre 747
Availability of medicines within the NHS 747
Conclusions 748
Reflection questions 749
Further exercises 749
References 749

29 End-of-life care and death 754

End-of-life care 755
Definition of death 757
Importance of exact time of death 759
Legality of switching machines off 760
Not for resuscitation 763
Patients refusing treatment 764
Relatives and treatment of the patient 766
Living wills/advance decisions 771
Certification and registration of death 772
Disposal of the body 775
Post-mortems 775
Deaths that have to be reported to the coroner 775
Inquests 776
Recommendations of the Shipman Inquiry 779
The Coroners and Justice Act 2009: overview 782

Property of the deceased 782
Wills 783
Conclusions 785
Reflection questions 785
Further exercises 785
References 785

30 Complementary and alternative therapies 789

Definitions of complementary and alternative therapies 790
The NMC practitioner as a complementary therapist 790
Liability for using complementary therapy at work 791
Patients receiving complementary therapies 792
House of Lords Select Committee 794
Herbal medicines and acupuncture 794
Complementary and Natural Healthcare Council (CNHC) 795
Conclusions 798
Reflection questions 799
Further exercises 799
References 799

31 The future 801

Glossary 803
Further reading 806
Websites 809
Index 812

Guided tour

This chapter discusses

- Initial stages of arrest and prosecution
- Magistrates' courts
- Plea and Case Management Hearing
- Crown Court proceedings
- Elements of a crime
- Cases of Dr Nigel Cox, Dr Adomako, Dr Shipman, Beverley Allitt and Kevin Cobb
- Administration of drug by epidural instead of intravenous injection
- Offence of ill-treatment or wilful neglect
- Defences
- Criminal injuries compensation

How can I get the most from my study?

This chapter discusses sections at the start of each chapter provide you with an instant point of reference that highlights what you can expect to learn within each chapter. You can use these as a checklist of key concepts during the course of your reading.

Will difficult concepts in law be presented in a manageable way?

Diagrams and **flowcharts** are used throughout to highlight complex legal processes.

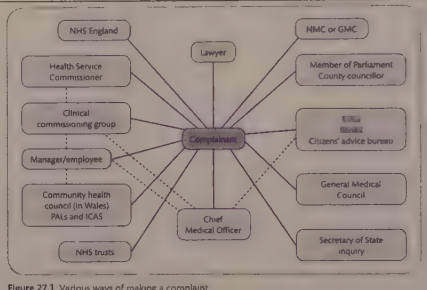


Figure 27.1 Various ways of making a complaint

Box 1.3 Some forms of civil action

1 Torts
- Negligence
- Trespass to property
  - to land
  - and to the person
- False imprisonment
- Wrongful interference
- Breach of a statutory duty
- Nuisance
- Defamation
- Malicious prosecution
- Deliberate interference with interests in trade or business

2 Breach of contract

Summary information boxes pick out key points, examples and list the essential information and legal principles of a given topic. These can be found at regular intervals throughout chapters.

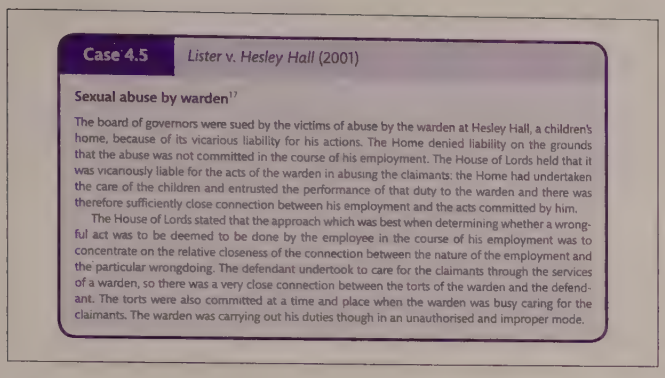
How can I contextualise all the theory I'll be learning?

Use the **practical dilemmas** located throughout the text to test that you understand the topics you are reading in relation to possible real life situations.

Practical Dilemma 2.1 Theft

A discrepancy is found between the ward drug control records and the stock. An investigation is initiated and suspicion falls upon Staff Nurse Jarvis. The police are brought in and, after making their enquiries, they decide that Staff Nurse Jarvis should be charged with the offence of theft.

A situation such as this involves several kinds of investigation. The NHS trust will be concerned to determine whether there are grounds to discipline and possibly eventually dismiss the staff nurse. The fact that the police are brought in does not mean that the NHS trust can abandon its own investigation, but clearly its enquiries should not conflict with those of the police. The NHS trust must allow the staff nurse to give a full explanation of what has occurred and she should be allowed a representative. Disciplinary proceedings by the employer are discussed in chapter 10. There is also the possibility of a hearing before the Conduct and Competence Committee (CCC) of the Nursing and Midwifery Council (NMC) (see chapter 11), but this may well be postponed pending the outcome of the police investigations and criminal charges. Here we are concerned only with the criminal proceedings.



Case 4.5 *Lister v. Hesley Hall* (2001)

Sexual abuse by warden[17]

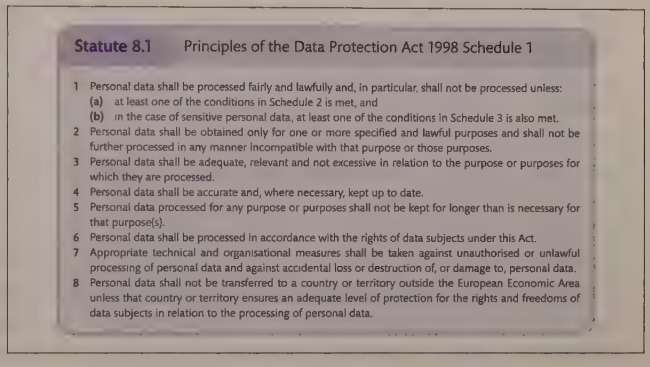
The board of governors were sued by the victims of abuse by the warden at Hesley Hall, a children's home, because of its vicarious liability for his actions. The Home denied liability on the grounds that the abuse was not committed in the course of his employment. The House of Lords held that it was vicariously liable for the acts of the warden in abusing the claimants: the Home had undertaken the care of the children and entrusted the performance of that duty to the warden and there was therefore sufficiently close connection between his employment and the acts committed by him.

The House of Lords stated that the approach which was best when determining whether a wrongful act was to be deemed to be done by the employee in the course of his employment was to concentrate on the relative closeness of the connection between the nature of the employment and the particular wrongdoing. The defendant undertook to care for the claimants through the services of a warden, so there was a very close connection between the torts of the warden and the defendant. The torts were also committed at a time and place when the warden was busy caring for the claimants. The warden was carrying out his duties though in an unauthorised and improper mode.

How will I know which are the most relevant cases and statutes to be aware of?

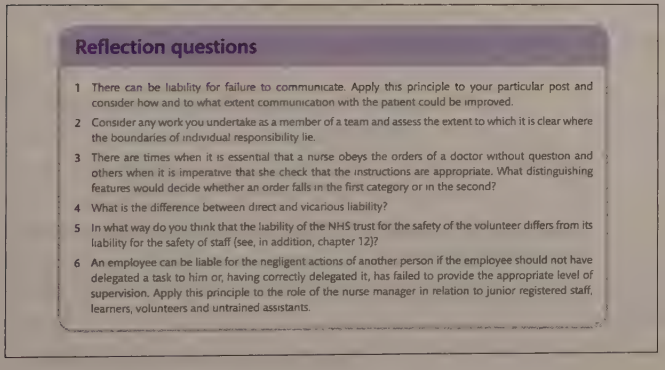
Key case boxes explicitly highlight the key facts and related legal principle of the essential cases you need to know.

Key statute boxes identify some of the most important statutory provisions and articles to learn for your studies.



Statute 8.1 Principles of the Data Protection Act 1998 Schedule 1

1 Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless:
   (a) at least one of the conditions in Schedule 2 is met, and
   (b) in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.
2 Personal data shall be obtained only for one or more specified and lawful purposes and shall not be further processed in any manner incompatible with that purpose or those purposes.
3 Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
4 Personal data shall be accurate and, where necessary, kept up to date.
5 Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose(s).
6 Personal data shall be processed in accordance with the rights of data subjects under this Act.
7 Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.
8 Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.



Reflection questions

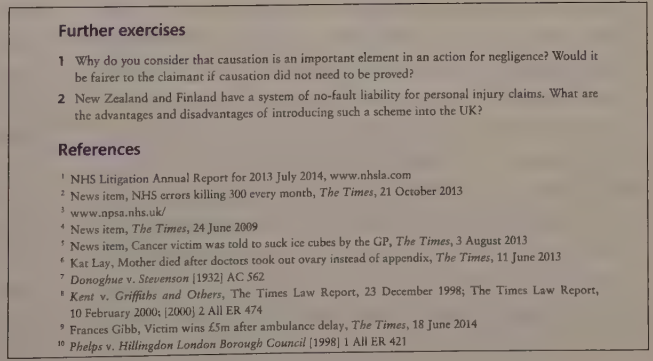
1 There can be liability for failure to communicate. Apply this principle to your particular post and consider how and to what extent communication with the patient could be improved.
2 Consider any work you undertake as a member of a team and assess the extent to which it is clear where the boundaries of individual responsibility lie.
3 There are times when it is essential that a nurse obeys the orders of a doctor without question and others when it is imperative that she check that the instructions are appropriate. What distinguishing features would decide whether an order falls in the first category or in the second?
4 What is the difference between direct and vicarious liability?
5 In what way do you think that the liability of the NHS trust for the safety of the volunteer differs from its liability for the safety of staff (see, in addition, chapter 12)?
6 An employee can be liable for the negligent actions of another person if the employee should not have delegated a task to him or, having correctly delegated it, has failed to provide the appropriate level of supervision. Apply this principle to the role of the nurse manager in relation to junior registered staff, learners, volunteers and untrained assistants.

How can I check I've understood what I've read?

Reflection questions at the end of each chapter can be used to test that you have followed and understood the key issues raised within the chapter.

How can I develop my understanding from the chapter?

Further exercises at the end of each chapter provide practical tasks that will help you apply what you have learnt and extend your knowledge.



Further exercises

1 Why do you consider that causation is an important element in an action for negligence? Would it be fairer to the claimant if causation did not need to be proved?
2 New Zealand and Finland have a system of no-fault liability for personal injury claims. What are the advantages and disadvantages of introducing such a scheme into the UK?

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An NHS Foundation Trust v *P* [ewhc 1650 Fam, **349, 351**
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An Adoption (re) (surrogacy) [1987] 2 All ER 826, **592**
An NHS Trust v *DE* [2013] EWHC 2562 Fam, **431, 478**
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Adesina v *NMC; Baines* v *NMC* [2013] EWCA Civ 818, **291**
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Aintree University Hospital NHS Foundation Trust v *James* [2013] UKSC 67, **171, 767**
Airedale NHS Trust v *Bland* [1993] 1 All ER 821, **761**
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AK (adult patient: medical treatment: consent) (re) [2001] 1 FLR 129, **761**
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Assisted Reproduction and Gynaecology Centre and Anor v *HFEA* [2013] EWHC 3087, **589**
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Balabel and Another v *Air India*, The Times Law Report, 19 March 1988, **196**
Balamoody v *UKCC*, The Independent, 15 June 1998, **284**
Ball v *Wirral HA* [2003] WLR 117, **87**
Barber v *Somerset CC*, The Times Law Report, 5 April 2004 HL, **328**
Barchester Healthcare Ltd v *Tayeh* [2013] EWCA Civ 29, **256**
Barker v *Corus (UK) Plc* [2006] UKHL 20; [2006] 3 All ER 785, **319**
Barnett v *Chelsea HMC* [1968] 1 All ER 1068, **57**
Barrett v *Enfield LBC* [1999] 2 FLR 426, **48**
Barnet Primary Care Trust v *X* [2006] EWHC 787; (2006) BMLR 17, **627**
Barr v *Matthews* (2000) 52 BMLR 217, **424**
Bartholomew v *London Borough of Hackney* [1999] IRLR 448, **234**
Bates van Winkelhof v *Clyde and Co LLP* [2014] UKSC 32, The Times Law Report, 4 June 2014, **93**
Bellinger v *Bellinger* [2003] UKHL 21; [2003] 2 WLR 1174, **15**
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British Home Stores v *Birchell* [1978] IRLR 379 **259**
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Buckland v *Bournemouth University Higher Education Corporation* [2010] EWCA Civ 121 **257**
Bucks and Others v *Nottinghamshire NHS Trust* [2006] EWCA Civ 1576, **322**
Bull and Anor v *Hall and Anor* [2013] UKSC 73, **18, 264**
Burley v *Langley* [2006] EWCA Civ 1778 [2007] 2 All ER 462, **256**

C v *S* [1987] 1 All ER 1230, **423**
C (re) (a child: immunisation: parental rights); and Others [2003] 3 FCR 156 CA, **698**
C (re) (a minor) (medical treatment – refusal of parental consent) [1997] 8 Lloyd's Rep Med 166 CA; [1997] 1 All ER 906 also known as *T(re)* [1997], **358**
C (re) (a minor) (wardship, medical treatment) [1989] 2 All ER 782, **401**
C (re) (a minor: wardship: surrogacy) [1985] FLR 846, **591**
C (re) (an adult) (refusal of medical treatment) [1994] 1 All ER 819; (1993) 15 BMLR 77, **161, 163, 544, 545, 636**
C (re) (HIV Test) [1999] 2 FLR 1004, **694**
CA (re) (a baby) [2012] EWHC 2190, **392**
Campbell v *MGN Ltd* [2004] UKHL 22; [2004] 2 AC 457 HL, **189**
Canterbury v *Spence* [1972] 464 F 2d 772, **174**
Cassidy v *Ministry of Health* [1939] 2 KB 14, **83**
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CD v *ST* [2014] EUECJ 167/12, **249**
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Century Insurance Co. Ltd v *Northern Ireland Road Transport Board* [1942] 1 All ER 491, **78, 80**
Chatterton v *Gerson* [1981] 1 All ER 257, **160**
Chester v *Afshar*, TLR, 13 June 2002; [2002] 3 All ER 552 CA, **175**

Chester v *Afshar*, TLR, 19 October 2004 HL; [2004] UKHL 41; [2004] 3 WLR 927, **175**
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Chinchen v *University Hospital of Wales Healthcare NHS Trust*, 8 November 2001, Current Law 340 April 2002, **176–7**
CIORAP v *Moldavia* [2007] ECHR 502, **166**
Clark v *Chief Constable of Essex* [2006] EWHC 229; (2006) 103(38) LSG 32, **335, 336**
CNWL NHS Foundation Trust v *H-JH* [2012] UKUT 210, **551**
Colclough v *Staffordshire CC*, 30 June 1994, Current Law 208, October 1994, **333**
Coles v *Reading HMC* (1963) 107 SJ 115, **69**
Commissioners for Revenue and Customs v *Annabels (Berkley Square) Ltd and Others*, The Times Law Report, 13 May 2009, **253**
Commission of the European Communities v *UK* (C484/04); [2006] 1 RLR 888 ECJ, **252**
Connor v *Surrey CC*, The Times Law Report, 29 March 2010, **48**
Coombs v *Dorset NHS Primary Care Trust* [2013] EWCA Civ 471, **532**
Cox v *Sun Alliance*; (2001) EWCA Civ. 649; [2001] IRLR 448 CA, **234**
CP (a child) First Tier Tribunal (criminal injury compensation) [2014] EWCA Civ 1554, **390, 802**
Craner v *Dorset CC*, The Times Law Report, 27 February 2009, **304**
Crawford v *Charing Cross Hospital*, The Times Law Report, 8 December 1953, **56**
Criminal Injuries Compensation Authority v *First-Tier Tribunal*, The Times Law Report, 21 February 2014, **41**
Croskery v *Belfast University*, NINHC/QB/2010/129; www.idras,ac.uk, **491**

D v *Bury MBC*, The Times Law Report, 24 January 2006; [2006] 1 WLR 917, **367**
D v *East Berkshire Community Health NHS Trust; MAK* v *Dewsbury Healthcare NHS Trust; RK* v *Oldham NHS Trust* [2005] 2 AC 373, **366**
D (re) v *NSPCC* [1977] 1 All ER 589, **497**
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D (re) (a child) [2003] EWCA Civ 182; [2005] UKHL 33, **586**
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D (re) (a minor: wardship, sterilisation), [1976] 1 All ER 327, **355, 477**
D (re) (medical treatment: consent: termination) v *An NHS Trust* [2004] 1FLR 1110, **478**
Davies v *Barking, Havering & Brentwood HA.* [1993] 4 Lloyd's Rep Med 85, **160**
Davies v *Eli Lilly and Co.* [1987] 1 All ER 801, **196**
Daw v *Intel Corp (UK) Ltd* [2007] EWCA Civ 70; [2007] 2 All ER 126; (2007) 104(8) LSG 36, **329**
DD v *Durham CC* [2013] EWCA Civ 96, **541**
DH NHS Foundation Trust v *PS* [2010] EWHC 1217 **165**
Deacon v *McVicar and Another*, 7 January 1984 QBD, **87, 196, 223, 566**
Dickson and Another v *UK*, The Times Law Report, 21 December 2007; [2007] ECHR 1050, **18, 579**
Dobell v *Thanet DC*, 22 March 1999, Current Law August 2000 No. 527, **308**
Donoghue v *Stevenson* [1932] AC 562, **46**
Doogan and Anor (re) Judicial Review [2012] Scot CS CSOH 32, **420**
Doogan and Anor v *NHS Greater Glasgow and Clyde Health Board* [2014] UKSC 68, **420**
Dothie v *NMC* [2012] EWHC 3021, **384**
Doy (a child) v *Gunn* [2013] EWCA Civ 547, **54**
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Dunhill v *Burgin*, The Times Law Report, 28 March 2014; [2014] UKSC 18, **165, 467**
Dunnachie v *Kingston upon Hull C.C.* [2004] 1 RLR 727, **259**
Dwyer v *Roderick*, 20 June 1984 QBD, **73, 732**

E and Others v *UK* (Application No. 33218/96), The Times Law Report, 4 December 2002 ECHR, **366**
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E (re) (medical treatment: anorexia) [2012] EWCOP 1639, **771**
Early v *Newham HA* [1994] 5 Lloyd's Rep Med 214, **53**
Eisai Ltd v *NICE (Alzheimer's Society and Shire Pharmaceuticals Ltd interested parties)* [2007] EWHC 1941, **104**
Elizabeth Warren v *Care Fertility (Northampton) Ltd and Other* [2014] EWHC 602 Fam, **590**
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Evans v *Amicus Healthcare Ltd and Others*, The Times Law Report, 30 June 2004; [2004] EWCA 727, **590**

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Eweida and Others v *UK* [2013] ECHR 37, **263**
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Express & Echo Publications Ltd v *Taunton*, The Times Law Report, 7 April 1999; [1999] EWCA Civ 949, **82**
Ezsias v *North Glamorgan NHS Trust* [2007] EWCA Civ 330, **90**

F v *F* [2013] EWHC 2683 Fam, **699**
F and Another v *Secretary of State for the Home Department* [2010] UKSC 17, **18**
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F (re) (in utero) [1988] 2 All ER 193, **392, 399, 422**
F (re) (mental patient: sterilisation) see F (re) v *W Berkshire HA and Another*
F (re) v *West Berkshire HA* [1990] 2 AC 1; [1989] 2 WLR 1025; [1989] 2 All ER 545, **17, 160, 167, 183, 389, 430, 462, 477, 531, 636**
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Fischer v *Diffley* [2013] EWHC 4567, **784**
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Foumeny v *University of Leeds* [2003] EWCA Civ. 557; [2003] ELR 443, **329**
Fraser v *Winchester HA*, The Times Law Report, 12 July 1999 CA, **322**
Freeman v *Home Office* [1984] 1 All ER 1036, **157**
Frenchay NHS Trust v *S*, The Times Law Report, 19 January 1994 CA, **761**
Froom v *Butcher* [1975] 3 All ER 520, **144**
Fulham Leisure Holdings Ltd v *Nicholson Graham and Jones (a firm)* [2006] EWHC158 Ch; [2006] 2 All ER 599, **196**

G v *E and Ors* [2010] EWHC 621 Fam, **467, 471**
G v *E* [2010] EWCA 822 Civ, **471**
G (re) (shared residence order: biological mother of donor egg) [2014] EWCA Civ 336, **580**
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Glass v *UK*, The Times Law Report, 11 March 2004, ECHR, **356**
GJ v *The Foundation Trust* [2009] EWHC 2972 Fam, **466**
Gold v *Essex CC* [1942] 2 All ER 237, **75**
Gold v *Haringey HA* [1987] 2 All ER 888, **177, 433**
Google Spain SL, Google In v *Agencia Espnaola de Protection Datos, Mario Costeja Gonzalez*, Case C-131/12, 13 May 2014 ECJ, **187, 188**
Gorringe v *Calderdale MBC* [2004] UKHL 15; [2004] 1 WLR 1057, **48**
Gough v *Thorne* [1966] 3 All ER 398 CA, **144**
Gouldbourn v *Balkan Holidays Ltd*, The Times Law Report 3 May 2010, **52**
Grainger plc v *Nicholson*, The Times Law Report, 11 November 2009, **263**
Grant v *UK* [2003] (32570/03) 44 EHRRI, **238**
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Gray v *ThamesTrains Ltd and Another*, The Times Law Report, 9 July 2008 CA; [2008] EWCA Civ 713, **60**
Gray v *Thames Trains Ltd and Another*, The Times Law Report, 10 June 2009; [2009] UKHL 33, **61**
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Greatorex v *Greatorex & another (Pope Pr20 Defendant)* [2000] 4 All ER 769, **62**
Great Western Hospitals NHS Foundation Trust v *AA and Others* [2014] EWHC Fam, **161, 389**
Green v *DB Group Services (UK) Ltd* [2006] EWHC 1898; [2006] 1RLR 754, **335**
Greens and MT v *UK* [2011] ECHR 686, **18**
Gregg v *Scott* [2005] UKHL 2; Lloyd's Rep Med 3, **60, 142**
Groom v *Selby* [2001] EWCA Civ 1522; [2000] PIQR P201 CA, **433**
Guillietta Galli-Atkinson v *Sudhaker Seghal*, [2003] 6 Lloyd's Rep Med 285, **63**

H (a healthcare worker) v *Associated Newspapers Ltd; H (a healthcare worker)* v *N (a HA)* [2002] Civ 195; [2002] Lloyd's Rep Med 210 CA, **200, 695**
Halford v *UK* (1997) 24 EHRR 523; [1997] IRLR 471; [1998] Crim LR 753, **254**
Halfpenny v *IGE Medical System Ltd* [1999] 1 FLR 944 CA, **249**
Harcourt (re) sub nom Public Guardian v *A* [2012] WTLR 1779, **526**
Hardman v *Admin* [2000] Lloyd's Law Rep Med 498, **432**
Harford v *NMC* [2013] EWHC 696, **290**
Harris v *Newcastle HA* [1989] 2 All ER 273, **136**
Harrison v *Surrey County Council and others*, The Times Law Report, 27 January 1994, **69**
Hart v *Brown* 289 A 2d 386 Conn, 1972, **452**
Hatton v *Sutherland; Baker Refractories Ltd*, The Times Law Report, 12 Feb 2002; [2002] EWCA 76; [2002] 2 All ER 1, **327**

Hawley v *Luminar Leisure Ltd* [2006] EWCA Civ 18, **83**
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Health Professions Council v *The Information Commissioner* [2008] UKITEA/2007/0116, 14 March 2008, **209**
Heart of England NHS Foundation Trust v *JB* [2014] EWHC 342, **162, 545**
Hedley Byrne v *Heller* [1963] 2 All ER 575 HL, **234**
Hefferon v *Committee of the UKCC*, Current Law, May 1988 221, **288**
Heil v *Rankin* [2000] EWCA 84; [2000] 2 WLR 1173, **142**
Hill v *Chief Constable of West Yorkshire* [1989] AC 53 HL, **48**
Hilton v *Thomas Burton (Rhodes) Ltd* [1961] 1 WLR 705, **81**
HJ (Ivan) v *Secretary of State for the Home Department and HT (Cameron)* v *Secretary of State for the Home Department*, UKSC, The Times Law Report, 9 July 2010, **19**
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Hobbs, Richards, Walsh, Goon v *UK*, The Times Law Report, 27 November 2006, **19**
Hodkin and Anor, R (on the application of) v *Register General of Births, Deaths and Marriages* [2013] UKSC 77, **263**
Hotson v *East Berkshire HA* [1987] AC 750, **59**
Hounga v *Allen (Anti-Slavery intervening)*, The Times Law Report, 6 August 2014, **263**
Hunter v *Mann* [1974] 1 QB 767, **197, 568**
Hurditch v *Sheffield HA* [1989] 2 All ER 869, **141**
Hussain v *Bradford Teaching Hospital NHS Foundation Trust* [2011] EWHC 2914, **60**

IM v *LM and Another* [2014] EWCA 37, **470**
Independent News and Media Ltd and Others v *A*, The Times Law Report, 17 November 2009; [2009] EWHC 2858, **678**
Inman v *Cambridge HA*, Jan 1998 (taken from 'Quantum of Damages' Vol 2, Kemp & Kemp, Sweet & Maxwell 1998 edition), **151**
Innes v *Information Commissioner and Another*, The Times Law Report, 8 August 2014 **209**
Isagheli v *NMC* [2014] EWHC 127, **284**

J Council v *GU* [2012] EWHC 3531 COP, **468**
J (re) (a minor) (wardship, medical treatment) [1990] 3 All ER 930, **402**
J (re) (a minor) (wardship, medical treatment) [1992] 4 All ER 614, **402**
JD v *E Berkshire Community NHS Trust, N Staffordshire Hospital NHS Trust & Others*, [2003] 1 Lloyd's Rep Med 9; [2005] UKHL 23; [2005] 2 All ER 443, **366**
JD v *Mather* [2012] EWHC 3063 QB, **60**
JE v *DE;* Sub nom *DE (re)* [2006] EWHC 3459 Fam, **626**
Jepson v *Chief Constable of West Mercia* [2003] EWHC 3318, **418**
Jessemey v *Rowstock Ltd and Another*, The Times Law Report, 15 April 2014, **268**
JM v *UK*, application no 37060/06, The Times Law Report, 11 October 2010, **264**
Johnson v *Medical Defence Union* [2007] EWCA 262, **188**
Jolley v *Sutton London Borough Council* [2000] 1 WLR 1082; [2000] 2 All ER 409, **59, 310**
Jonathan Yearworth and Others v *North Bristol NHS Trust* [2009] EWCA Civ 37, **588**
Jones v *Manchester Corporation* CA [1952] 2 All ER 125, **85**
JP v *LP and Ors* [2014] EWHC 595 Fam, **594**

K (a child) (medical treatment: declaration) [2006] EWHC 1007; [2006] 2 FLR 883, **401**
Kay v *Ayrshire and Arran Health Board* [1987] 2 All ER 417, **58**
Kay v *Northumberland Healthcare NHS Trust* 2001, www.pcaw.co.uk/policy_pub, **92**
Kelly v *Kelly* [1997] SLT 896, **423**
Kennedy v *Charity Commission* [2014] UKSC 20, **209**
Kennedy v *UK*, application no 26839/05, The Times Law Report, 3 June 2010, **18**
Kent v *Griffiths & Others*, The Times Law Report, 23 December 1998, The Times Law Report, 10 February 2000; [2000] 2 All ER 474, **47, 565**
Khan v *UK*, application no 47486/06, The Times Law Report, 3 February 2010, **18**
King v *Sussex Ambulance NHS Trust* [2002] EWCA 953; [2002] 1 CR 1413, **331**
Knauer v *Ministry of Justice* [2014] EWHC 2553, **139**

L v *UK* (application no 45508/99) [2004] ECHR 720, The Times Law Report, 19 October 2004, **464**
L (re) (care proceedings: disclosure to third parties) [2000] 1 FLR 913, **201**
LC (re) (children) (custody: habitual residence), The Times Law Report, 21 January 2014, **375**
Lee v *South West Thames Regional Health Authority*; [1985] 2 All ER 385, **195**
Leeds Teaching Hospital NHS Trust v *Mr A, Mrs A, YA & ZA (by their litigation friend the Official Solicitor), the Human Fertilisation & Embryology Authority, Mr B & Mrs B* [2003] 3 Lloyd's Rep Med 151, **588**
Leigh v *Gladstone* (1909) 26 The Times Law Report 139, **166**
Less v *Hussein* [2012] EWHC 3513 QB, **63**
Liberty and Others v *UK*, The Times Law Report, 11 July 2008, **190**

Lister & others v *Helsey Hall Ltd*, The Times Law Report, 10 May 2001; [2001] 2 WLR 1311, **80**
Lister v *Romford Ice and Cold Storage Co. Ltd* [1957] 1 All ER 125 HL, **84**
Lloyd v *Grace Smith & Co.* [1912] AC 716; *Morris* v *C.W. Martin & Sons Ltd*; [1965] 2 All ER 725, **78**
Local Authority X v *MM* [2007] EWHC 2003 Fam, **469, 476**
London Borough of Hillingdon v *Neary and Another* [2011] EWCOP 1377, **468, 627**
London Borough of Redbridge v *G and Others* [2014] EWHC; [2014] EWCOP 959; [2014] EWCOP 1361, **511**
Loveday v *Renton and Another*, The Times Law Report, 31 March 1988, **697**

M v *Blackpool Victoria Hospital NHS Trust* [2003] EWHC 1744, **52**
M v *F and H (legal paternity)* [2013] EWHC 1901, **580**
M (re) (best interests: deprivation of liberty) [2013] EWCOP 3456, **467**
M (re) (medical treatment: consent) [1999] 2 FLR 1097, **354, 452**
MA v *Secretary of State for Health* [2012] UKUT 474, **535**
MD v *Nottinghamshire Healthcare NHS Trust* [2010] UKUT 59, **542**
MAGA v *Trustees of Birmingham Archdiocese of the Roman Catholic Church* [2010] EWCA 256 **80**
Malette v *Shulman* [1991] 2 Lloyd's Rep Med 162, **168, 447**
Manjaz v *UK* (application no 2913/06), The Times Law Report, 9 October 2012; [2012] ECHR 1704, **545**
Marper v *UK* [2007] EHCR 110, application nos 30562/04 and 30566/04, **210**
MB (re) (adult medical treatment) [1997] 2 FLR 426, **161, 162, 385, 387–8, 446, 470, 545, 636, 757**
Mc Caughey and Others v *UK*, The Times Law Report, 4 October 2013 ECHR, **776**
McCormack v *Redpath Brown*, The Times Law Report, 24 March 1961, **87**
McDaid v *NMC* [2013] EWHC 586, **282**
McDonald v *UK*, application no 4241/12 ECHR, The Times Law Report, 20 May 2014 ECHR 492, **18, 626**
McE v *Prison Services of Northern Ireland and Another; C and A* v *Chief Constable of the Police Service of Northern Ireland; M* v *Chief Constable of the Police Service of Northern Ireland*, The Times Law Report, 12 March 2009, **196**
McFarlane & Another v *Tayside HA* [1999] 4 All ER 961 HL; [2000] 2 AC 59, **431–2, 434**
McGlinchey & Others v *UK* [2003] Lloyd's Rep Med 265, **16**
McKay v *Essex AHA* [1982] 2 All ER 771, **400**
McLoughlin v *O'Brian* [1982] 2 All ER 298, **61**
McPake v *SRCL Ltd* [2013] CSOH 157, **313**
Majrowski v *Guy's and St Thomas's NHS Trust* [2006] UKHL 34; [2007] 1 AC 224; [2005] 1CR 977, **80, 335**
MAK and RK v *UK*, The Times Law Report, 19 April 2010 ECHR; [2010] 363 ECHR, **352, 366, 367**
Marley v *Rawlings and Another*, The Times Law Report, 28 January 2014 UKSC, **784**
Maynard v *West Midlands RHA* [1984] 1 WLR 634, **51**
Meadows v *GMC* [2006] EWCA Civ 1390; [2007] 1 All ER 1, **231**
Meiklejohn v *St Geargе's Healthcare NHS Trust* [2014] EWCA Civ 120, **176**
Mental Health Trust and Anor v *DD and Anor* [2014] EWCOP 11, **162**
Mersey Care NHS Trust v *Ackroyd* [2007] EWCA 101, **700**
Mersey Docks and Harbour Board v *Coggins and Griffith (Liverpool) Ltd* [1947] AC1 HL, **83**
MH v *UK* [2006] AC 441; [2013] ECHR 1008, **468, 535**
Michael Hyde & Assoc Ltd v *JD Williams & Co Ltd*, The Times Law Report, 4 Aug 2000, **52**
Michael John Durant v *Financial Services Authority* [2003] EWCA Civ 1746, **185**
Ministry of Justice v *Carter* [2010] EWCA Civ 694, **51**
Morgan v *Phillips* [2006] All ER (D) 189 March, **482**
Mosley v *News Group Newspapers* [2008] EWHC 1777, **190**
Moyhing v *Barts and London NHS Trust* [2006] IRLR 860, **270**
Mrs U v *Centre for Reproductive Medicine* [2002] Lloyd's Rep Med 259 CA, **590**
Mughal v *Reuters Ltd* [1993] IRLR 571, **336**

N v *Chief Constable of Merseyside Police* [2006] EWHC 3041 QB, **80**
N v *Secretary of State for the Home Department* [2005] UKHL 31, **695**
Napier and Another v *Pressdram Ltd*, The Times Law Report, 2 June 2009, **192**
NHS Manchester v *Fecitt and Others* [2011] EWCA 1190, **91**
NHS Trust v *AW* [2013] EWCOP 78, **762**
NHS Trust v *DJ and Others* [2012] EWHCOP 3524, **762**
NHS Trust v *Dr A* [2013] EWHC 2442 COP, **467**
NHS Trust v *Ms T* [2004] EWHC 1279, **161**
NHS Trust A v *D and Others* [2000] Lloyd's Rep Med 411, **15**
NHS Trust A v *M; NHS Trust B* v *H*; [2001] 1 All ER 801, **15**
Nettleship v *Weston* [1971] 3 All ER 581, **70**
Nicholson v *Halton General Hospital NHS Trust*, Current Law 46 Nov 1999, **193**
Nicklinson R v *Ministry of Justice and Others* [2012] EWHC 304; [2012] EWHC 2381; [2013] EWCA Civ 961, **769–770**
Nicklinson and Anor R (on the application of) (Rev1) [2014] UKSC 38, **11, 770**
Norfolk & Norwich NHS Trust v *W* [1996] 2 FLR 613, **387, 545**

North and Others v *Dumfries and Galloway Council, Equality and Human Rights Commission intervening*, [2013] UKSC 45, **263**
North Glamorgan Trust v *Walters* [2003] 2 Lloyd's Rep Med 49 CA, **63**
N W Lancashire HA v *A, D & G* [1999] Lloyd's Rep Med; (1999) 2 CCL Rep 419; [2000] 1 WLR 977, **104**
Nottinghamshire Healthcare NHS Trust v *RC* [2014] EWCOP 1136, 1317, **162, 546**
Nunnerley & Another v *Warrington HA & Another*, The Times Law Report, 26 Nov 1999; [2000] PIQR 069, **432**

O (re) (a minor) (medical treatment) [1993] 4 Lloyd's Rep Med 272, **357**
O'Brien v *Cunard Steamship Co.* (1891) 28 NE 266, **160**
O'Byrne v *Aventis Pasteur MSD Ltd*, The Times Law Report, 27 May 2010 SC, **313**
Okele v *NMC* [2013] EWHC 714 admin, **384**
O'Neil v *DSG Retail Ltd*, TLR, 9 Sept 2002; [2002] EWCA 1139; [2003] ICR 222, **331**
Orwell v *Salford Royal NHS Foundation Trust* [2013] EWHC 3245 QB, **57**

P and Q v *SurreyCC* [2011] EWCA Civ 190, **467**
P (by his litigation friend the Official Solicitor) v *Cheshire West and Cheshire Council and Anor* [2014] UKSC 19, **17, 49, 173, 267, 467, 512, 626**
P (re) (abortion) [2013] EWHC 50; [2013] MHLO (mental health law online) 1 COP, **429**
P (re) (a child) [2013] EWHC 4048 Fam, **389**
P (re) (a minor) [1981] 80 LGR 301, **427**
P v *Hillingdon Hospital NHS Trust*, (2000) AVMA Medical Journal, 6, 6 p. 253, **520**
Palmer v *Tees HA & Another*, The Times Law Report, 1 June 1998; [1998] Lloyd's Rep Med 447 QBD, **62**
Palmer & Tees HA & Another, (2000), 2 LGLR 69 CA, **62**
Parkinson v *St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530, **433, 434**
Paton v *Trustees of British Pregnancy Advisory Service* [1978] 2 All ER 987, **423**
Paton v *UK* (1980) 3 EHRR 408, **18, 423**
Pearce v *United Bristol Healthcare Trust*, (1998) 48 BMLR 118 CA, **175**
Penney, Palmer & Cannon v *E Kent HA* [2000] Lloyd's Rep Med; [2000] p. 41 CA, **52, 645**
Perry v *NMC* [2013] EWCA Civ 145, **280**
PH v *Local Authority* [2011] EWHC 1704, **169**
Pharmaceutical Society of Great Britain v *Logan*, (1982) Crim. LR 443, **33**
Phelps v *Hillingdon LBC* [1998] 1 ALL ER 421, **47**
Phelps v *Hillingdon LBC; Anderton* v *Clwyd CC; Jarvis* v *Hampshire CC; G (re) (a minor) (Bromley);* [2000] 4 All ER 504, **47**
Pickford v *Imperial Chemical Industries plc*, The Times Law Report, 30 June 1998 HL, **336**
Pierce v *Doncaster Metropolitan Borough Council*, The Times Law Report, 27 December 2007, **360**
Poland v *Parr and Sons* [1926] All ER 177 CA, **78**
Popple v *Birmingham Women's NHS Foundation Trust* [2012] EWCA Civ 1628, **392**
Prendergast . Sam Dee Ltd and Others, The Times Law Report, 14 March 1989, **730**
Pretty v *UK* [2002] ECHR **427**
Public Guardian v *Boff* [2013] WTLR 1349, **526**
Public Prosecution Service of Northern Ireland v *Elliott and Another*, The Times Law Report, 18 June 2013, **211**

Q (re) (parental order) [1996] 1 FLR 369, **592**

R v *Adomako* [1995] 1 AC 171; [1994] 3 All ER 79, **33**
R v *Ahmed*, The Times Law Report, 6 September 2010, **425**
R v *Arthur* (1981) 12 BMLR 1, **358**
R v *Bodkin Adams* [1957] Crim LR 365, **33, 755**
R v *Bourne* [1939] 1KB 687, **426**
R v *Bournewood Community & Mental Health NHS Trust ex parte L* [1998] 3 All ER 289; [1999] AC 458, **17, 464**
R v *Broadmoor Special HA* [2002] 1 WLR 419, **463**
R v *Brown and Others*, House of Lords, The Times Law Report, 12 March 1993, **157, 167**
R v *Burns*, The Times Law Report, 10 June 2010, **311**
R v *Cambridge HA ex parte B (a minor)* (1995) 23 BMLR 1 CA; [1995] 2 All ER 129, **103**
R v *Cardiff Crown Court ex parte Kellam*, The Times Law Report, 3 May 1993, **202**
R v *Central Birmingham HA ex parte Walker* (1987) 3 BMLR 32 CA, **103**
R v *Chargot and Others*, The Times Law Report, 16 December 2008, **300**
R v *Chaylor, Morley, Devine and Hanningfield*, The Times Law Report, 23 August 2010, **23**
R v *Collins ex parte Brady*, (2001) 58 BMLR 173; [2000] Lloyd's Rep Med 355, **166, 544**
R v *Cooper*, The Times Law Report, 7 August 2009, **158**
R v *Cox*, The Times Law Report, (1992) 12 BMLR 38, **33**
R v *Dawes; R* v *Hatter; R* v *Bowyer*, The Times Law Report, 25 July 2013 CA Crim, **39**
R v *Dhingra* (1991) unreported, **426**
R v *Dica* [2004] EWCA Crim 1103, **695**
R v *Dixon (Reginald)* [1995] (unreported), **426**
R v *DH ex parte Source Informatics Ltd* [1999] Lloyd's Rep Med 264; [1999] 4 All ER 185, **205**

R v *DH ex parte Source Informatics Ltd* [2000] The Times Law Report 17; [2000] 1 All ER 786 CA, **205**
R v *Ethical Committee of St Mary's Hospital ex parte Harriot*, The Times Law Report, 27 October 1987; [1988] 1 FLR 512, **585**
R v *Family HS Appeal Authority ex parte Mualidhar* [1999] COD 80, **632**
R v *H; R* v *C*, The Times Law Report, 6 February 2004; [2004] 2 WLR 335, **195**
R v *Hamilton*, The Times Law Report, 16 Sept 1983, **422**
R v *Hillingdon Health Authority ex parte Wyatt*, The Times Law Report, 20 December 1977 CA, **634**
R v *Hinks* [2001] 2 AC 241, **682**
R v *Horncastle and Another; R* v *Marquis and Another*, The Times Law Report, 8 December 2009 UKSC, **14**
R v *Hudson* [1965] 1 All ER 721, **476**
R v *Human Fertilisation & Embryology Authority ex parte Blood* [1997] 2 WLR 806, **589**
R v *Hussain (Shabbir)*, The Times Law Report, 17 March 2010, **728**
R v *Inglis*, The Times Law Report, 22 November 2010, **769**
R v *JTB* [2009] UKHL 20, **37**
R v *Killick* [2011] EWCA Crim 1608, **26**
R v *Konzani* [2005] EWCA Crim 706, **695**
R v *Lincolnshire (Kesteven) Justices, ex parte Connor* [1983] 1 All ER 901 QBD, **322**
R v *McLoughlin*, The Times Law Report, 24 February 2014, **19**
R v *Malcherek; R* v *Steel* [1981] 2 All ER 422 CA, **759**
R v *Mid Glamorgan Family HSA, ex parte Martin* [1995] All ER 356, **213**
R v *Nelson Group Services (Maintenance) Ltd*, The Times Law Report, 17 Sept 1998 CA, **302**
R v *North and East Devon HA ex parte Coughlan* [2000] 3 All ER 850; [2000] 2WLR 622, **609**
R v *North Derbyshire HA* [1997] 8 Lloyd's Rep Med 327, **104, 106**
R v *Nursing (Ligaya)* [2012] EWCA Crim 2521, **525**
R v *Parkins (John Robert)* [2012] EWCA Crim 856, **535**
R v *Patel (Parulben)* [2013] EWCA Crim 959, **525**
R v *Porter*, The Times Law Report, 9 July 2008; [2009] EWCA Crim 1271, **299**
R v *Portsmouth Hospitals NHS Trust ex parte Glass* [1999] 2 FLR 905; [1999] Lloyd's Rep Med 367, **355**
R v *Richmond LBC ex parte Watson & Other Appeals* [2001] 1 All ER 436, **548**
R v *Salford Health Authority ex parte Janaway*, The Times Law Report, 2 December 1988; [1998] 3 All ER 1079, **419**
R v *Saunders (Red Damian); R* v *G; R* v *Edwards (Ian Peter)*, The Times Law Report, 17 October 2013, **32**
R v *Secretary of State for Health ex parte Pfizer Ltd* [1999] 3 CMLR 875; Lloyd's Rep Med 289, **105**
R v *Secretary of State for the Home Dept ex parte Mellor* [2000] 2 FLR 951, **18**
R v *Secretary of State for the Home Department ex parte Mellor* [2001] EWCA 472, **18**
R v *Secretary of State for Social Services ex parte Hincks and Others*, Solicitors' Journal, 29 June 1979 436, **102**
R v *Secretary of State for Trade & Industry*, The Times Law Report, 28 June 2001, **252**
R v *Sefton Metropolitan Borough Council ex parte Help the Aged* [1997] 3 FCR 573 CA, **610**
R v *Sheffield HA ex parte Seale* [1994] 25 BMLR 1, **585**
R v *Smith* [1979] Crim Law Report 251, **36**
R v *Tabassum* [2000] 2 Cr App Rep 328, **157**
R v *Twomey, Blake, Cameron and Hibberd*, The Times Law Report, 25 June 2009, **32**
R v *Upper Bay Ltd*, The Times Law Report, 28 April 2010, **301**
R v *Williams*, 24 November 2004, Llanelli Magistrates unreported, **158**
R (Association of the British Pharmaceutical Industry) v *MHRA, the NHS Confederation (Employers) Co Lts interested party*, The Times Law Report, 7 May 2010, Case C-62/09, **747**
R (B) v *Islington LBC*, The Times Law Report, 6 October 2010, **475**
R (E) v *Governing Body of JFS and Another, United Synagogue and Others intervening*, The Times Law Report, 17 December 2009, **262**
R (E) v *Nottingham Healthcare NHS Trust and R (N)* v *Secretary of State for Health*, The Times Law Report, 10 August 2009, **337**
R (Evans) v *Attorney General and Information commissioner* [2014] EWCA 254, **210**
R (F) v *Secretary of State for Justice; R (Thompson)* v *Secretary of State for the Home Department*, The Times Law Report, 22 April 2010, **246**
R (G) v *Southwark LBC*, The Times Law Report, 4 June 2009, **360**
R (Grogan) v *Bexley NHS Care Trust* [2006] EWHC 44, (2006) 9 CCL 188, **609–10**
R (H) v *Secretary of State for Home Dept & Another* [2003] UKHL 59, **531**
R (Hunt) v *North Somerset Council*, The Times Law Report, 20 November 2013 CA, **478**
R (Jones) v *First Tier Tribunal (Social Entitlement Chamber) and Another*, The Times Law Report, 31 May 2013, **41**
R (Kebede and Another) v *Newcastle City Council*, The Times Law Report, 28 October 2013, **360**
R (L) (medical treatment: Gillick competency) [1999] 1 Lloyd's Rep Med 58; [1998] 2 FLR 810, **354**

R (Limbuela) v *Secretary of State for the Home Dept*, The Times Law Report, 9 Feb 2004, **16**
R (McDonald) v *Kensington and Chelsea Royal LBC* [2011] UKSC 11, **626**
R (Manchester City Council) v *St Helens Metropolitan Borough Council*, The Times Law Report, 13 November 2009, **611**
R (Miss Glen Walford) v *Worcestershire CC, (Secretary of State for Health intervening)* [2014] EWHC 234, **614**
R (Modaresi) v *Secretary of State for Health and Others*, The Times Law Report, 8 August 2013, **531**
R (re) (a child) [2003] EWCA 182, **586**
R (re) (a child) (care proceedings), The Times Law Report, 19 July 2000 FD, **391**
R (re) (a minor) (wardship: consent to medical treatment) [1991] 4 All ER 177 CA, **352**
R (Reilly and Another) v *Secretary of State for Work and Pensions*, The Times Law Report, 18 November 2013 UKSC, **19**
R (on the application of Ali) v *Newham LBC* [2012] EWHC 2970, **270**
R (on the application of A & B & Y) v *East Sussex CC (the Disability Rights Commission: an interested party)* Case No. CO/4843/2001, 10 Feb 2003, **332**
R (on the application of Antoniou) v *Central and NW London NHS Foundation Trust* [2013] EWHC 3055, **776**
R (on the application of Assisted Reproduction & Gynaecology Centre) v *Human Fertilisation & Embryology Authority*; [2002] EWCA Civ. 20, The Independent, 6 Feb 2002; [2003] 1 FLR 266 CA, **588**
R (on the application of Axon) v *Secretary of State for Health* [2006] EWHC 37 admin; [2006] 2 WLR 1130, **205, 352**
R (on the application of Burke) v *GMC and Disability Rights Commission and the Official Solicitor to the Supreme Court* [2004] EWHC 1879; [2004] Lloyd's Rep Med 451, **763, 772**
R (on the application of Bishop) v *Bromley LBC* [2006] EWHC 2148, (2006) 9 CCL Rep 635, **507, 736**
R (on the application of Cavanagh, Bhatt and Redmund) v *Health Service Commissioner* [2005] EWCA Civ 1578; [2006] 3 All ER 543, **715**
R (on the application of Chavda) v *Harrow LBC* [2007] EWHC 3064 admin; (2008) 11 CCL Rep 187, **612**
R (on the application of Condliff) v *North Staffordshire PCT* [2011] EWCA 910, **105**
R (on the application of D) v *Secretary of State for the Home Department (Inquest intervening)* [2006] EWCA Civ 143; [2006] 3 All ER 946, **16**
R (on the application of G) v *Nottingham City Council* [2008] EWHC 400, **392**
R (on the application of Gunter) v *South Western Staffordshire PCT* EWAC 1894, **626**
R (on the application of Heather) v *Leonard Cheshire Foundation* [2002] EWCA Civ 366, The Times Law Report, 8 April 2002, **625**
R (on the application of Hurst) v *London Northern District Coroner* [2007] UKHL 13; [2007] 2 All ER 1025, **16, 776**
R (on the application of Ireneschild) v *Lambeth LBC* [2006] EWHC 2354; (2006) 2 CCL Rep 686, **640**
R (on the application of JL) v *Secretary of State for the Home Department* [2007] EWCA Civ 767, **16**
R (on the application of Johnson) v *Havering LBC* [2007] EWCA 26; The Times Law Report, 2 February 2007, **625**
R (on the application of KentCC) v *HM Coroner for Kent (NW District)* [2012] EWHC 2768, **776**
R (on the application of Malik) v *Waltham Forest Primary Care Trust (Secretary of State forHealth interested party)* [2006] EWHC 487 admin; [2006] 3 All ER 71, **17**
R (on the application of Middleton) v *HM Coroner for Western Somerset* [2004] UKHL 10, **776**
R (on the application of N) v *Doctor M & Others*; Lloyd's Rep Med 2 [2003] 81, **544**
R (on the application of Paul and others) v *Deputy Coroner of the Queen's Household and Assistant Deputy Coroner for Surrey)* [2007] EWHC 408; [2007] 2 All ER 509, **778**
R (on the application of Pretty) v *DPP* [2001] UKHL 61; [2001] 3 WLR 1598, **16, 767**
R (on the application of R) v *A Chief Constable* [2013] EWHC 2864 admin, **211**
R (on the application of Rogers) v *Swindon NHS Primary Care Trust and Another* [2006] EWCA Civ 392, **104**
R (on the application of S) v *Plymouth City Council* [2002] EWCA Civ 388, **205**
R (on the application for the Secretary of State for the Home Department) v *Information Tribunal (Information Commissioner interested party)* [2006] EWHC 2958 Admin; [2007] 2 All ER 703, **186**
R (on the application of Smith) v *Secretary of State for Defence, Equality and Human Rights Commissioner intervening* [2010] UKSC 29, The Times Law Report, 8 July 2010, **14, 16**
R (on the application of SSG) v *Liverpool CC, the Secretary of State for Health and LS (interested party)* [2002] EWHC admin 2803 (4000), **531**
R (on the application of Streedharan) v *HM Coroner for the County of Greater Manchester* [2013] EWCA Civ 181, **776**
R (on the application of Touche) v *HM Coroner for Inner London District* [2001] EWCA Civ. 383; [2001] QB 1206 CA, **776**
R (on the application of Wright and others) v *Secretary of State for Health and Another* [2006] EWHC 2888; [2007] 1 All ER 825, The Times Law Report, 16 November 2007 CA, **245**

R (Purdy) v *DPP*, The Times Law Report, 31 July 2009; [2009] UKHL 45, **18, 765, 767**
R (Quintavalle) v *Secretary of State for Health*, The Times Law Report, 5 Dec 2001; [2001] 4 All ER 1013, **587**
R (Quintavalle) v *Secretary of State for Health*, The Times Law Report 25 Jan 2002; [2002] 2 WLR 550, **587**
R (Quintavalle) v *Secretary of State for Health*, The Times Law Report, 14 March 2003; [2003] 2 WLR 692 HL, **587**
R (Quintavalle) v *HFEA* [2002] EWHC 3000; [2003] EWCA Civ 667; [2005] UKHL 28, **596**
R (Savva) v *Kensington and Chelsea Royal LBC*, The Times Law Report, 15 November 2010, **612**
R (Smeaton) v *Secretary of State for Health* [2002] EWHC 610; [2002] 2 FCR 193, **426**
R (Smith) (on the application of) v *Assistant Deputy Coroner for Oxfordshire (Equality and Human Rights Commission intervening)*, The Times Law Report, 20 May 2010 CA, **14**
R (T) v *Chief Constable of Greater Manchester Police and Others*, The Times Law Report, 23 June 2014, **187, 246**
R (Veolia ES Nottinghamshire Ltd) v *Nottinghamshire CC*, The Times Law Report, 9 November 2010, **187**
R (Watts) v *Bedford Primary Care Trust & Another*, The Times Law Report, 3 Oct 2003; [2004] EWCA Civ 166; (C372/04) [2006] ECJ, **102, 104, 105**
R (Wood) v *Commissioner of Police of the Metropolis*, The Times Law Report, 1 June 2009, **206**
Rabone and Another v *Pennine Care NHS Trust* [2012] UKSC 2, **16, 49, 532**
Rance and another v *Mid Downs Health Authority and Anothe* [1991] 1 All ER 801, **422**
Rand v *East Dorset HA* [2000] Lloyd's Rep Med 181, **432**
Ratcliffe v *Plymouth and Torbay HA* [1998] PIQR p170, **138**
RB (by his litigation friend the Official Solicitor) v *Brighton and Hove City Council*, The Times Law Report, 12 June 2014, **466**
Re (on the application of AB) v *HFEA* [2014] nataliegambleassociates,co.uk, **590**
Ready-Mixed Concrete (South-East) Ltd v *Ministry of Pensions and National Insurance* [1968] 1 All ER 433, **81**
Rees v *Darlington Memorial Hospital NHS Trust*, The Times Law Report, 21 Oct 2003 HL; [2002] 2 All ER 177 CA, **433, 434**
RK & MK v *Oldham Communit NHS Trust* [2003] 1 Lloyd's Rep Med 1, **366**
Robb v *Salamis (M and I) Ltd* [2006] EWHL 56; [2007] 2 All ER 97, **331**
Robinson v *Chief Constable of West Yorkshire* [2014] EWCA Civ 15 **48**
Rochdale NHS Trust v *C* [1997] 1 FCR 274, **387**
Roe v *Minister of Health* [1954] 2 QB 66, **55**
Rose v *Plenty* [1976] 1 All ER 97, **78**
RCN v *DHSS* [1981] All ER 545, **420**
RT v *LT and Anor* [2010] EWHC 1910 Fam, **165**
Ruscillo v *Council for the Regulation of Health Care Professionals and Anor; Council for the Regulation of Health Care Professionals* v *NMC and Truscott* [2004] EWCA Civ 1356, **292**

S v *Airedale NHS Trust* 1 [2003] Lloyd's Rep Med 21, **54**
S and Marper v *UK* (application nos 30562/04 and 30566/04), The Times Law Report, 8 December 2008; [2008] ECHR 1581, **210**
S (a child) v *Royal Bournemouth and Christchurch Hospital NHS Trust*, October 2012, (taken from Quantum of Damages Vol 3, Kemp and Kemp, Sweet and Maxwell, B1-014, **141**
S (Coleman) v *Attridge* [2008] ECJ Case C/303/06, 31 January 2008; [2008] 1 CR 1128, **266**
S (re) (a minor) (consent to medical treatment) [1994] 2 FLR 1065, **352**
S (re) (an adult) (refusal of medical treatment) [1992] 4 All ER 671, **163, 387**
S (re) (sterilisation: patient's best interest) [2000] 2 FLR 389, **430**
St George's NHS Trust v *S* [1998] 3 All ER 673, **161, 388, 636**
St George's NHS Trust v *S (Guidelines)* (No. 2) [1999] Fam 26, **388**
Saint Prix v *Secretary of State for Work and Pensions*, (Case C-507/12), The Times Law Report, 26 June 2014, **249**
Savage v *South Essex Partvership NHS Fondation Trust* [2006] EWHC 3562; The Times Law Report, 16 February 2007, **531**
SB (re) (a patient: capacity to consent to termination) [2013] EWHC 1417, **169, 429**
Scott v *Thomas Cook Tour Operators*, The Times Law Report, 13 March 2014, **262**
Secretary of State for Home Department (Respondent) v *Forhah (FC) (Appellant)* [2006] UKHL 46, **436**
Secretary of State for the Home Department v *Robb* [1995] All ER 677, **166**
Selvanayagam v *University of West Indies* [1983] 1 All ER 824, **139**
Shakoor (deceased) v *Situ* [2000] 4 All ER 181, **793**
Shackleford v *NMC* [2014] EWHC 1112, **284**
Sidaway v *Bethlem Royal Hospital Governors and Other* [1985] 1 All ER 643, **173**
Simms v *Simms* [2003] 1 All ER 669, **498**
Simmons v *Castle* [2012] EWCA Civ 1039, **142**
Slade v *Battersea HMC* [1955] 1 WLR 207, **308**
Slater v *UKCC*, TLR, 10 June 1987, **287–8**
Smith v *Leech Brain & Co. Ltd* [1961] 3 All ER 1159 QBD, **59**

Smith v *Tunbridge Wells HA* [1994] 5 Lloyd's Rep Med 334, **175**
Smith and Others v *The Ministry of Defence* [2013] UKSC 41, **14**
Smith (Jean) v *Northamptonshire CC*, The Times Law Report, 24 March 2008, **304**
Smith (Jean) v *Northamptonshire CC*, The Times Law Report, 21 May 2009, **304**
Spencer-Franks v *Kellog Brown and Root Ltd and Another*, The Times Law Report, 3 July 2008 HL, **304**
Stephens v *Avery and Others* [1988] 2 All ER 477, **189**
Strunk v *Strunk* 445 SW 2d 145 (Ky App) 1969, **452**
Stubbings v *Webb* [1993] AC 498, **147**
Sud v *Ealing Borough Council*, The Times Law Report, 23 October 2013 CA, **256**
Szuluk v *UK*, application no 36936/05, The Times Law Report, 3 June 2010, **18**

T v *T* [1988] 1 All ER 613, **428, 430**
T v *UK; V* v *UK* [2000] 2 All ER 1024 ECHR, **37**
T (re) (a child) (surrogacy: residence order) [2011] EWHC 33, **592**
T (re) (a minor) (wardship: medical treatment) [1997] 1 All ER 906, also known as *C (re)* [1997], **403**
T (re) (an adult) (refusal of medical treatment) [1992] 4 All ER 649, **163, 389, 636**
Taaffe v *East of England Ambulance NHS Trust* [2012] EWHC 1335, **54**
Tameside & Glossop Acute Services Trust v *CH* [1996] 1 FLR 762, **387, 545**
Tarasoff v *Regents of University of California*, 17 Cal 3d 425 (1976) (USA), **198**
Thake v *Maurice* [1986] QB 644; [1984] 2 All ER 513, **434**
The Mental Health Trust and Anor v *DD and Anor* [2014] EWCOP 11, **389, 463**
Thomas v *Curley* [2013] EWCA Civ 117, **139**
Thompson v *Bradford* [2005] EWCA 1439, **698**
Thour v *Royal Free Hampstead NHS Trust* [2012] EWHC 1473, **234**
Tracey (on the application of) v *Cambridge University Hospital NHS Trust Foundation and Others* [2012] EWHC 3670; [2014] EWCA Civ 33; [2014] EWCA Civ 822, **763**

Udale v *Bloomsbury AHA* [1983] 2 All ER 522, **431**
UF v *XCC and Others (No 2)* [2014] EWCOP 18, **511**

Van Colle and another v *Chief Constable of Hertfordshire Police* [2006] EWHC 360 QBD; [2006] 3 All ER 963, **16**
Veakins v *Kier Islington Ltd*, The Times Law Report, 13 January 2010, **335**
Vegetarian Society v *Scott* [2013] EWHC 4097, **784**
Venables & Another v *News Group Newspapers Ltd & Others* [2001] 1 All ER 430 Fam, **187, 191**
Vinter and Others v *UK* [2013] ECHR 645, **16**
Vo v *France* [2004] 2 FCR 577 ECHR, **422**

W v *Egdell* [1989] 1 All ER 1089 HC; [1990] 1 All ER 835 CA, **199**
W v *M and Others* [2011] EWCOP 2443, **762**
W (re) (a child) (adoption: leave to oppose adoption order) and In re H (a child) (adoption: leave to oppose adoption order), The Times Law Report, 13 January 2014, **367**
W (re) (children) (Family Proceedings: Evidence), The Times Law Report, 8 March 2010 UKSC, **37**
W (re) (a minor) (medical treatment) [1992] 4 All ER 627, **163, 349, 351**
W and others v *Essex CC & Another* [1998] 3 All ER 111, **48**
W and others v *Essex CC & Another* [2000] 2 All ER 237 HL; [2000] 2 WLR 601; [2000] 1 FLR 657, **48**
W (Court of Protection order) [2014] EWCOP 138, **470**
Waghorn v *CQC* [2012] EWHC 1816, **627**
Walker v *Northumberland CC*, The Times Law Report, 24 Nov 1994 QBD, **327**
Ward v *Tesco Stores Ltd* [1976] 1 WLR 810 HL, **138**
Watkins v *Birmingham City Council*, The Times Law Report, 1 August 1975, **81**
Watling v *Gloucester CC Employment Tribunal*, EAT/868/94, 17 March 1995, 23 Nov 1994, Lexis transcript, **792**
Waugh v *British Railway Board* [1980] AC 521, **195**
Webb v *EMO Air Cargo (UK)*, The Times Law Report, 15 July 1994; [1995] IRLR 645 HL, **249**
Weir v *Chief Constable of Merseyside Police* [2003] EWCA Civ 111 CA, **80**
Wells v *Wells* [1999] AC 345, **142**
Westminster City Council v *Sykes* [2014] EWCOP 139, **757**
Whiston v *London Strategic HA*, The Times Law Report, 4 May 2010; [2010] EWCA 195, **149**
White & Others v *Chief Constable of S Yorkshire Police & Others* [1999] 1 All ER 1, **62**
Whitehouse v *Jordan* [1981] 1 All ER 267, **50**
Whittlestone v *BJP Home Supplies Ltd* [2014] 1 CR 275, **253**
Wilsher v *Essex Area Health Authority* [1986] 3 All ER 801 CA; [1988] 1 All ER 871 HL, **57, 72, 84, 441, 726**
Woodland v *Essex Council* [2013] UKSC 66, **82, 84**
Woolgar v *Chief Counstable of Sussex Police & Another* [1999] 3 All ER 604 CA, **204**
Wright v *Cambridge Medical Group* [2011] EWCA Civ 669, **57**
Wyatt v *Portsmouth Hospital NHS Trust* [2004] EWHC Civ 2247; [2005] EWHC 117; [2005] EWHC 693, **403**

Wyatt v *Portsmouth Hospital NHS Trust* [2005] EWCA Civ 1181, **403**
Wyatt v *Portsmouth Hospital NHS Trust* [2005] EWHC 2293, **403**

X v *Y and Another* [1988] 2 All ER 648, **200, 572, 700**
X and Others v *Bedfordshire CC* [1995] All ER 353, **366**
X (a woman formerly known as Mary Bell) v *SO* [2003] EWHC 1101; [2003] 2 FCR 686, **187**

Y (re) (adult patient) (transplant & bone marrow) (1996) BMLR 111; [1996] 4 Lloyd's Rep Med 204, **452**
YL v *Birmingham City Council and Others* [2007] UKHL 22; The Times Law Report, 21 June 2007, **15, 625**
YM (a child) v *Gloucestershire Hospitals NHS Foundation Trust; Kanu* v *King's College Hospital NHS Trust* [2006] EWHC 820; [2006] PIQR p27, **142**
York City Council v C [2013] EWCA 478, **166**
Young v *Post Office* [2002] EWCA Civ 661; (2002) 1 RLR 660, **329**

Z v *UK* (2002) 34 EHRR 3, **16**
Z and Others v *UK* [2001] ECHR 333, application no 29392/95, **366**

Table of statutes

Abortion Act 1967, **197, 419, 422–4, 426, 427, 429, 478, 582, 802**
S.1(1), **418, 421**
S.4(2), **419**
S.5(1), **418, 421**
Access to Health Records 1990, **211, 213**
S. 3(1)(f), **212**
Access to Justice Act 1999, **13**
Access to Medical Reports Act 1988, **213**
Adoption Act 1958
S.50, **591–2**
Adoption and Children Act 2002, **593**
Administration of Justice Act 1982
S.1(1)(a), **140**
S.2(a), **435**
S.17, **784**
Adults with Incapacity (Scotland) Act 2000, **678–9**
AIDS Control Act 1987, **695**
The Apprenticeships, Skills, Children and Learning Act 2009, **371**

Births and Deaths Registration Act 1953
S.41, **405**
Breastfeeding etc. (Scotland) Act 2005
S.2, **395**

Care Standards Act 2000, **117, 245, 521, 639, 663**
S.5, **112**
S.82(4)(b), **245**
Care Act 2014, **93, 102, 118–19, 180, 191, 311, 360, 469, 495–6, 501–2, 521–3, 548, 614–25, 626–7, 629, 638, 647, 664, 676, 801**
S.1, **20, 615, 617**
S.2, **615, 617, 619**
S.3, **110, 615, 617**
S.4, **8, 615, 619**
S.9, **10, 616, 619, 621**
S.13, **615, 619–21**
S.24, **615, 620–1**
S.25–9, **621–3**
S.31–3, **479–81, 615**
S.35–7, **615, 624**
S.42–7, **522–3, 677**
S.58–66, **360**
S.67, **624**
S.73, **521, 615, 626**
S.81–95, **126, 118, 444, 615**
S.96, **102, 501–2**
S.103–7, **502**
S.109–116, **496**
S.112(2), **495**
Carers and Disabled Children Act 2000, **473, 629**
Carers (Recognition and Services) Act 1995, **629**
Children Act 1933
S.1 **365**
Children Act 1989, **196, 199, 347, 351, 357, 390, 392, 428, 477, 638, 644**
S.1, **698**
S.1(3)(a), **351**
S.3(5), **350, 352**
S.20, **392, 471**
S.23(4), **360**
S.27, 47, **360–1**
S.31, **52, 359–60, 391**
Children Act 2004, **192, 348, 375**
S.11, **362**
S.58, **369**
Children and Families Act 2014, **247, 249, 361, 375, 801**
S.100, **371**
Children and Young Person Act 1933
S.1, **359, 369–70**
Children and Young Person Act 1969
S.1(2)(a), **392**
Children (Leaving Care) Act 2000, **360**
Children, Schools and Families Act 2010, **375**
Chronic Sick and Disabled Persons Act 1970, **609**
Ss.2(1), 21, **610**
Civil Liability (Contribution) Act 1978, **73, 732**
Civil Partnership Act 2004, **265**
Civil Evidence Act 1968, **226**
Community Care (Direct Payments) Act 1997, **478**
Community Care (Residential Accommodation) Act 1998
S.1, **610**
Community Discharge (Delayed Discharges) Act 2003, **509, 613, 627**

Compensation Act 2006, **319**
Congenital Disabilities (Civil Liabilities) Act 1976, **400**
S.1(a), **397**
S.1(5), **52, 398–9**
S.2, **399**
Congenital Disabilities (Civil Liability) Act 1976, **389, 591**
Consumer Protection Act 1987, **148, 311, 313, 314, 316, 320, 321, 329, 448, 453, 500, 697, 738, 744**
S.2(3), 3(2), **312, 314**
S.3, 4, **312**
S.5(1)(5)(6)(7), **314**
Contracts (Rights of Third Parties) Act 1999, **244, 681**
Coroners Act 1988, **776**
Coroners and Justice Act 2009, **55, 186, 450, 755, 760, 765–6, 782, 785**
S.5, 6, 10, **777**
S.7, **778**
S.20, **772, 774**
S.54, **38**
Corporate Manslaughter and Corporate Homicide Act 2007, **34, 35, 105, 318, 395, 689**
Courts and Legal Services Act 1990
S.58 (4A and B), **150**
Crime and Disorder Act 1998, **323**
S.34, **37**
Crime and Justice Act 2013, **745**
Crimes Act 1958, **421**
Criminal Courts Act 2013, **24**
Criminal Evidence (Witness Anonymity) Act 2008, **782**
Criminal Injuries Compensation Act 1995, **40**
Criminal Justice Act 1988
Ss 23–28, **226**
Criminal Justice Act 2003, **26, 28, 31, 226**
Criminal Justice and Immigration Act 2008, **186, 187**
Criminal Justice and Public Order Act 1994, **587**
Criminal Law Act 1977, **27**

Damages Act 1996
S.1(2), **142**
Data Protection Act 1998, **19, 179, 185–8, 189, 205, 209, 211–13, 252, 497, 569**
S.2, **186**
S.7, **185**
S.55, **186**
Defamation Act 2013, **233, 500**
Disability Discrimination Act 1995, **482**
S.49A, **611**
Disability Discrimination Act 2005, **262, 371**
Domestic Violence, Crime and Victims Act 2004, **326, 327, 524**
Domestic Violence, Crime and Victims (Amendment) Act 2012
S.5, **326**

Education Act 1993
S.289, **370**
Education Act 1996
S.2 (5), **475**
S.19 (1), (4), (6), **370, 371**
Emergency Workers (Obstruction) Act 2006, **565**
Employer's Liability (Compulsory Insurance) Act 1969, **299, 319**
Employer's Liability (Defective Equipment) Act 1969, **313, 314, 320, 321**
Employment Act 1988, **260**
Employment Act 2002, **247**
S.47, **251**
Employment Act 2008, **247**
Employment Relations Act 1999, **247, 249**
Employment Relations Act 2004, **247**
Employment Rights Act 1996, **90, 247, 307**
S.117, **256**
Employment Tribunals Act 1996, **258**
Enduring Power of Attorney Act 1985, **677**
Enterprise and Regulatory Reform Act 2013, **247**
S.8, **255**
Ss.17, 19, **90–91**
S.69, **298, 320, 333**
Environmental Protection Act 1990, **303**
Equality Act 2006, **261, 482**
Ss.3, 8–12, **261**
S.35, **532**
Equality Act 2010, **234, 240, 247, 248, 249, 262–4, 335, 462, 482, 507, 532, 695**
S.13, 14, **266, 395, 506**
S.15, 16, **265**
S.17, 18, **266, 395**
S.20, **267**
S.158, 159, **104, 268**
S.149, **267, 478**
Equal Pay Act 1970, **261**

Family Reform Act 1987
S.27, **580**
Family Law Reform Act 1969
S.8(1)(2)(3), **348, 349, 350, 351, 354**
Female Genital Mutilation Act 2003
S.1(1)(2), 2, 3, **435–6**
Financial Services (Banking Reform) Act 2013, **150**
Forced Marriage (Civil Protection) Act 2007, **389**

Freedom of Information Act 2000, **19, 92, 93, 185, 187, 189, 208, 252, 374, 375, 711**
S.14, **208**
S.31, 36, **209**
S.40, **187, 209**
S41, 45, **210**
S.50, 57(2), **209**

Gender Recognition Act 2004, **15**

Health Act 1999, **276, 282, 624, 718, 720, 795**
S.18, **115**
S.60, **276**
Health Act 2006
S.4, **337**
S.16, **300, 692**
S.17–25, **727**
Health Act 2009, **101**
S.2, **127**
S.11, 12, **481**
Health and Safety at Work Act 1974, **12, 263, 298–302, 303, 319, 321, 500, 633**
S.2(4)(6), S.28(8), **260**
S.2, **298–90, 300, 332**
S.3, **300, 302, 332**
S.7(a)(b), **299, 300**
S.8, **302**
S.20, **299, 301**
S.33(1)(a), **300**
S.47, **333**
Health and Social Care Act 2001, **114**
S.12, **717**
Ss.60–1, **191**
S.63, **741**
Health and Social Care Act 2008, **101, 118, 192, 248, 283, 291, 294, 639, 676, 685, 686, 690–1, 700**
S.2–5, **116**
S.20, **116, 118, 126, 690**
S.45, **115, 122, 408, 690–1, 716**
S.46, **115–16, 118**
S.52, **719**
S.76–9, **197**
S.112, **282**
S.157, **191, 497**
Health and Social Care Act 2012, **83, 98, 99, 106, 108, 129, 180, 224, 294, 306, 608, 686, 695, 719, 801**
S.1, **99–102**
S.2, 3, **101, 127**
S.9(1), **106**
S.13, **108–9**
S.23, **107, 127**
S.26, 27, **109–10**
S.61–71, **111–13**
S.81–110, **113–14**
S.179, **111**
S.181–9, **716–17**
S.200, **114**
S.214, **293**
S.222–9, **291**
S.232–49, **102, 107, 116, 119–21**
S.252, **102**
S.299, **552**
Health and Social Care (Community Health and Standards) Act 2003, **111, 663**
S.46, **115, 408**
S.53A, **300, 692**
Ss.113, 114, 115, **710**
Health Protection Agency Act 2004, **692**
Health Service Commissioners Act 1993, **714**
S.14(4), **715**
Health Services and Public Health Act 1968, **101, 501**
Homicide Act 1957, **38**
Hospital Complaints Procedure Act 1985, **708**
Human Fertilisation and Embryology Act 1990, **398, 418, 478, 578–9, 581–602**
S.1(1), **587**
S.3, **499, 585, 587**
S.4, **585, 590**
S.11, **590**
S.13(5), **585**
S.30, **592–3**
S.31–35, **591**
S.37, **426**
S.36(1), **592**
S.38, **594–5**
Human Fertilisation and Embryology Act 2008, **357, 499, 578, 581–602, 664**
S.24, 33–9, **580, 589**
S.54, 55, 59, **593–4**
S.145, **625**
Human Fertilisation and Embryology (Deceased Fathers) Act 2003, **589**
Human Fertilisation and Embryology (Disclosure of Information) Act 1992, **591**
Human Organ Transplant Act 1989, **453**
Human Reproductive Cloning Act 2001, **587**
Human Rights Act 1998, **10, 11, 14–19, 105, 347, 531, 625, 705, 777**
Article 1, **14**
Article 2, **14–16, 187, 350, 351, 371, 402, 405, 422–3, 531, 546, 590, 769, 776**

Article 3, **15, 16, 19, 37, 104, 166, 178, 238, 354, 366, 369, 402, 464, 513–14, 531, 544, 574, 590, 695**
Article 4, **19**
Article 5, **17, 172, 464–5, 467, 471, 512–14, 535, 544–5, 555, 626, 695**
Article 6, **17, 37, 238, 245, 279, 366, 384, 471**
Article 8, **11, 17–19, 37, 104–5, 178, 187, 189, 200 205–6, 210–11, 213, 238, 245–6, 254, 279, 333, 337, 350–2, 356, 366–7, 392, 422–3, 427, 468, 471, 507, 544–6, 579, 581, 590, 625–6, 763, 768–70**
Article 10, 19, 92, 187–9, 238
Article 9, **19, 238, 354, 546**
Article 11, **238**
Article 13, **366, 367, 422**
Article 14, **19, 238, 337, 354, 422, 506, 507, 590**
Human Tissue Act 2004, **158, 356, 406, 449, 452, 455, 457, 499, 775**
S.27, **449**
Ss.33, 43, **450**
S.47, **758**
Human Tranplant (Wales) Act 2013, **454**

Infant Life Preservation Act 1929, **6, 390, 417–18, 421, 423, 426, 511**
Interception of Communications Act 1985, **190**

Justice and Security Act 2013, **20**

Law Reform (Contributory Negligence) Act 1945
S.1, **143–4**
Legal Aid, Sentencing and Punishment of Offenders Act 2012
S.44, **150**
Limitation Act 1980
S.14, **148**
S.33, **149**
Local Government Act 1974, **711, 713–14**
Local Government and Public Involvement in Health Act 2007
S.221, 222, **117, 716–17**

Marriage (Same Sex Couples) Act 2013, **263**
Medical Act 1983, **708**
Medicinal Products (Prescription by Nurses) 1992, **738**
Medicines Act 1968, **725–6, 741**
S.4, **743–4**
S.52, **33**
S.53, **725**
Medicines Act 1971, **726**
Mental Capacity Act 2005, **17, 157, 158, 160, 163, 167–73, 181, 205, 350–1, 373, 386, 389, 428–31, 437, 446, 462–70, 475, 477–8, 513, 518, 524–6, 531, 626, 627, 636, 675, 682, 719, 737, 755, 761, 764–8, 771–2**
S.1, **169**
Ss.1(2), 2(4), **157, 348**
Ss.2, 3, **157, 158, 164–5, 169, 678**
S.2(2), **510**
S.4, **170, 764**
S.5, **511**
S.9, 10, **525–6**
S.15, **470**
S.24(1), **771**
S.30–34, **498–9**
S.44, **36, 126, 476, 524–5, 639**
S.45–56, **470**
Mental Health Act 1959
S.128, **476**
Mental Health Act 1983, **62, 162, 167, 172, 173, 205, 311, 428, 461–2, 465–6, 512–14, 531–2, 534–57, 636, 678, 719**
S.2, **388, 389, 535, 538, 542, 548**
S.3, **166, 538, 542, 547, 548, 776**
S.4, **535, 538, 548, 551**
S.5(2), (3), (4), **161, 389, 533–5, 541, 548**
S.7, **538, 547**
S.11, **540**
S.12, **538**
Ss.13, 14, **540**
S.17, **547–51, 557**
S.18(1)(5), **534**
S.20 A, B, **551**
S.26(1), **359**
S.29, **535**
S.37, **31, 542, 548**
S.41, **31, 542**
Ss.47, 48, **548**
Ss.57–62, **542–6**
S.63, **387, 545–6**
S.64A-K, **551**
S.66, **535**
S.73, **531, 555**
Ss.115, 129, **637**
S.117, **518, 540, 547, 548**
S.118, **532**
S.131, **351, 464**
S.132, **541–2**
S.134, **718**
S.135, **524, 535, 552, 637–8, 801**
S.136. **553, 801**
S.139, **540**
Ss.140, 145, **542**
S.141, **270**

Mental Health Act 2007, **167, 173, 461, 463, 465, 518, 531–2, 534–57, 636**
S.27, **543**
S.32, **548**
S.43, **351**
Mental Health (Approved Functions) Act 2012, **538**
Mental Health (Discrimination) Act 2013, **270**
Mental Health (Patients in the Community) Act 1995, **548**
Mesothelioma Act 2014, **141, 150**
Misuse of Drugs Act 1971, **725–8**

National Assistance Act 1948
S.21, 22, **548, 610, 625**
Ss.47, 48, **615, 637**
National Health Service Act 1946 (as amended), **98**
S.25, **634**
S.62, **370**
National Health Service Act 1977, **83, 98**
S.1, **102**
S.3, **102–3**
S.11, **692**
S.84, **719**
S.85, **103**
NHS Act 2006, **83, 98, 102, 127, 197, 628**
S.1(1)(3), **102, 106, 111, 502**
S.3, **18, 111**
S.7A, **119**
S.12, A-D, **481**
S.13, 14, **107, 109, 110, 112, 113, 501, 615, 719**
S.23G-K, **110**
S.28, **114**
Ss.30–65, **111**
S.100, **502**
Ss. 251, 252, **191, 496**
S.258, **111**
NHS (Amendment) Act 1986
S.1, 2, **299**
NHS Consequential Amendment Act 2006, **98**
NHS Redress Act 2006, **8, 444**
NHS Reform and Health Care Professions Act 2002, **291, 292**
S.20, **716**
NHS and Community Care Act 1990, **111, 114, 319, 608**
S.47, **524, 528**
S.60, **243**
NHS (Reorganisation) Act 1973, **634**
National Minimum Wage (NMW) Act 1998, **253**
Nurses Agencies Act 1957, **663**
Nurses, Midwives and Health Visitors Act 1979, **276**
Nurses, Midwives and Health Visitors Act 1997
S.16, **385**

Occupier's Liability Act 1957, **307, 310, 319, 500, 633**
S.2–7, **147, 307–10**
Occupier's Liability Act 1984 **307**
S.1(3)(4), **310**
Offences Against the Person Act 1861, **157**
S.1(1)(b), **426**
S.18, **32, 369–70, 426**
S.20, **32, 41, 369–70**
S.47, **369–70**
Ss.58, 59, **390, 417, 421, 425–6**
S.60, **426**

Personal Care at Home Act 2010, **613**
Presumption of Death Act 2013, **759**
Police Reform Act 2002, **323**
Police and Criminal Evidence Act 1984, **24, 202, 211, 326, 426, 476, 533, 552, 568**
Ss.9, 12, 14, **201–2**
S.17(e), **636**
S.78, **25**
Powers of Attorney Act 1971, **677**
Prevention of Terrorism (Temporary Provisions) Act 1988, **192**
S.11, **197**
Prohibition of Female Circumcision Act 1985, **435**
Protection from Harassment Act 1997, **80, 268, 335**
S.1, **334–5**
Protection of Children Act 1999, **244, 367**
Protection of Freedoms Act 2012, **211**
S.87(1), **246**
Public Health (Control of Disease) Act 1984, **197, 685–7, 690, 700**
S.11, **687**
S.45, **690–1**
Public Interest Disclosure Act 1998, **89–90, 91, 98, 180, 213, 255, 257, 307, 491, 494, 495, 631, 689**

Race Relations Act 1976, **261**
Regulation of Investigatory Powers Act 2000, **196, 254**
Regulatory Reform (Vaccine Damage Payments) Act 1979, **696**
Rehabilitation of Offenders Act 1974, **240**
Road Traffic Act 1972, **27**
Road Traffic Act 1985, **745**
Road Traffic Act 1988 as amended by the Traffic Act 1991, **192, 643**
S.170, **197**

Safeguarding Vulnerable Groups Act 2006, **245, 476, 525**
Ss.21–7, 59, **246**

Sex Discrimination Act 1975, **249, 261, 270**
Sex Discrimination Act 1986, **261**
Sexual Offences Act 1956,
S.7, **476**
Sexual Offences Act 2003
S.38–42, **476**
Sexual Offenders Act 1997, **244**
Stillbirth Definition Act 1992
S.1, **405**
Suicide Act 1961, **11, 15, 767–8**
Ss.1, 2(1), **764–5, 770**
Superannuation Act 1972, **711**
Supreme Court Act 1981
S.32A, **141**
S.33, **136, 196**
S.34, **196**
Special Educational Needs and Disability Act 2001, **371**
Surrogacy Arrangements Act 1985, **582, 592–3**

Tax Credits Act 2002, **258**
Terrorism Act 2000
S.44, **18**
Theft Act 1968
S.1(1), **32**
Tobaccos Advertising and Promotion Act 2002, **337**
Trade Union Reform and Employment Rights Act 1993, **307**
Trespassers and Occupier's Liability Act 1984, **310**

Unfair Contract Terms Act 1977, **146, 147–8, 792**
S.11, **673**

Vaccine Damage Payments Act 1979, **696**

Wills Act 1837
S.9, **784**

Youth Justice and Criminal Evidence Act 1999, **37**

Abbreviations

The health services are awash with abbreviations and jargon. It would, however, be immeasurably tedious and unrealistic to ignore these and always use the full words. Some of the most commonly used abbreviations are therefore set out here. Where there is any possibility of confusion, words are spelt out in full.

ABI Association of British Insurers
ABPI Association of the British Pharmaceutical Industry
ACAS Advisory, Conciliation and Arbitration Service
ACGT Advisory Committee on Genetic Testing
ADR Adverse Drug Reaction
A&E accident and emergency department
AGMR Advisory Group on Medical Research
AID artificial insemination by donor
AIDS acquired immune deficiency syndrome
AIH artificial insemination by husband
AIP artificial insemination by partner
ALB arm's-length bodies
AMHP approved mental health professional
ARC AIDS-related complex
ASW approved social worker
AVMA Action for the Victims of Medical Accidents
BARNA British Anaesthetic and Recovery Nurses Association
BCA British Chiropractic Association
BID brought in dead
BMA British Medical Association
BMJ *British Medical Journal*
BNF *British National Formulary*
BP blood pressure
BPAS British Pregnancy Advisory Service
CAA Comprehensive Area Assessment
CAB Citizens' Advice Bureau
CAM complementary and alternative medicines
CCC Conduct and Competence Committee
CCETSW Central Council for Education and Training in Social Work
CCIAG Critical Care Information Advisory Group
CDRP crime and disorder reduction partnerships
CE Conformité Européenne (marking following EC directive 93/68/EEC)
CESDI Confidential Enquiry into Stillbirths and Deaths in Infancy
CESU Clinical Effectiveness Support Unit
CFA conditional fee agreement
CGWTs Care Group Workforce Teams
CHAI Commission for Healthcare Audit and Inspection (known as the Healthcare Commission)
CHC community health council
CHI Commission for Health Improvement (now CHAI)
CHRE Council for Healthcare Regulatory Excellence (formerly CRHCP) (now the PSA)
CICA Criminal Injuries Compensation Authority
CMI Chartered Management Institute
CMO Chief Medical Officer
CNHC Complementary and Natural Healthcare Council
CNR cell nuclear replacement
CNST Clinical Negligence Scheme for Trusts
COREC Central Office for Research Ethics Committees (replaced in 2007 by NRES)
COSHH Control of Substances Hazardous to Health (Regulations)
CPD continuing professional development
CPN community psychiatric nurse
CPPIH Commission for Patient and Public Involvement in Health
CPR cardiopulmonary resuscitation
CPS Crown Prosecution Service
CQC Care Quality Commission
CRHCP Council for the Regulation of Health Care Professionals (now *see* CHRE)
CSAG Clinical Standards Advisory Group
CSCI Commission for Social Care Inspection
CSIP Care Services Improvement Partnership
CSSD central sterile supply department
CTO Compulsory Treatment Order
D and C dilatation and curettage
DBERR Department for Business, Enterprise and Regulatory Reform
DBS Disclosure and Barring Service (replacing the Independent Safeguarding Service)
DCA Department for Constitutional Affairs
DCSF Department for Children, Schools and Families (formerly DfES)
DH Department of Health
DHA district health authority

DHSS Department of Health and Social Security (divided in 1989 into DH, Department of Health, and DSS, Department of Social Security)
DMD Drug Misuse Database
DNAR do not attempt resuscitation
DNR do not resuscitate
DoLS Deprivation of Liberty Safeguards
DPA Data Protection Act 1998
DPP Director of Public Prosecutions
DSS Department of Social Security
EC European Community
ECC Ethics and Confidentiality Committee
ECHR European Court of Human Rights
ECJ European Court of Justice
ECL emergency care leads
ECP emergency care practitioner
ECT electroconvulsive therapy
EEA European Economic Area
EHR electronic health record
EHRC Equality and Human Rights Commission
EL executive letter (guidance from DH)
ELS Existing Liabilities Scheme
ENDPB executive non-departmental public body
EPR electronic patient record
ERG external reference group
eSET elective single embryo transfer
ET embryo transfer
EWC expected week of confinement
GDC General Dental Council
GIFT gamete intrafallopian transfer
GMC General Medical Council
GMS general medical services
GP general practitioner
GSL general sales list
GTAC Gene Therapy Advisory Committee
GUM genito-urinary medicine
GWC General Whitley Council
HAI hospital-acquired infection
HASC(CHS)A Health and Social Care (Community Health and Standards) Act 2003
HASWA Health and Safety at Work Act
HCPC Health and Care Professions Council (replacing HPC)
HCSS healthcare support staff
HEI higher education institution
HFEA Human Fertilisation and Embryology Authority
HGAC Human Genetics Advisory Commission
HGC Human Genetics Commission
HIV human immunodeficiency virus
HPA Health Protection Agency
HPC Health Professions Council (renamed HCPC)
HRA Health Research Authority (established 2011)
HSC Health and Safety Commission
HSC Health Service Commissioner
HSC health service circular
HSCIC Health and Social Care Information Centre
HSE Health and Safety Executive
HTA Human Tissue Authority
IAG Independent Advisory Group
IBB Independent Barring Board
ICAS Independent Complaints Advocacy Services
ICO Information Commissioner's Office
ICRS integrated care records service
IC(T)U intensive care (treatment) unit
IDMG inter-departmental ministerial group
IM and T information management and technology
IMCA independent mental capacity advocate
IMHA independent mental health advocate
ISA Independent Safeguarding Authority (replaced by DBS)
IUD intrauterine device
IV intravenous(ly)
IVF *in vitro* fertilisation
LA local authority
LBC liquid-based cytology
LCP Liverpool Care Pathway
LHB local health board (equivalent of PCT in Wales)
LINKS Local Involvement Networks
LOLER Lifting Operations and Lifting Equipment Regulations
LPA lasting power of attorney
LREC local research ethics committee
LSA Local Supervising Authority
LSC Legal Services Commission
LSP local service provider
MA maternity allowance
MCA Mental Capacity Act
MCA Medicines Control Agency (*see* MHRA)
MDA Medical Devices Agency (*see* MHRA)
MDU Medical Defence Union
MGN Mirror Group Newspapers
MHAC Mental Health Act Commission
MHRA Medicines and Healthcare products Regulatory Agency (since 1 April 2003)
MPP maternity period pay
MREC multi-centre research ethics committee
MRSA methicillin-resistant *Staphylococcus aureus*
MSW maternity support worker
NAI non-accidental injury
NAO National Audit Office
NASP national application service provider
NCAA National Clinical Assessment Authority
NCAS National Clinical Assessment Service

NCSC National Care Standards Commission
NFI National Fraud Initiative
NFR not for resuscitation
NHS National Health Service
NHSBT NHS Blood and Transplant
NHSTDA NHS Trust Development Authority
NHSFT NHS Foundation Trust
NHSLA National Health Service Litigation Authority
NHSU National Health Service University
NICE National Institute for Health and Care Excellence
NIGB National Information and Governance Board for Health and Social Care
NIHR National Institute for Health Research
NMC Nursing and Midwifery Council
NMQP non-medically qualified practitioners
NMW national minimum wage
NPEU National Perinatal Epidemiology Unit
NPfIT National Programme for Information Technology
NPRB National Pay Review Body
NPSA National Patient Safety Agency
NQB National Quality Board
NRES National Research Ethics Service (replaced COREC in 2007)
NRLS National Reporting and Learning System
NRT nicotine replacement therapy
NSDU National Safeguarding Delivery Unit
NSF National Service Framework
ODP operating department practitioner
OFV opportunities for volunteering scheme
OOS occupational overuse syndrome
OPD Outpatients department
OPSI Office of Public Sector Information
OTC over the counter
PALS Patient Advice and Liaison Service
PBC prudential borrowing code
PCC Professional Conduct Committee
PCG primary care group
PCMH Plea and Case Management Hearing
PCT primary care trust
PDR personal development review
PEP post-exposure prophylaxis
PGD pre-implantation genetic diagnosis
PGD patient group directions
PIAG Patient Information Advisory Group
PMS primary medical services
POM prescription-only medicine
POVA protection of vulnerable adults
PPE personal protective equipment
PPIFs patient and public involvement forums
PREP post-registration education and practice
PRN *pro re nata* (as required, whenever necessary)
PRSB Professional Records Standards Body
PSA Professional Standards Authority for Health and Social Care (replacing CHRE)
PUWER Provision and Use of Work Equipment Regulations
PVS persistent vegetative state
QA quality assurance
QC Queen's Counsel
QOF quality outcome framework
QSG Quality Surveillance Group
QW qualifying week
RATE Regulatory Authority for Tissue and Embryos
RCM Royal College of Midwifery
RCN Royal College of Nursing
RCP Royal College of Psychiatrists
RCPCH Royal College of Paediatrics and Child Health
RCS Royal College of Surgeons
REC research ethics committee
RIDDOR Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RMN registered mental nurse
RMO responsible medical officer
RSI repetitive strain injury
SAP single assessment process
SCIE Social Care Institute for Excellence
SCPHN specialist community public health nurse
SCR summary care record
SEN state enrolled nurse
SHA strategic health authority
SLA service level agreement
SMP statutory maternity pay
SOP standard operating procedures
SPP statutory paternity pay
SRSC Safety Representative and Safety Committee
SSI Social Services Inspectorate
SSP statutory sick pay
TB tuberculosis
T+P temperature and pulse
TUR & ER 93 Trade Union Reform and Employee Rights Act 1993
UKCC United Kingdom Central Council for Nursing, Midwifery and Health Visiting
UKCRC United Kingdom Clinical Research Collaboration
UKECA United Kingdom Ethics Committee Authority
ULTRA Unrelated Live Transplant Regulatory Authority
VBS Vetting and Barring Scheme
VD venereal disease
WDC workforce development confederation
WTD Working Time Directives

Foreword to first edition

The author, Bridgit Dimond, is well known to nurses working in Wales. She has assisted many of us in developing an increased awareness of the need for expert legal advice and knowledge of the law to inform our practice in the interests of our patients, our colleagues and ourselves.

The text of the book illustrates very graphically that she has skilfully drawn her material from frequent contact with nurses, midwives and health visitors working in a variety of settings. The *topics* are relevant to the work of the practitioner, the educator and the manager and presented in a form that encourages the reader to delve further into the subject. Although this book is seen by the author primarily as a work of reference, the very fact that many of the issues identified are at the centre of the profound changes taking place in the pattern and organisation of services, and within the nursing profession itself, ensures that it will have wider interest and will assist nurses considerably with understanding their responsibilities in a period of significant development.

Bridgit Dimond has, through this publication, yet again provided valuable assistance for improving the practice of nursing – by encouraging nurses to acquire a deeper understanding of the relevant legal aspects of the work of nursing.

Miss M. Bull
Chief Nursing Officer
Welsh Office

Foreword to seventh edition

In an era where there is a higher scrutiny on nursing practice than ever, Bridgit Dimond's text is essential reading for nurses and those involved in the management of nurses.

Bridgit Dimond is to be congratulated on the seventh edition of her book which will do so much to help nurses understand their responsibilities in relation to the law and to remind nurses of both their ethical and moral responsibilities in relation to their own personal conduct and for the care for their patients and service users.

I trust that all nurse educators will ensure that as part of the teaching and training of nurses, consideration is given to this text and attention is drawn to the serious implications of caring for people who are often at their most vulnerable.

With the increasing complexity of nursing including the carrying out of tasks that hitherto were the province of our medical colleagues, such as prescribing, this text will help individuals understand the requirements of the law, how to safeguard themselves and, just as importantly, how to ensure there are safe standards of patient care.

The Mid Staffordshire inquiry and the public's greater awareness of their rights and responsibilities should not be something nurses should be fearful of. However, they should be cognisant that their practice can be challenged and scrutinised to a level never previously experienced.

This valuable text should be readily available to all nursing students and qualified nurses and in the libraries of all nursing schools and other institutions, such as the Royal College of Nursing. I hope that people in authority will highlight its existence and the real need for nurses to read it.

Dr Peter Carter OBE
Chief Executive
Royal College of Nursing

Preface to first edition

I make no apologies for producing a book on law for nurses. It is apparent to me that nurses are increasingly aware of the need for up-to-date legal knowledge, that they realise that they practise their profession within the constraints and limitations of the law and very occasionally with the powers of the law and that they are increasingly held responsible. The approach adopted here is, however, a practical one. I attempt to start with the problems and move outwards to the legal significance of the events described. The result is very different from the traditional textbook approach. My aim is not to teach the nurse the academic niceties of contract law or of the law of negligence but, rather, to take some everyday situations in which the nurse finds herself and examine the legal consequences of the situations so that she comes to an understanding of the legal principles that arise. In this way her legal understanding will develop and she will then be able to apply those principles to similar situations.

I am aware of the dangers of this approach. Any situation is, of course, very complex; there are considerable dangers of oversimplification. However, I am not of the persuasion that because a little knowledge is a dangerous thing law must be kept for the lawyers. It is essential that nurses understand the legal implications of their work so that they can protect both themselves and their patients. With a basic understanding of the law they should know when they need to seek expert legal advice and also know what elementary precautions they should be taking to protect themselves. Where possible, actual wording of Acts of Parliament has been placed in figures, so that it would not break the flow of the text, and so that the nurse can see the actual wording. It is anticipated that the book would be used as a source book to dip into rather than be read from cover to cover. The appendices thus include much reference information and the index has been designed with this purpose in mind. I have not flinched from including some of the technical legal terms and have given the case references so that the nurse who wishes to pursue the subject in more detail can follow the cases.

Many of the problems discussed here are ones cited to me by hundreds of nurses in seminars I have conducted throughout the country and this explains the apparent concentration on issues relating to negligence litigation. This is a field that nurses are considerably anxious about and constantly ask questions on problems relating to the extended role, responsibility for others and aspects relating to resourcing.

A note of caution: there are many situations that arise where there are no clear legal guidelines; the dilemmas arising are of an ethical rather than a legal dimension. The law is both narrower and wider than the field of ethics. There are some problems where ethical issues arise and where the law as yet provides no specific guidelines other than the basic legal principles: for example many issues arising from the developments in reproductive technology have still not been covered by legislation although, following the Warnock Report, this situation is about to be changed. In other respects, the law is wider than ethical issues: for example the need to register a birth, marriage or death raises no ethical issues other than that of obeying the law. Some of these ethical issues will be covered although, clearly, it is only where there is a breach of the law that specific guidance can be given. This is not to say that ethical issues are not important. It is simply that there is no space for their discussion here. However, reference is made in the extended reading list to books that deal solely with these issues.

Some of the discussion relates to nursing procedure and practice that does not have legal status. However, it is considered essential to include this in a work of this kind.

A word about terminology. I have used the term 'nurse' to cover all categories of nursing staff from auxiliary to nursing officer. When it is significant that the nurse has a particular rank, then I have used the appropriate grade. I have also tended to refer to the nurse as she; this is not meant to be sexist: it

simply covers the vast majority of nursing staff and is less clumsy than any contrived alternative such as 'he/she'. To illustrate practical situations two different terms have been applied: **situation** to describe an imaginary series of events that could well occur but, in fact, the names are fictitious and not intended to refer to any actual persons living or dead; **case** to cover actual cases that were heard before the courts. Not all of these refer to nursing staff; indeed the actual number of cases in which nurses have personally been defendant or accused are comparatively rare. Many of the cases involve medical staff or are not directly concerned with the health professions. However, principles that do arise are significant for nursing practice and on that account have been included. Because law even more than healthcare is a jargon-dominated profession, a glossary has been included to explain those legal terms that could cause difficulties.

The aim is to provide some practical guidance to nursing staff on the many problems that they might encounter. Part I of the book deals with those general problems facing all nursing staff, covering principles of professional negligence and the rights of the patient and also those areas where the nurse herself is a victim of an accident or assault, etc. Part II deals with those specialist areas that are more likely to be encountered by nurses working in different fields but they may also be of general interest. Finally, certain areas that seem to require attention in their own right such as property matters, handling complaints, drugs and AIDS are considered separately, in Part III. Appendices provide additional useful information to which the nurse may wish to refer. I have endeavoured to state the law for England and Wales at 31 August 1989.

I am grateful for the support and encouragement of so many in the preparation of this book. I am considerably indebted to Tessa Shellens and Dr Sue Revel who painstakingly read through the draft and offered much advice and guidance and to Mrs Brenda Hall, my indexer, for her patience, tenacity and thoroughness. I also thank Ann Cross for her detective work. In addition, I am grateful to the following who read individual sections: Dawn O'Brien, Val Taylor, Margaret Winter, Anne Ryall-Davies, Sylvia Parker, Sue Bowers, Yvonne Peters, Gillian Davies, Helen Gray, Keith Weeks, Heather Anderson, Duncan Bloy, Helen Power, Jean Jones and Jean Whyte. The responsibility for the accuracy and contents of the book, however, remains mine. I also acknowledge the support and encouragement of my publishers, particularly Cathy Peck and Mike Cash.

Finally, I am conscious of the great debt I owe to my family whose delight in my work is encouragement in itself. I thank you all.

Preface to seventh edition

It is now over 25 years since the first edition of this book was published and once again the changes in law since the last edition in 2011 are significant and numerous. There have been momentous decisions of the Supreme Court and major new Acts of Parliament, including the Health and Social Care Act 2012 which has led to arguably the most controversial and disruptive reorganisation of health services in England since it was established in 1948. New legislation includes the Care Act 2014 which has been described as the most significant reform of care and support in more than 60 years. Public health is now under the aegis of local authorities and new watchdog organisations are enabling local people to have a say in the configuration of their health and social services. The aim of the book remains the same: to take some everyday situations in which the nurse finds herself and examine the legal consequences of these situations so that she comes to an understanding of the legal principles that arise. A knowledge of the legal context within which she practices enables the nurse to maintain her standards and exercise her professional role safely and confidently.

Acknowledgements

To Clare and Beck

I wish to convey my thanks to the Stationery Office for being able to print sections of the statutes and the statutory instruments, to the various law reports for the quotations from the cases and to the Department of Health for citing many documents. In the preparation of this seventh edition, I am grateful once again to so many people – not least the hundreds of nurses who have raised legal concerns at the seminars and conferences I have spoken at – that it is invidious to mention just a few by name. I would, however, like to convey my very grateful thanks to HH Judge Jacqueline Davies and HH Judge Jonathan Bennett, Dr Basil Cardoza, Robert Jenkins and Sian Jones. My thanks are also due to Bette, who prepared the index and tables and provided constant encouragement and support, as did my daughters Clare and Beck to whom this book is dedicated.

Part I

General principles affecting all nurses





Chapter 1

Introduction:

four arenas of accountability, the legal system and human rights

This chapter discusses

- Accountability
- Criminal liability
- Professional liability
- Civil liability
- Accountability to employer
- Relationship between the four arenas of accountability
- Sources of law
- Differences between civil and criminal law
- Civil actions
- Judicial review
- Legal personnel and legal complaints
- Legal language
- Human Rights Act 1998
- Freedom of Information Act 2000
- Devolved law-making powers

Introduction

This book is about the accountability of the nurse, which means that it is concerned with how far the nurse can be held in law to account for her actions. No distinction is drawn in this context between responsibility and accountability. Responsibility is seen as being liable to be called to account, answerable for, accountable for. Space does not permit discussion of the moral or ethical dimensions. There may be circumstances in which a nurse could be held morally responsible but there is no legal liability. For example, if a nurse fails to volunteer her services at the scene of a road accident, the law at present recognises no legal duty to volunteer help and thus any legal **action** brought against the nurse would fail. The Nursing and Midwifery Council (NMC) may, however, consider that she was guilty of **professional misconduct** and refer to its Code of Professional Conduct.[1] This issue is considered in chapter 3.

Many would hold that there is a moral duty to use her skills to help a fellow human being. Obviously, the law and ethics overlap, but each is both wider and narrower than the other. The Further Reading section promotes further consideration of the moral dilemmas in healthcare. The topics to be covered in this chapter are shown above.

Accountability

In this book we are concerned with the legal aspects of the accountability of the nurse. Many problems arise, however. Can a nurse, who does not have control over the resources, be held liable for harm suffered by a patient? Can a nurse be held responsible if she is ignorant, through lack of training, of certain procedures, and as a result the patient is harmed? Issues such as these are of significant concern to the nurse.

In order to be responsible it is necessary to have knowledge and this includes legal knowledge. Ignorance of the law is no defence and the nurse should be aware of the limits that the law imposes on her and also of the power it gives her. The increase in litigation over past years and the possibility of the nurse being personally involved in court proceedings is also a major anxiety for nurses.

Four main arenas of accountability in law are identified and discussed in detail. It might be considered that the most important has been omitted, i.e. accountability to oneself. This, however, is the moral dimension. There are no legal means of enforcing this form of accountability, although many would recognise it as being at the heart of the best of professional competence and skill.

Figure 1.1 illustrates the many areas of law that concern the nurse, and most of these topics are considered in Part I. Some of the more specialist areas, e.g. the Abortion Act, are considered in Part II of the book, which deals with different specialties. In this introductory chapter, the four fields of accountability that the nurse faces will be considered.

When a patient suffers harm or there is loss of or damage to property, the nurse may be called to account in four different courts and tribunals. Not all actions will be heard in all four but we shall give as an example an incident to illustrate the different procedures that could involve all four. Figure 1.2 illustrates the four arenas of accountability: accountability in the civil and criminal courts, in disciplinary proceedings and before the committees of the NMC.

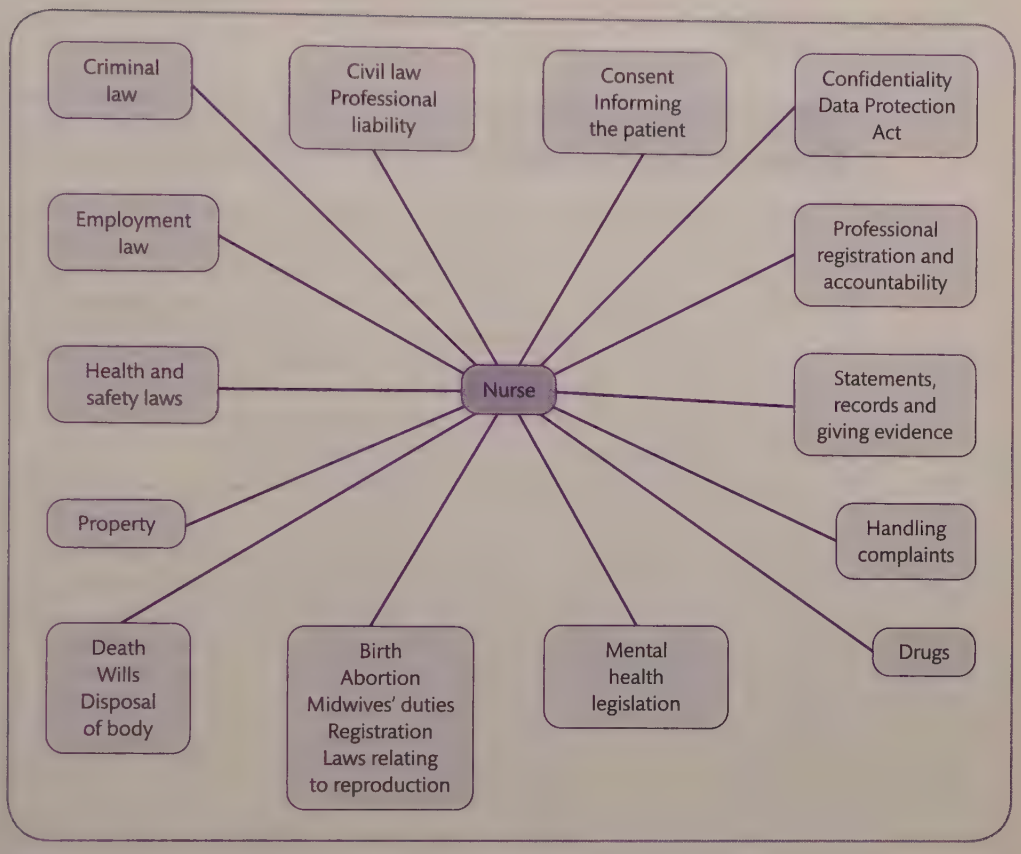


Figure 1.1 Areas that concern the nurse

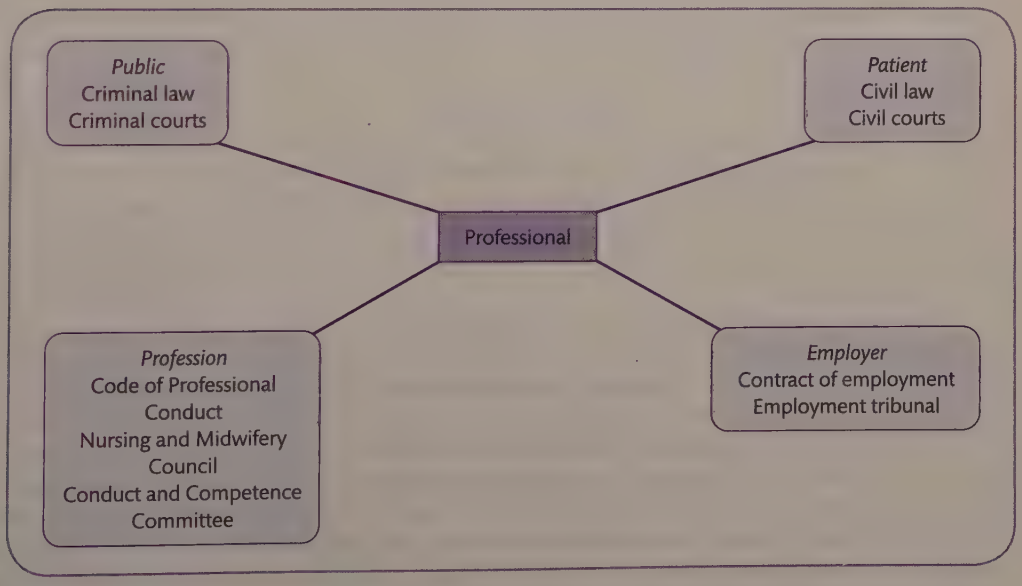


Figure 1.2 Arenas of accountability

Criminal liability

Practical Dilemma 1.1 The wrong drug

Staff Nurse Greaves was under considerable pressure on the children's ward. A spate of very seriously ill patients being admitted and a few staff absences from flu put great strains on the ward. A junior doctor wrote up a 4-year-old child with suspected meningitis for a high dose of antibiotics and told the staff nurse that he was prescribing a higher dose than was usual because of the severity of the child's condition. Normally, Staff Nurse Greaves would have checked the dose in the *British National Formulary* (*BNF*), but since they were so busy she took the doctor's word for it and gave the child the dose indicated on the sheet. Not long afterwards, the child showed signs of kidney failure and, despite efforts to save him, he died. Subsequently, the post-mortem investigations revealed that the child had been given a thousand-fold overdose of the antibiotic.

Death in circumstances such as those described in Practical Dilemma 1.1 would have to be reported to the **coroner**, who would immediately take control of the whole case, would probably order a post-mortem, which the relatives would have no right to refuse, and may hold an inquest to establish the cause of death. Details of the coroner's powers and the progress of an inquest and the changes following the Shipman Inquiry[2] are discussed in chapter 29. The staff nurse is likely to be asked to provide a statement and may well be called to give evidence at the inquest. The Chief Officer of Police or the Director of Public Prosecutions can request the coroner to adjourn the inquest on the grounds that a person may be charged with an offence committed in circumstances connected with the death of the deceased. The coroner also has the power to adjourn the hearing.

In a case like this, it is highly likely that, after investigation by the police, a decision might be taken to prosecute the nurse and the doctor for a criminal offence in connection with the child's death. Offences are classified as indictable or summary. An indictable offence is one that is heard before a judge and jury in the Crown Court, such as murder, manslaughter, rape and very serious offences. A **summary offence** is one heard by the magistrates in a magistrates' court, such as driving without due care and attention and some parking offences. Many offences can be tried in either a magistrates' court or the Crown Court and are known as 'triable either way'. (For further discussion on this see chapter 2.)

Figure 1.3 shows the system of our criminal courts. Even where a case is to be heard in the Crown Court because it concerns an offence that can be tried only on **indictment**, a short appearance by the defendant will still take place before the magistrates. A date will be set for the Plea and Case Management Hearing (PCMH) (see chapter 2).

In a situation like the one just described, it is quite likely that the inquest would be adjourned and that criminal proceedings would then take place against the staff. The prosecution has the burden of establishing to the satisfaction of the jury that the accused is guilty beyond reasonable doubt of the offence.

Once the jury has found the accused **guilty**, the judge has considerable discretion (except in the case of murder) over sentencing (see chapter 2) which ranges from an absolute discharge to imprisonment. There is a right of both the prosecution and the defendant to appeal against sentencing.

Criminal charges in relation to the care of the patient are rare, but when they do arise they attract considerable publicity. The **trial** of Dr Arthur in connection with the death of a severely handicapped Down's syndrome baby, the **committal proceedings** of Dr Hamilton on a charge under the Infant Life Preservation Act, the conviction of Dr Nigel Cox (for attempting to cause the death of a woman suffering from rheumatoid arthritis by prescribing and administering potassium chloride) and the case of Dr Shipman, who was convicted of the murder of 15 women, have raised serious issues in relation to the position of the doctor and the criminal law. (The nature of criminal proceedings is considered at

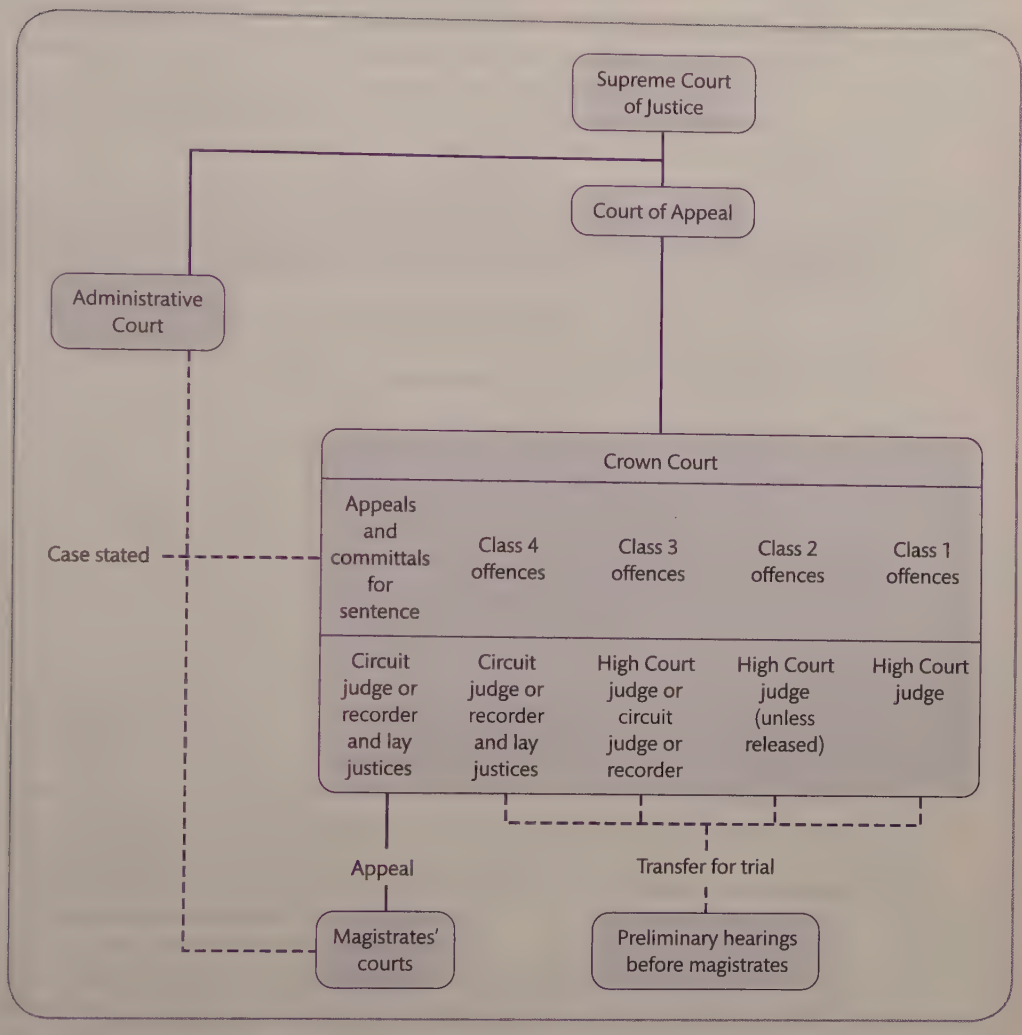


Figure 1.3 System of criminal courts

greater length in chapter 2 and laws relating to death in chapter 29.) Changes to the funding of defendants in criminal cases are also considered in chapter 2.

Professional liability

In Practical Dilemma 1.1, Staff Nurse Greaves could be found guilty of causing the death of the child, although this obviously depends on the detailed facts of the case. The result would automatically be reported to the NMC, and it is highly likely that, after preliminary investigation had taken place, a Conduct and Competence Committee (CCC) would hear the case to decide if Staff Nurse Greaves is unfit to practise by reason of her misconduct and, if so, whether she should be removed from the Register. Information goes to the NMC from a variety of sources about the conduct of a nurse and in a case like this the police would also report it to the registration body. Non-criminal misconduct may also be reported. The nurse could argue that the special circumstances of the case do not warrant her being removed from the Register. (The full details of the powers and procedures of the CCC and the

other practice committees are discussed in chapter 11.) In contrast to the criminal **prosecution** in the Crown Court, there is no jury here and the members who make up the constitution of the CCC are concerned with protecting the public from an irresponsible nurse; their intention is not to punish the nurse. The powers of the CCC are set out in Box 1.1. Following any decision by the CCC, an appeal on a point of law can be made to the High Court which can instigate a **judicial review**.

Box 1.1 Powers of the Conduct and Competence Committee

Following investigation by the Investigating Committee and referral to the Conduct and Competence Committee of the NMC, after a finding of unfitness to practise by the nurse the Conduct and Competence Committee can take one of the following courses:

1 No action
2 Refer respondent to the Health Committee or to screeners
3 Postpone decision or issue interim order
4 Strike off the Register
5 Issue a caution (for 1–5 years) or condition of practice order (for 1–3 years)
6 Suspend from registration (for up to 1 year).

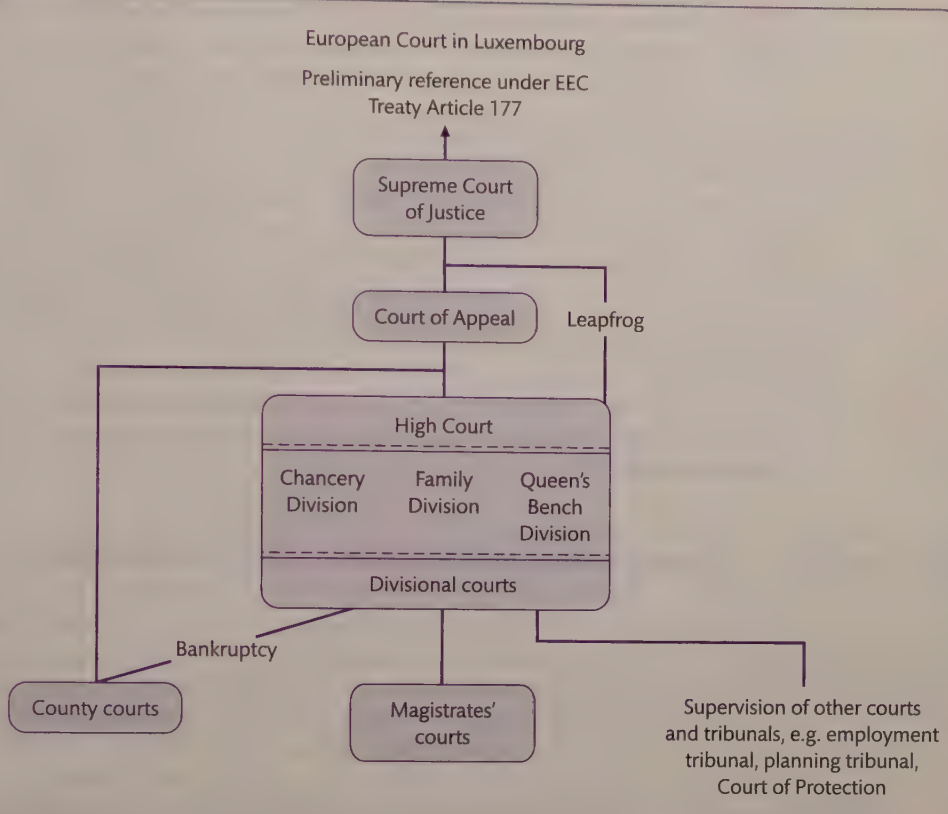
Civil liability

The death of the child gives the child's personal representative the right to sue in the civil courts (Figure 1.4) for the **negligence** that led to the child's death. The action could be brought against the nurse and the doctor personally, and/or against the NHS trust, which could be sued either for its direct responsibility for the death of the child or its **vicarious** (**indirect**) **liability** for the negligence of its staff while acting in the course of employment. If the NHS trust is found vicariously liable, then it has a right under the contract of employment to seek an indemnity from the negligent employee, although this right is rarely exercised. (The vicarious liability of the employer is considered in chapter 4.) The claimant, i.e. the person who is bringing a civil action for negligence, must show fault on the part of the person or organisation he is suing. Box 1.2 shows the elements that must be established by the **claimant** (the importance of these elements in a claim for compensation for negligence is considered in chapter 3).

Box 1.2 Elements in an action for negligence

1 A duty of care is owed by the defendant to the claimant. (Duty)
2 There is a breach in the standard of the duty of care owed. (Breach)
3 This breach has caused reasonably foreseeable harm. (Causation)
4 Harm.

Because of rising costs and awards of compensation, and owing to the injustice to claimants should they fail to obtain compensation, many associations are now urging the adoption of a system of no fault liability. Parliament has enacted a new NHS redress scheme,[1] for which the secondary legislation necessary for its implementation has not been drafted. The Act itself fell considerably short of accepting a no fault system of liability (see chapter 6). Wales and Scotland have implemented their own NHS redress schemes.



The European Economic Community set up by the First Treaty of Rome in 1957 was joined by the United Kingdom in 1973. Sovereign powers were surrendered and the supremacy of Community law over the national systems of law was accepted. There are four main institutions responsible for discharging the functions of the EEC:

1 The Commission – the executive body
2 The Council of Ministers – one representative from each state
3 The Assembly or European Parliament directly elected by voting in member states
4 The Court of Justice – sits in Luxembourg

Figure 1.4 The civil courts

In the situation that Staff Nurse Greaves faces here, it is particularly unlikely that the NHS trust would defend an action for vicarious liability for her negligence if she had already been found guilty of a criminal offence. They would be more likely to offer a sum in compensation for the death of the child, the only likely dispute being over the appropriate sum of compensation. (The problems of quantifying harm and putting a monetary figure on loss suffered are discussed in chapter 6.)

In the civil courts, the claimant has to establish liability of the defendant on a **balance of probabilities**. This is an easier task than that facing the prosecution in the criminal courts, where **proof** is required beyond **reasonable doubt**.

Accountability to employer

Finally, the staff nurse has to account to her employer. There is an implied term (i.e. a term that may never even be discussed or written down but which is assumed by the courts to exist unless there is

evidence to the contrary) in every **contract** of employment that the employee will obey the reasonable instructions of the employer and will use all care and skill in carrying out her duties. (See chapter 10 on implied terms in the contract of employment.) In a case such as this where it is evident that the employee has been grossly negligent, then that employee is in breach of contract and the employer can take appropriate disciplinary action. This might mean a warning – oral or written – demotion, suspension or even dismissal. (Disciplinary powers of the employer are considered in chapter 10.)

In the case discussed here, the employer might initially suspend the staff nurse on full pay pending an inquiry and then, after all reasonable enquiries have been made and she has had an opportunity to respond, dismiss her. If she has the requisite length of continuous service, the staff nurse would be able to apply initially to the Advisory, Conciliation and Arbitration Service[4] (ACAS) and then to an employment tribunal for a hearing of unfair dismissal. At this hearing the tribunal is concerned with the following issues:

1 What was the reason for the dismissal and was it one recognised by statute (i.e. Act of Parliament)?
2 Did the employer act reasonably in treating that reason as justification for dismissal? (This is considered in more detail in chapter 10.)

Relationship between the four arenas of accountability

In a situation such as the one described here, if the staff nurse has been grossly negligent, then consistent results for all four hearings are likely: she will be found guilty in the criminal courts; liable in the civil court; removed from the Register by the NMC; and dismissed by the employer. However, this is not necessarily so and cases are on record where the employer dismisses the nurse, but the NMC keeps her on the Register, or where the employer does not dismiss the nurse, but she is removed from the Register (in which case, of course, the nurse would lose her registered post). In addition, a criminal charge may fail where a civil charge succeeds. The reason for the lack of consistency is that the four forums are concerned with different aspects of the situation and have different standards of proof.

Sources of law

A brief word is appropriate on what is meant by the term 'law' and what its origin is. The law derives from two main sources:

1 Acts *of Parliament and Statutory Instruments that are enacted under the powers given by the former*: these are known as statutory sources, include the legislation of the European Community and take precedence over all other laws. Laws of the European Community automatically become part of the law of the United Kingdom (Figure 1.4). The Council and the Commission have law-making powers and this can be in the form of Regulations or Directives. The Human Rights Act 1998 is in a special position (see pages 14–15).
2 *The* **common law** *(also known as case law or judge-made law)*: this is made up of the decisions by judges in individual cases that are often, but not always, interpretations of **statute** law. The judge, in deciding a particular case, is bound by a previous decision on the law made by judges in an earlier case if it is relevant to the facts before him and if that decision was made by a higher court than the one in which he is sitting. There is a recognised order of precedence so that, for example, a decision by the Supreme Court of Justice is binding on all other courts except itself, but would be subject to relevant precedents of the European Court of Justice. (In 2009 the House of Lords as a judicial body was abolished and its powers transferred to a new Supreme Court of Justice. The House of Lords still remains as part of the parliamentary system.) The decisions of the courts are recorded by officially recognised reporters, so that in a case similar to a previous one the earlier decision can be put

before the court. If the facts and the situation are comparable and the decision was made by a court whose decisions are binding, then the earlier precedent will be followed. If there are grounds for distinguishing the case then a different decision may follow.

Of vital importance to the system of precedence is a reliable procedure for recording the facts and decisions on any court case. Each court has a recognised system of reporting and the case is quoted by a reference that should enable the full report of the case to be found easily. (An example is given in the Glossary – see 'Citation'.)

Similarly, Acts of Parliament and Statutory Instruments have chapter numbers for each year or a serial number.

There are recognised rules for interpreting Acts of Parliament and in relation to the following of precedents. Ultimately, however, if the law is unsatisfactory and fails to provide justice, the courts look to the Houses of Parliament to remedy the situation by new legislation. There is a right of appeal on matters of law to courts of higher jurisdiction. An appeal can be taken to the Court of Appeal and from there to the Supreme Court of Justice, if permission is granted. Until the Supreme Court of Justice has pronounced on a particular point of law, there may be considerable uncertainty as to what the law in a given situation is. A considerable number of medical law cases have been referred to the House of Lords, the predecessor to the Supreme Court of Justice, in recent years. In July 2014 the Supreme Court referred the issue of assisted suicide to Parliament since in a majority judgment it was not prepared to declare that the existing law was contrary to Article 8 of the European Convention on Human Rights (see chapter 29).[5]

Department of Health (DH) circulars and other government memoranda and NMC Codes of Practice are not legally binding, but they are recommended practice. Breach of these codes may be evidence of failure to follow the approved practice, but cannot in itself result in successful criminal or **civil action**. This does not apply to the Midwives' Rules, which do have statutory force (see chapter 14).

European Court of Justice and the European Court of Human Rights

The distinction must be drawn between these two courts. The European Court of Justice (ECJ) is part of the judicial machinery of the European Union, of which the UK is a member. The ECJ sits in Luxembourg. In contrast, the European Court of Human Rights is the judicial body for hearing cases on the European Convention on Human Rights. It meets in Strasbourg. The website for this book sets out the Schedule to the Human Rights Act 1998, listing the articles of the Convention.

Differences between civil and criminal law

What is the difference between civil law and criminal law? The only safe answer is that a breach of criminal law can be followed by prosecution in the criminal courts, whereas **liability** in civil law is actionable in the civil courts and may or may not be a crime. There is no necessary moral difference between the two. Prior to the Suicide Act of 1961 (which decriminalised an attempt to commit suicide), suicide and attempted suicide were crimes and, as such, the latter was subject to criminal proceedings. To many people, however, suicide may still be regarded as morally wrong irrespective of its non-criminal status and it is still a criminal offence to assist someone in a suicide attempt. Some acts may be both **criminal and civil wrongs**: thus to drive without due care and attention and cause harm can be followed by both criminal and civil proceedings. How does one know if an act is a civil wrong? One way would be to consider previous cases to find out whether there is a **precedent**. The ultimate way would be to establish in the Supreme Court of Justice whether a particular action gives rise to civil liability. There is, for example, an increasing acceptance by the courts that information given in specific circumstances can give rise to an action for breach of confidence. Liability in civil law is thus a growth area.

Civil actions

A civil action for negligence will be the main one considered here in relation to the liability of the nurse or NHS trust, but there are other civil actions which will be considered briefly. The various forms of civil action are shown in Box 1.3. All these, except actions for breach of contract, are known as **torts**, i.e. civil wrongs.

Box 1.3 Some forms of civil action

1 Torts
- Negligence
- Trespass to property
  - to land
  - and to the person
- False imprisonment
- Wrongful interference
- Breach of a statutory duty
- Nuisance
- Defamation
- Malicious prosecution
- Deliberate interference with interests in trade or business

2 Breach of contract

The action for breach of a statutory duty arises when an Act of Parliament or Statutory Regulations place duties on organisations or individuals. In certain circumstances where an individual suffers harm as a result of the breach of these statutory duties, an action for compensation may ensue in the civil courts. For example, many of the provisions of the Factories Acts give rise to such actions. In contrast, a breach of the general duties under the Health and Safety at Work Act does not give rise to such an action, and nor since October 2013 do breach of the regulations made under the Health and Safety at Work Act (this is considered in chapter 12). The funding of civil cases and the no win, no fee system is considered in chapter 6.

Defamation is another tort that is considered in chapter 9. An action for nuisance is not considered in this book and is unlikely to concern the nurse at work. An action for breach of contract will be briefly considered in chapter 10 in connection with the nurse's contract of employment. An action for trespass to the person exists where a person alleges that they have been touched without their consent, and this is considered in chapter 7.

Judicial review

The legality of a judicial or administrative action by a public body can be challenged by judicial review in which the High Court is asked to rule on the legality of the specified action. Concerns about the increase in applications for judicial review led to government proposals to remove legal aid for judicial review cases before they are given permission to proceed by a judge. This proposal has led to an outcry.[6] The changes contained in the 2014 Regulations[7] require the Lord Chancellor to refuse to pay legal aid for judicial review unless the court gives permission to bring judicial review proceedings or (the court neither refusing or granting permission) the Lord Chancellor thinks it reasonable to pay remuneration. The plans include limiting an application for judicial review to those who have a direct link to the

policy or decision. The changes have been strongly criticised as politically motivated.[8] Charities and others including the QC David Pannick[9] and the Chief Executive of Shelter Campbell Robb have opposed the plans. The latter cited a case of a homeless family for whom the local authority was only prepared to provide emergency accommodation when it was faced with a challenge by judicial review.[10] The Criminal Justice and Courts Bill clause 50 aims to restrict judicial review by providing that an application for judicial review must be refused if the defendant shows that it is highly likely that the outcome for the applicant would not have been substantially different if the conduct complained of had not occurred. David Pannick QC argues strongly against the clause.[11]

Other proposed changes to the legal aid system include reducing the right to choose lawyers paid by the legal aid fund, those on £37,500 joint household disposable income will have to fund their own lawyer in criminal cases.

Family courts

On 22 April 2014 a new system of family courts came into existence for England and Wales. From this date all matters relating to a family including divorce, financial arrangements, adoption and care of children are dealt with by the Family Court. Care cases must be completed within six months by this single Family Court. Other changes include the requirement that separating couples attend a mediation awareness session before taking disputes over their finances or their children to court, and law students are being drafted in to set up advice centres and to assist in mediation. Expert evidence in cases involving children is only permitted when it is necessary to resolve the case justly.

Legal personnel and legal complaints

At present we have a divided legal profession: **solicitors** and **barristers** (counsel). There are over 128,000 solicitors and about 15,000 barristers. The former are the main link with the client. Thus, in Practical Dilemma 1.1, if the parents of the child decided to take civil action against the NHS trust, they would consult a solicitor, who would give them advice and possibly prepare an application for financial aid or consider bringing the case on a no win, no fee basis (see below). If the case were to proceed, s/he would probably instruct counsel (i.e. a barrister) to prepare the pleadings (see chapter 6) and represent the client in court. Under Part III of the Access to Justice Act 1999, major reforms were made to the law on lawyers' rights of audience before the courts and rights to conduct **litigation**, and as a result all lawyers have full rights of audience before any court, subject only to meeting reasonable training requirements. The 1999 Act replaced the Lord Chancellor's Advisory Committee on Legal Education and Conduct with a new Legal Services Consultative Panel. The Act also made changes relating to complaints against lawyers. It gave additional powers to the Law Society and the Legal Services **Ombudsman** to strengthen the system for handling complaints against lawyers and created a Legal Services Complaints Commissioner to set targets for the handling of complaints by the professional bodies. Having completed its work in improving the speed, quality and consistency of complaints handling, the Office of the Legal Services Complaints Commissioner was abolished on 31 March 2010 and replaced by the Legal Services Board.[12] In October 2010, the Legal Ombudsman, an independent, lay organisation, was established to handle complaints. Unlike the former Legal Services Ombudsman, which was a last-stop appeal for people with complaints, the Legal Ombudsman is the frontline body handling complaints and there is no further appeal apart from judicial review.[13] The House of Lords decided that professional work in court is no longer immune from actions for negligence.[14]

These reforms may, in the long term, lead to a single legal profession. At present the initial training for both solicitors and barristers is the same (a law degree or Part 1 of the Common Professional Examination). Would-be solicitors then undertake practical training with a firm of solicitors, and then take the Law Society's Part 2 examination, called the Legal Practice Course, while would-be barristers study for the Bar to which they are 'called'. They must join one of the Inns of Court and must participate

in 12 qualifying sessions of education and training including dining. The barrister must then undertake pupillage, where they are attached to a practising barrister. Barristers usually work together in chambers managed by a clerk who negotiates and collects the fees from solicitors. Fees are at present negotiated in advance and include a brief fee for accepting a case and a refresher fee, which is a daily fee for each day that the case is in court. Senior barristers and solicitor-**advocates** are eligible to 'take silk', i.e. they become **Queen's Counsel** (QC) appointed by the Lord Chancellor on the recommendation of an independent panel. The term 'lawyer' includes both solicitor and barrister.

Legal language

Lawyers, like any profession, have their own language, which can create barriers. In April 1999, new procedures for civil litigation were introduced together with a simplification of language to assist communication: thus the term '**plaintiff**' (used to describe a person bringing a civil action) was replaced by the word 'claimant'; a '**writ**' (the document issued by the court which begins the civil case) is replaced by 'claim form'. A Glossary is provided to assist the reader with any specialist terms. It is the aim of this book to break down the barriers between the law and the nurse and to facilitate communication.

Human Rights Act 1998

The United Kingdom was a signatory of the European Convention for the Protection of Human Rights and Fundamental Freedoms in 1950. However, anyone who sought to bring an action for breach of their human rights, as set out in the Convention, was unable to take the case to the courts in this country but had to go to the European Court of Human Rights in Strasbourg. (NB: This is *not* the court of the European Union, the European Court of Justice, which meets in Luxembourg.) It was estimated that to take a case to Strasbourg cost over £30,000 and took over five years. The Human Rights Act 1998 came into force on 2 October 2000. (It came into force in Scotland on devolution.) It has three main effects: first, it is unlawful for a public authority (or organisation exercising functions of a public nature) to breach the rights set out in the Convention; second, from 2 October 2000 an allegation of a breach of the rights can be brought in the courts of this country; and third, judges can make a **declaration** that legislation that is raised in a case before them is incompatible with the articles of the Convention and the legislation will then be referred back to Parliament for reconsideration. The domestic courts are obliged to take into account the judgments of the ECHR under section 2(1) of the Human Rights Act 1998, but this does not apply on rare occasions when there are concerns as to whether the Strasbourg court's decision sufficiently appreciated or accommodated particular aspects of the domestic process.[15]

Action can be brought against a public authority or an organisation exercising functions of a public nature for breach of the Convention articles in the courts of this country. The Court of Appeal held that those permitted to bring an action included soldiers on military service overseas.[16] However, this was overruled by the Supreme Court, which held (in a majority judgment) that British Armed Forces overseas were not within the jurisdiction of the UK within the meaning of Article 1 of the European Court of Human Rights (ECHR). If, however, it did apply (they held unanimously) that an inquest compliant with Article 2 was not required automatically whenever a member of the armed forces died on active service.[17]

In June 2013 the Supreme Court ruled in a majority judgement that the families of British soldiers killed and wounded in Snatch Land Rovers in Iraq had the legal right to sue the government over their deaths, i.e they could bring claims in negligence and under Human Rights legislation.[18]

The fact that a person is a paedophile does not mean that he has no human rights. In 2013 the Court of Appeal held that excessive detention of a convicted paedophile was contrary to his human rights even though he had been convicted of sex offences against school girls.[19]

An example of a declaration of the court of law incompatible with the articles of Human Rights is a declaration of the House of Lords,[20] which held that the then marriage laws in the country that prevented a transsexual marrying following his gender change (because the law did not recognise the change of gender) were incompatible with Human Rights articles; a Gender Recognition Act 2004 was passed and implemented, which enables applicants who meet specified criteria to apply for a replacement birth certificate and who are then allowed to marry in their adopted sex. It is possible for a person to take a case to the ECHR in Strasbourg if he or she is dissatisfied with the decision of the Supreme Court of Justice on a human rights issue.

The book's website sets out Schedule 1 to the Human Rights Act 1998. The alarmist prophecies of a huge increase in litigation were not realised, although there has been an increase in the number of cases alleging breach of the articles, often alongside another course of action. Some of the more significant articles will be considered below, but articles are also considered in relevant chapters. It is recommended that healthcare staff should undertake a proactive exercise in identifying possible breaches of the Act and be proactive in taking any necessary remedial action. Further information is available from the Ministry of Justice website,[21] which took over the responsibilities on human rights from the Department for Constitutional Affairs (DCA) in 2007.[22] The Equality and Human Rights Commission also publishes practical guidance on human rights together with case reports.[23] It carried out a review in 2012. (For further information see chapter 10.)

In June 2007 the House of Lords[24] decided, in a majority decision, that private care homes under contract with local authorities for the provision of places were not exercising functions of a public nature for the purposes of the Human Rights Act. The Human Rights Act has subsequently been amended to extend the definition of exercising functions of a public nature. Those provided with care support, whether in residential homes or their own homes are entitled to the protection of the Human Rights Act but not those who fund their own care (see chapter 23).

Right to life

Statute 1.1 Article 2(1) European Convention for the Protection of Human Rights and Fundamental Freedoms

Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction for a crime for which this penalty is provided by law. (The sixth Protocol Article 1 states that 'The death penalty shall be abolished. No one shall be condemned to such penalty or executed.')

Claims have been made that this right to life could be used as the basis for legal action when resources are refused or when decisions are made for a person not to be resuscitated or treatment is withdrawn or withheld. For example, in a case where parents challenged a not for resuscitation (NFR) decision for their severely disabled baby,[25] the court held that the full palliative care recommended by the doctors, allowing the baby to die with dignity, was not a breach of either Article 2 or Article 3 (see below) of the European Convention for the Protection of Human Rights and Fundamental Freedoms. The President of the Family Division, Dame Elizabeth Butler-Sloss, held that the withdrawal of life-sustaining medical treatment was not contrary to Article 2 of the Human Rights Convention and the right to life, where the patient was in a persistent vegetative state. The ruling was made on 25 October 2000 in cases involving Mrs M, aged 49, who suffered brain damage during an operation abroad in 1997 and was diagnosed as being in a persistent vegetative state (PVS) in October 1998, and Mrs H, 36, who fell ill in America as a result of pancreatitis at Christmas 1999.[26] Diane Pretty failed in her attempt to see the Suicide Act 1961 (which makes it an offence for her husband to aid and abet her suicide) as incompatible

with her right to a dignified death and therefore a breach of Articles 2, 3, 8 and 14.[27] She took her case to the ECHR but failed.[28] Article 2 has also been relied upon by those who claim that there has been a miscarriage of justice in relation to a death in custody or near death. Thus, in one case[29] the claimant, who was assessed as a real suicide risk in prison, attempted to hang himself and was left severely brain damaged. A prison investigation took place but the report was not published. The Secretary of State proposed a private inquiry by the Prisons and Probation Ombudsman, but the claimant sought judicial review of this proposal, arguing that Article 2 rights implied an obligation on the State to carry out an effective investigation into the circumstances relating to a death. The judge upheld the claim, setting out the characteristics of an effective investigation. The Secretary of State appealed and the Court of Appeal held that any investigation should be held in public but that the claimant's representatives would not be entitled to **cross-examine** witnesses. In a subsequent case a young man attempted suicide in Feltham Young Offenders Institution and was left brain damaged. The Court of Appeal held that in such a situation Article 2 rights required that there was a clear obligation on the Secretary of State to ensure that there was an effective inquiry into the near death.[30] A breach of Article 2 was successfully claimed when a witness for the prosecution who was known to be subject to intimidation did not receive police protection and was murdered before the trial took place.[31] Article 2 rights were also considered by the House of Lords when considering a coroner's refusal to resume an inquest[32] (see chapter 29). See above, the case of Jason Smith, who died on active service but whose mother failed in her argument that his Section 2 rights required an inquest to be held.[33] The Supreme Court held that an NHS trust was in breach of the Article 2 rights of an informal patient who committed suicide when on home leave to which the parents had objected in fear for her safety[34] (see chapter 20 Case 20.1).

Right not to be subjected to inhuman or degrading treatment

Statute 1.2 Article 3

Article 3 of the Convention states that:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

It could be argued that patients who spend six hours on a stretcher in a corridor outside the A&E department while a bed is being sought are being subjected to both degrading and inhuman treatment. The physical conditions in some hospitals or nursing or residential care homes may be seen to be an infringement of this right. Other examples could probably be given where patients are not treated with dignity or humanity. In the field of manual handling, there have been suggestions that to require a person to use a hoist is contrary to their human rights. However, it is thought that such an argument will not succeed, since if the alternative to a hoist is manual handling by another person, then that might be contrary to the rights of the other. This issue was considered in a manual handling case involving East Sussex County Council (see chapter 12). The High Court has held that requiring an asylum seeker to sleep rough was inhuman and degrading treatment under Article 3. It was insufficient for the Home Office to provide a list of charities for the homeless.[35] In a case where a woman died after being imprisoned, her children won a case in the ECHR that the conditions of her imprisonment prior to her death were inhuman and degrading and therefore a breach of Article 3. There were serious lapses of procedures to monitor her condition, especially her weight loss (from 50 kg to 40 kg) and her vomiting, and to arrange for earlier hospital admission.[36] The restraint of an autistic boy was held to be inhuman under Article 3[37] (see chapter 17 Case 17.2). Failure by the local authority (LA) to protect children from serious neglect and abuse (which was known to the LA) was held to be a breach of their Article 3 rights.[38] The ECHR held that mandatory life sentences for murder in the UK, without any real likelihood of reduction of period to be served amounted to a breach of Article 3 rights for the prisoners.[39]

Right to liberty and security

Statute 1.3 Article 5

Article 5 of the Convention states:

> Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in accordance with a procedure prescribed by law.

The use of common law powers (i.e. powers recognised by the courts as in the *Re F*[40] case) to detain mentally incapacitated adults in psychiatric hospitals was regarded as a breach of this article, since, although the article envisages the lawful detention of persons of unsound mind, a decision of the House of Lords did not lay down a procedure. This issue was raised in the Bournewood case[41] where the ECHR ruled against the UK. (The case is discussed in chapters 7 and 17.) Amendments to the Mental Capacity Act 2005 to fill the gap revealed by the Bournewood case have been made by the Mental Health Act 2007 and are considered in chapter 17. The Supreme Court held that disabled persons were deprived of their liberty and there was a breach of Article 5 in a recent case (see chapter 17 Case 17.4).[42]

Right to a fair trial

Statute 1.4 Article 6

Article 6 of the Convention states:

> In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.

This will apply to disciplinary hearings as well as courts and tribunals. Hearings must be independent and impartial. In criminal prosecutions, the accused is presumed innocent until proved guilty. A GP's claim that his suspension from his practice was a breach of Article 6 was not upheld since the suspension was an interim measure during which his pay was maintained. There was, however, a breach of the right to protection of property under Article 1 of the First Protocol to the Convention.[43]

Right to respect for private and family life, home and correspondence

Statute 1.5 Article 8

Under Article 8 of the Convention:

1. Everyone has the right to respect for his private and family life, his home and his correspondence
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

It was argued by a father[44] whose wife wished to obtain an abortion that for it to be undertaken against the wishes of the father was contrary to Article 8. (This is considered in chapter 15.) Failures to recognise confidential information or support the privacy of patients may lead to court action against hospitals and other organisations. In a case heard by the ECHR, it was held that the fact that the rights in law of an unmarried father differed from those of a married father were not a breach of Article 8 since there was an objective and reasonable justification for the difference in treatment.[45] The High Court held that restrictions on child visits to patients in high-security hospitals who had committed murder, manslaughter or certain sexual offences, unless the child was one of a permitted category, were lawful and were not in breach of Article 8 of the European Convention on Human Rights.[46] The onus of establishing family life lay on an applicant. The High Court also held that a prisoner serving a life sentence for murder did not have a right to his wife to be artificially inseminated with his sperm. The right to found a family did not mean that an individual was guaranteed to the right at all times to conceive children.[47] The appeal to the Court of Appeal failed.[48] However, the majority of the Grand Chamber of the ECHR found a breach of Article 8 when a prisoner was refused artificial insemination. There was a strong **dissenting judgment** that there was no breach[49] (see chapter 22). The Supreme Court held that there was a breach of Article 8 where sex offenders were denied a right of review of the notification provisions.[50] In 2009, Debbie Purdy sought clarification of the law relating to the offence of assisted suicide and claimed that the uncertainty relating to whether a prosecution would be brought against relatives who took terminally ill persons to Switzerland to end their lives was a breach of their Article 8 rights. She failed before the High Court and Court of Appeal but the House of Lords held unanimously that the Director of Public Prosecutions (DPP) should be required to promulgate a policy identifying the facts and circumstances he would take into account in considering whether to prosecute persons such as the claimant's husband for aiding and abetting an assisted suicide abroad. The lack of clarity on whether there would be a prosecution of relatives who took someone abroad to die was an infringement of Article 8 rights[51] (see chapter 29). The ECHR held that the order of deportation of a Pakistani who had lived in the UK since the age of 3 years and had no connections with Pakistan was a disproportionate response to the offence of smuggling heroin. He had not reoffended since his release from prison in 2006.[52] In contrast, the ECHR held, in the case of a man who alleged that there was secret surveillance of his removal business, that these measures did not interfere with his private life since there were sufficient safeguards in the UK's interception of communications regime to ensure that an individual's rights were not breached. There was no breach of Article 8.[53] In two further cases, breaches of Article 8 were established. In the first, the ECHR held that monitoring by prison authorities of medical correspondence between a convicted prisoner and his neuroradiology specialist violated his right for respect for his correspondence as guaranteed by Article 8.[54] In the second, the ECHR held in January 2010 that the police powers of stop and search were illegal as a breach of Article 8, holding that section 44 of the Terrorism Act 2000 violated individual freedoms guaranteeing the right to private life. The action was brought by Kevin Gillian and Pennie Quinton, who were awarded £30,400 in costs.[55]

The allegation that Kensington and Chelsea RLBC breached Article 8 rights when withdrawing a night service for disabled persons and the ECHR decision is considered in chapter 23.[56]

The Supreme Court held that hoteliers who refused to let a double room to a gay couple unlawfully discriminated against the court on grounds of sexual orientation. The limitation on their religious beliefs that such relationships were sinful was justified as a proportionate means of achieving a legitimate aim of protecting the rights and freedoms of others. To rule otherwise would be to create a class of people who were exempt from the discrimination legislation.[57]

Article 2 of Protocol 1 of the ECHR recognises a right to education. The Supreme Court held that a delay of 18 months in providing special education for a severely disabled child while the local authority secured a place in a specialist school was not a breach of Article 2 of Protocol 1 of the ECHR.[58]

The European Court of Human Rights ruled that a blanket ban by the UK on prisoners having a right to vote was a breach of their human rights.[59] Under the ECHR ruling almost 2,300 prisoners were bringing claims for compensation as a consequence of their being refused voting rights. However, in

August 2014 the ECHR confirmed its earlier ruling that a blanket ban on prisoners voting was contrary to their human rights but did not award compensation.[60]

In February 2014 the Court of Appeal held that whole life sentences did not amount to inhuman or degrading treatment contrary to Article 3 because there was a power to review the order where exceptional circumstances had arisen.[61]

It was held that there was no breach of Article 4(2) (no one shall be required to perform forced or compulsory labour) in the back to work scheme since it was a condition imposed for the payment of a claim for state benefit, i.e. jobseeker's allowance.[62]

Other significant articles include Article 9, freedom of thought, conscience and religion; Article 10, freedom of expression; and Article 14, prohibition of discrimination. As cases come before the courts, case law develops on the interpretation to be given to the various articles and the extent to which the NHS is recognising the rights of its staff and its patients. Further information on human rights and equalities can be found on the Equalities and Human Rights Commission website.[63] There are many other Conventions recognising the rights of specific groups. For example, the UN Convention on the Rights of the Child, while not directly enforceable in the UK, is observed, and compliance with it is monitored by a joint committee of the Houses of Parliament. The Convention and Protocol relating to the status of Refugees (1951 and 1967) was considered by the Supreme Court when it held that gay asylum seekers could stay in the UK if they feared that they would face persecution were they to live openly in their home countries.[64] The ECHR held in 2006 that the UK bereavement tax regime was discriminatory.[65]

Controversy over human rights

At the time of writing, controversy has arisen over whether this country should continue to be a signatory of the Convention in the light of recent decisions of the ECHR, particularly those relating to life sentences, voting rights for prisoners and sex offenders being permitted to come off the sex register after 15 years. This relates to a further controversy over the extent, if any, to which the European Union Charter for Fundamental Rights applies in the UK. There are calls for the UK to have its own Bill of Human Rights and cease to be a signatory of the European Convention and the Conservative Party is preparing a British Bill of Rights to be included in its election manifesto for 2015 which would limit the powers of the European Court of Human Rights and reassert the sovereignty of Parliament. The answer to the controversy might, however, rest in judicial hands. Lord Neuberger, president of the Supreme Court, stated that the Human Rights Act had led to an 'age of enlightenment' but Britain was required to take account of Strasbourg's rulings but not necessarily follow them: 'We should be more ready not to follow Strasbourg chamber decisions.'[66]

Freedom of Information Act 2000

This Act, which gives a right of access to information held by public authorities, was brought into force in 2005. An Information Commissioner was appointed to monitor both the FOI Act and the Data Protection Act 1998, and Codes of Practice and Guidance have been issued. There are many exceptions to the right of access, including personal information, information provided in confidence and legal professional privilege. (Both Acts are considered in chapter 8.) Information on both the Data Protection Act and the Freedom of Information Act is available from the Information Commissioner's Office website.[67]

Devolved law-making powers

Increasingly, the four constituent parts of the UK are going their separate ways as law-making powers are devolved from Westminster. This book is of necessity focused on England. A fascinating analysis of the differences is provided by Nicholas Timmins[68] illustrating the difficulties in making any comparison

of performance across the UK. The respective assemblies of Scotland, Northern Ireland and Wales have websites from which the specific laws and guidance for those countries can be accessed.[69] However, it is hoped that the general structure and content of this book will be relevant to readers across the UK.

Conclusions

The law and our legal systems are continually changing. There is currently concern for greater openness particularly in the family courts. In January 2014 practice guidance was issued by Sir James Mumby, President of the Court of Protection, and in keeping with similar guidance issued at the same time for the family courts with the aim of bringing about an immediate and significant change in practice in relation to the publication of judgments in family courts and the Court of Protection.[70] The Justice and Security Act 2013 extended closed material procedures (CMP) to civil cases. From June 2013 Ministers have been able to apply for a CMP to bar the public, media and claimant from the proceedings, usually on grounds of national security. Two of five applications for secret hearings have been granted by judges in the 12 months to July 2014. There are likely to be major upheavals in the criminal courts system with plans to close more magistrates' courts and introduce privatisation.[71] Two recent reports recommend changes. The first from the charity Transform Justice is concerned that **magistrates** are older and less diverse than 15 years ago. It recommends that recruiting should be changed to encourage diversity; recruiting through social media, changing the application process, giving recruitment to the Judicial Appointments Committee, targeting specific groups and considering positive discrimination. The second from the Policy Exchange outlines a new role for **justices of the peace** (**JPs**) who would dispense justice from new police courts in a drive to speed up the justice system. Offenders would be punished on the spot, with magistrates sitting in police stations at peak times including evenings and Saturdays.[72] Further changes to the legal system are proposed by the Secretary of State for Justice who is seeking to restrict the right to seek judicial review which is considered above.

In October 2013 the Court of Appeal was televised for the first time with the aim of opening up the workings of the appeal courts and making the justice system more transparent. Judges are being trained for such developments.

Reflection questions

1 What is the difference between law that derives from a statute and the common law?

2 What is the difference between a solicitor and a barrister?

3 Look at the Glossary and identify those words with which you are not familiar.

Further exercises

1 Consider any situation you know of where a patient (almost) suffered harm as a result of a careless act by a professional and analyse the potential consequences as far as the civil and criminal courts, the CCC and the employment tribunal are concerned. Refer to chapters 2, 3, 10 and 11 for more details.

2 Try to arrange a visit to one of the four forums described here or a coroner's court (see chapter 29) and draw up a plan for the procedure that you witness.

3 With colleagues, choose any Article in the Convention on Human Rights (see the book's website) that is relevant to your work and decide on the extent to which there are any infringements of that right. What action could you take?

4 If you work in Wales, Scotland or Northern Ireland, access the website of the relevant devolved assembly and obtain information on the statutes and regulations which have been enacted through their devolved powers.

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Chapter 2

Actions in the criminal courts and defences to criminal charges

This chapter discusses

- Initial stages of arrest and prosecution
- Magistrates' courts
- Plea and Case Management Hearing
- Crown Court proceedings
- Elements of a crime
- Cases of Dr Nigel Cox, Dr Adomako, Dr Shipman, Beverley Allitt and Kevin Cobb
- Administration of drug by epidural instead of intravenous injection
- Offence of ill-treatment or wilful neglect
- Defences
- Criminal injuries compensation

Introduction

In this chapter, we consider the course followed if criminal proceedings are brought against a nurse and the ways in which she could defend herself. It must be emphasised that the burden is on the prosecution to establish the guilt of the accused beyond reasonable doubt. The accused still has a right of silence at all stages of the prosecution, but failure by the accused to answer questions or mention something she later relies on in court or failure to give evidence may allow adverse inferences to be drawn during the trial. The principle that no one is exempt from the criminal law was upheld by the Supreme Court on 10 November 2010, upholding the Court of Appeal's decision,[1] when it held that former MPs who were

charged with expenses fraud would have to stand trial in criminal proceedings, and parliamentary privilege or immunity did not attach to ordinary criminal activities.

The National Crime Agency was set up under part 1 of The Criminal Courts Act 2013 with the functions of crime reduction and crime intelligence. For further details about its fight against organised crime see its website.[2]

Practical Dilemma 2.1 Theft

A discrepancy is found between the ward drug control records and the stock. An investigation is initiated and suspicion falls upon Staff Nurse Jarvis. The police are brought in and, after making their enquiries, they decide that Staff Nurse Jarvis should be charged with the offence of theft.

A situation such as this involves several kinds of investigation. The NHS trust will be concerned to determine whether there are grounds to discipline and possibly eventually dismiss the staff nurse. The fact that the police are brought in does not mean that the NHS trust can abandon its own investigation, but clearly its enquiries should not conflict with those of the police. The NHS trust must allow the staff nurse to give a full explanation of what has occurred and she should be allowed a representative. Disciplinary proceedings by the employer are discussed in chapter 10. There is also the possibility of a hearing before the Conduct and Competence Committee (CCC) of the Nursing and Midwifery Council (NMC) (see chapter 11), but this may well be postponed pending the outcome of the police investigations and criminal charges. Here we are concerned only with the criminal proceedings.

Initial stages of arrest and prosecution

The staff nurse may well be asked to accompany the police to the station (see Figure 2.1). A Code of Practice (C) prepared under the Police and Criminal Evidence Act 1984 provides guidance on the detention, treatment and questioning of persons by police officers and is intended to provide clear

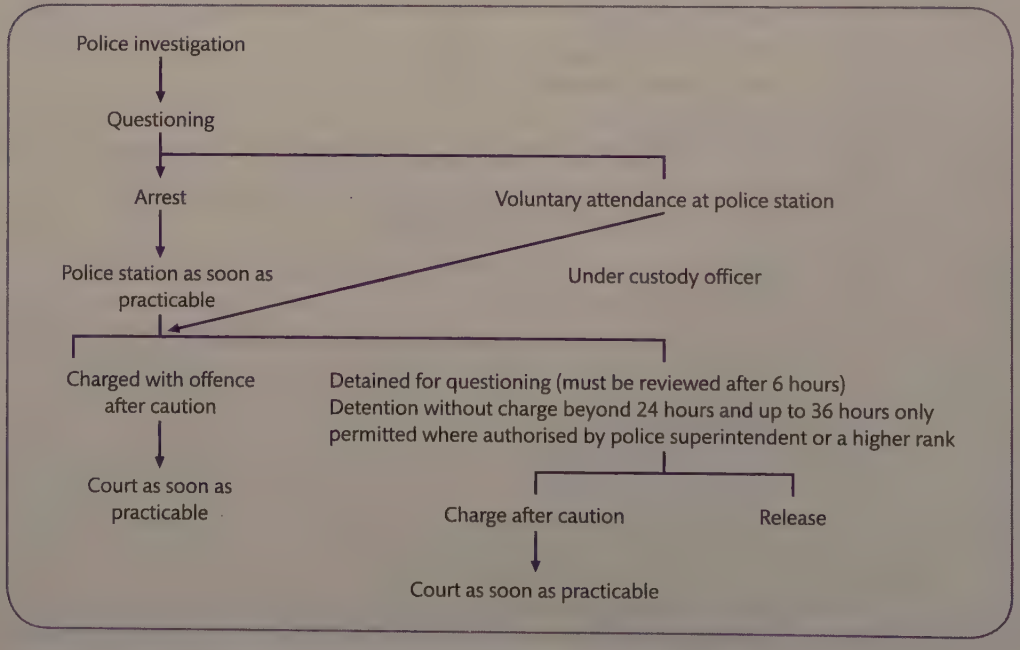


Figure 2.1 Initial stages of arrest and prosecution

and workable guidelines for the police, while strengthening safeguards for the public at the same time. The Codes of Practice were most recently revised in 2012 and are available on the UK government website.[3] They cover:

Code of Practice A: exercise of police officers of their statutory powers of stop and search
Code of Practice B: searches of premises and seizure of property
Code of Practice C: detention, treatment and questioning of persons by police officers (C includes annexes on A: intimate and strip search; B: delay in notifying arrest or allowing access to legal advice; C: restriction on drawing adverse inference from silence and the terms of the caution; D: written statements under caution; E: summary of provisions for mentally disordered and otherwise mentally vulnerable people; F: not used; G: fitness to be interviewed; and H: detained persons: observation list); Annex I and J not used; Annex K – X-rays and ultrasound scans; L: establishing gender of persons for the purpose of searching
Code of Practice D: identification of persons by police officers
Code of Practice E: tape-recording interviews with suspects
Code of Practice F: visual recording with sound of interviews with suspects
Code of Practice G: the statutory power of arrest by police officers
Code of Practice H: requirements for the detention, treatment and questioning of suspects related to terrorism in police custody by police officers.

The Code of Practice must be readily available at all police stations. The Code applies both to those who have been arrested and those who have voluntarily attended the police station. One of the most important safeguards is the right of the detained person to have access to free legal advice at the police station before and during any interview.

The staff nurse may have been arrested before she is taken to the police station or she may be arrested there. In either case, she should be given a caution as soon as there are grounds to suspect her of the offence and before she is questioned about it for the purpose of obtaining evidence that may be given to a court in a prosecution. The caution should be given in the following terms: 'You do not have to say anything but it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say may be given in evidence.'

Minor deviations may be a breach of the Code, but do not necessarily affect the fairness of the trial and make the evidence inadmissible under section 78 of the Police and Criminal Evidence Act. The documentation that the police must retain is shown in Box 2.1. The Code sets out rules for the police in the interview. The usual procedure now is for the interview to be tape-recorded and the guidelines and Code of Practice for tape-recording should be followed. From May 2010, recording by secure digital network, as an alternative to audio tape, is permitted following a pilot study in East Lancashire. Visual recordings (which, unlike audio or secure digital recordings, are optional) can also be made digitally.[4]

Box 2.1 Documentation kept by the police

Custody records should be kept for each person who is brought to a police station under arrest or who is arrested at the police station after attending there voluntarily. He is entitled on request to be supplied with a copy when he leaves the police station.

The information must be recorded as soon as practicable and should include the following:

1 Grounds for a person's detention.
2 Detained person's property.
3 Request made for a person to be informed and action taken; any letters or messages sent, calls made or visits received, and any refusal on the part of a person to have information about himself or his whereabouts given to an outside enquirer.

4 Any request for legal advice and the action taken on it.
5 Replacement clothing and meals offered.
6 Medical examination by a police surgeon, or request for one and the arrangements made; any medication the detained person is on.
7 An interview record should record:
- the times at which the detained person is not in the custody of the custody officer and why, and the reason for any refusal to deliver him out of that custody
- any intoxicating liquor supplied to a detained person
- any decision to delay a break in an interview
- a written record of the interview (unless tape-recorded) signed by the detained person as correct.

8 Any action taken to call an interpreter and any agreement to be interviewed in the absence of an interpreter.
9 Grounds for and the extent of any delay in conducting a review.
10 Anything a detained person says when charged, any questions put after the charge and answers given relating to the offence shall be contemporaneously recorded in full on the forms provided and the record signed by the detained person.
11 Details of any intimate or strip search: which parts were searched, by whom, who was present, reasons and the result.
12 Grounds for any action in delaying the notification of an arrest or allowing access to legal advice.

When the officer considers that there is sufficient evidence to prosecute a detained person, he should bring her without delay before the custody officer, who will then be responsible for considering whether or not she should be charged. A further caution must then be given. In addition, a written notice should be given showing the particulars of the offence with which she is charged and including the name of the officer in the case (except in terrorist cases or where naming the officer would cause reasonable fear of danger), their police station and a reference number for the case. Questions relating to an offence may not be put to a person after she has been charged with that offence or after she has been informed that she may be prosecuted for it, unless they are necessary to prevent or minimise harm or loss to some other person or to the public, to clear up an ambiguity in a previous answer or statement or where it is in the interests of justice that she should have an opportunity to comment on some fresh information. Before these additional questions are put, the accused must be given another caution. Annex D to the Code of Practice C gives rules on written statements given under caution.

The Criminal Justice Act 2003 has introduced the power of a constable, investigating officer or person authorised by a relevant prosecutor to give a conditional caution provided five requirements are satisfied: evidence the offender has committed the offence; there is sufficient evidence to charge the person and a conditional caution should be given; the offender admits the offence; the effect of the conditional caution is explained; and the offender signs a document setting out specified details. The Secretary of State was required to prepare a Code of Practice in relation to conditional cautions covering specified topics (CJA 2003 ss. 22–25). It is accessible on the CPS website.[5]

Role of the Crown Prosecution Service

Since the introduction of the Crown Prosecution Service (CPS), the responsibility for the conduct of most criminal proceedings is on the CPS, the head of which is the Director of Public Prosecution (DPP), who acts under the Attorney General. They have the responsibility of instituting criminal proceedings and appearing for the prosecution. A recent reform enables victims to appeal in specified circumstances when the Crown Prosecution Service decides not to pursue suspects.[6] This follows a Court of Appeal ruling in a case in 2007 where the CPS decided not to bring sexual assault charges. The decision was reversed in 2011 and Christopher Killick was jailed for three and a half years.[7] To prevent the CPS being swamped by appeals, strict criteria apply to the right to appeal including a requirement to show that the decision not to prosecute was wrong and needs to be reversed to maintain public confidence.

Magistrates' courts

If the staff nurse is charged with the offence of theft, she would probably be given police bail and told to appear at a magistrates' court. Almost all criminal cases begin in a magistrates' court and 98 per cent are dealt with completely there. The remaining cases go before the Crown Court before judge and jury. New criminal procedure rules for the criminal courts came into force in April 2010[8] and are regularly updated.[9] They are comparable to the Civil Procedure Rules (see chapter 6) and, like the Civil Procedure Rules, set an overriding objective which is shown in Box 2.2 and give the courts case management powers.

Box 2.2 Overriding objective of criminal court

1.1

(1) The overriding objective of this new code is that criminal cases be dealt with justly

(2) Dealing with a criminal case justly includes:

- **(a)** acquitting the innocent and convicting the guilty;
- **(b)** dealing with the prosecution and the defence fairly;
- **(c)** recognising the rights of a defendant, particularly those under Article 6 of the European Convention on Human Rights;
- **(d)** respecting the interests of witnesses, victims and jurors and keeping them informed of the progress of the case;
- **(e)** dealing with the case efficiently and expeditiously;
- **(f)** ensuring that appropriate information is available to the court when bail and sentence are considered; and
- **(g)** dealing with the case in ways that take into account:
  - **(i)** the gravity of the offence alleged
  - **(ii)** the complexity of what is in issue
  - **(iii)** the severity of the consequences for the defendant and others affected, and
  - **(iv)** the needs of other cases.

Participants in the conduct of a criminal case must prepare and conduct the case in accordance with the overriding objective and comply with procedure rules, practice directions and directions made by the court and inform the court if there is any significant failure to take any procedural step required by the rules, and so on.

Indictable-only offences can be heard only before a judge and jury in the Crown Court, summary offences can be heard only by magistrates, but many offences are triable either way. Box 2.3 shows the classification of the offences and Box 2.4 shows the course of a hearing.

Box 2.3 Classification of offences

1. Offences triable only on indictment (i.e. by judge and jury): murder; genocide; infanticide; causing death by reckless driving; robbery; treason; wounding with intent; and many others.
2. Offences triable only summarily (i.e. by magistrates): drunk and disorderly; careless driving; assault on police; and other offences set down by statute, such as the Road Traffic Act 1972 and Schedule 1 of the Criminal Law Act 1977.
3. Offences triable either way (by judge and jury or by magistrates) – case can be heard by magistrates in summary trial or on indictment in the Crown Court. Offences include: theft; handling, obtaining property or pecuniary advantage by deception; assault occasioning actual bodily harm.

Box 2.4 Course of a hearing in a magistrates' court

The magistrates' courts hear:

(a) offences that are triable only as summary offences, e.g. careless driving
(b) offences that are triable either way.

Hearing

1 Plea:
  a plea of guilty must be unequivocal
  a plea of guilty may be made by post, but only to summary non-imprisonable offences.
2 Summary trial where the defendant pleads not guilty:
  A Prosecution:
    1 Opening speech by prosecution lawyer
    2 Examination in chief of prosecution witnesses
    3 Cross-examination by defence
    4 Re-examination by prosecution lawyer.
  B Submission by defence of no case to answer (if appropriate). Prosecution have the right to reply and magistrates determine the question.
  C Defence case:
    1 Defendant can remain silent or give evidence. (The court may in certain circumstances draw adverse inferences from silence.)
    2 Defence witnesses are called and can be cross-examined by the prosecution.
    3 Defence lawyer addresses the magistrates and the prosecution lawyer can make a closing speech.
  D The finding: the magistrates determine the guilt or innocence and determine the sentence if a guilty verdict and if they feel their powers are adequate.

When the staff nurse is brought before the magistrates she will be asked to indicate a plea. If she indicates a plea of guilty to the summary offence, she will be sentenced by the magistrates. If she pleads not guilty, she will be tried by the magistrates.

If she is charged with an offence that is triable either way (i.e. as a summary offence before the magistrates or on indictment by a judge and jury) and she indicates a plea of guilty, then the magistrates will decide whether she should be sentenced by them; if they consider their powers are inadequate, they may then commit her to the Crown Court for sentencing. If she indicates that she intends to plead not guilty or declines to indicate a plea, the magistrate will then decide whether the trial should be before them or whether the case should be allocated to the Crown Court for trial. If the magistrates decide the case is suitable for trial before them, the defendant will be asked to consent to that procedure. The defendant has the right at that stage to elect trial by judge and jury at the Crown Court. New procedures under the Criminal Justice Act 2003 enable the magistrates to give an indication, if the accused were to plead guilty, of whether a custodial sentence would be imposed.

Plea and Case Management Hearing

If, by the same token, Staff Nurse Jarvis elects to have the case heard in the Crown Court, she would in the past have faced committal proceedings before the magistrates where they act as examining justices and decide if there is sufficient evidence for the case to be committed to the Crown Court. There used to be two forms of committal proceedings: old style where there was a mini hearing of the prosecution evidence which the defence can challenge, and the new style committal proceedings where the defendant agreed that there was a case to answer. With the implementation of Schedule 3 of the Criminal Justice Act 2003, committal proceedings have been abolished and, once the magistrates decide that an

'either way' offence should be tried in the Crown Court, it will be sent there directly and a date for the Plea and Case Management Hearing agreed. Indictable-only cases are transferred to the Crown Court immediately (i.e. at first appearance before the magistrates), and sometimes before witness statements are taken. At this preliminary hearing, a timetable will be set for the service of the prosecution evidence, service of defence statements and a date for the Plea and Case Management Hearing (PCMH).

Crown Court proceedings

Let us assume that Staff Nurse Jarvis's case is to appear in the Crown Court for trial, since it is an offence which is triable either way. (If she had been charged with an indictable-only offence, the case would have been transferred to the Crown Court.) The procedure followed is shown in Box 2.5. Changes have been made regarding the right to challenge the jury (see Box 2.6). Once the jury have been sworn in, the hearing follows the same path as that in a magistrates' court, but only counsel or a solicitor-advocate can represent the accused before the court, and a barrister may therefore have been briefed by Staff Nurse Jarvis's solicitor.

Box 2.5 Procedure in the Crown Court

1 Attendance of the defendant (in person or by video link if the defendant has been remanded in custody).
2 The indictment (the document embodying the charge(s) brought by the Crown against the defendant) is read by the clerk to the accused and he is asked whether he pleads guilty or not guilty. This is known as the arraignment.
The accused can:
(a) plead guilty – if accepted, court proceeds to sentencing
(b) plead not guilty – see point 4, below
(c) stand silent – if mute of malice (this is determined by the jury), a plea of not guilty is entered – if mute by visitation of God, court will decide if accused is fit to plead (see insanity, p. 37)
(d) object on legal grounds – e.g. indictment is invalid and should be quashed.
3 Directions for smooth running of the trial: identification of all the issues.
4 Empanelling of the jury: if the defendant has pleaded not guilty to any count on the indictment, a jury must be empanelled. The jury is not usually present during the arraignment so that they are kept in ignorance if the accused has pleaded guilty to some offences and not guilty to others, unless the guilty pleas are admissible in the trial.
The jurors are called in after the arraignment and the names of 12 are called out. A list of the witnesses is read out to the jurors so that any jurors who know any witness can be excused from the jury. They can be challenged by defence or prosecution for cause (see Box 2.6). They are then sworn in and the clerk reads the indictment to them, tells them the defendant has pleaded not guilty and that their charge is to say, having heard the evidence, whether he be 'guilty' or 'not guilty'.
5 The hearing:
The judge will make introductory remarks telling the jury that they must base their decisions on the finding on the evidence given and they are not to use the internet.
A Prosecution:
1 Opening speech by the prosecution
2 Prosecution evidence:
Examination in chief: prosecution witnesses questioned by the prosecution
3 Cross-examination – to discredit witnesses, leading questions can be used and earlier inconsistent statements by the witness can be put to him
4 Re-examination – to offset the effects of cross-examination. It cannot be used to produce new evidence, which should have been brought out in the examination in chief
5 Written statements of witnesses whose evidence the defence does not wish to dispute will be read out or summarised as agreed facts

6 Challenges to admissibility of evidence: the defence can (in the absence of the jury) challenge the admissibility of evidence. The judge will rule on the admissibility and, if he upholds the defence objections to the evidence, all reference to the evidence must be omitted.

B Defence:

1 Defence submission: after the conclusion of the prosecution evidence, the defence can ask the trial judge to direct the jury as a matter of law that they should acquit the defendant:

(a) either because the prosecution has failed to produce any evidence to establish some essential ingredient of the offence

(b) or because the evidence produced is so weak or so discredited by cross-examination that no reasonable jury could convict. If the defence submission is upheld, an acquittal is directed.

If this submission fails then the defence case is put.

2 Case for the defence: an opening speech can be made where the defendant and other witnesses are being called to give evidence as to facts (not where only the defendant is called or the other witnesses are only called as to character).

Procedure as above
Examination in chief
Cross-examination
Re-examination

C Closing speeches: by prosecution and defence counsel.

D Summing up by judge.

E Verdict of jury.

F Sentencing following finding of guilt.

Box 2.6 Challenging the jury

Prosecution: can ask for any would-be juror to 'stand by' until they have gone right through the panel. Can challenge for cause (e.g. ineligibility, disqualification, presumed or actual bias).

Defence: has lost the right to three peremptory challenges (i.e. challenging without having to give any reasons). Can challenge for cause (e.g. ineligibility, disqualification, presumed or actual bias). (There have been changes to the rules on ineligibility to sit as a juror, and now judges, barristers, police officers, prison officers and others who were formerly ineligible to sit can be summoned.)

The judge has a discretionary power to remove a juror.

The effect of challenging for cause is that if either side can show that a juror is personally concerned in the facts of the particular case or closely connected with a party to the proceedings or with a prospective witness he can be removed. A challenge for cause should not succeed if the only ground for bias is so insubstantial as to be unlikely to affect the jurors' approach to the case.

The challenging party says 'challenge' immediately before the juror takes the oath. He then has the burden of satisfying the judge on a balance of probabilities that his objection is well founded and produce prima facie evidence of this.

The charges on the indictment must be put to Staff Nurse Jarvis at the Plea and Case Management Hearing. If she pleads not guilty, directions will be given to ensure the smooth running of the trial and a trial date will be fixed. The trial will then proceed as set out in Box 2.5. There will be an opening address by the prosecution counsel, setting out the elements that the prosecution have to prove and the standard of proof. This has no evidential value, but can be an important scene-setting for the jury. The prosecution then calls its witnesses who are examined in chief, which means that the witness cannot be asked leading questions. The witness can be cross-examined by the defence and here leading questions, designed to show the irrelevance of this evidence or in some other way discredit it, can be asked (see chapter 9 on evidence in court). After the cross-examination has finished, the party calling that witness

can re-examine the witness on points arising from the cross-examination. The judge can call a halt to the case on completion of the prosecution evidence if he is not satisfied that there is sufficient evidence to go before the jury, in which case the jury is asked to bring in a not-guilty verdict. For example, in a Crown Court hearing in Cardiff when two surgeons from Prince Philip Hospital Llanelli were charged with manslaughter following the removal of the wrong kidney, the pathologist giving evidence for the prosecution could not confirm that death was caused by the removal of the wrong kidney and thus the judge instructed the jury to bring forward a not-guilty verdict, since the causal link between an alleged act of gross negligence and the death had not been established by the prosecution. An NMC report[10] on 29 October 2003 stated that two nurses were convicted of manslaughter when an elderly patient died from septicaemia resulting from pressure sores while a resident in a nursing home, of which the nurses were managers. Their defence that it was the system, rather than themselves, that was to blame was rejected.

If the case proceeds, the defence calls its witnesses. At present, although the accused does not have to give evidence, the judge may in certain circumstances allow adverse inferences to be drawn by the jury.

After all the evidence has been given, the defence and prosecution conclude their cases in final speeches. The judge then sums up the case for the jury. He has the task of explaining to the jury all the relevant directions of law: the elements of the crime that the prosecution must prove the accused committed, the nature of the burden of proof that is on the prosecution; and he analyses the evidence which both sides have put before the jury.

The jurors then retire to decide their verdict and elect a foreman after they have retired. Initially, the jury is asked to return a unanimous verdict. If it is clear that they can never reach a unanimous verdict, then they can return to court and can be given instructions on returning a majority verdict which must be at least 10 to 2. The minimum period of jury discussion before a majority verdict is possible is 2 hours and 10 minutes, but in practice it may be a much longer time.

If the jury decides that the staff nurse is guilty, evidence of previous convictions (until this moment usually kept secret from the jury, but under the Criminal Justice Act 2003 evidence of bad character is admissible in certain circumstances) and her present social and economic circumstances will be given before sentencing. Sentencing will usually be adjourned for a pre-sentencing report from a probation officer. Box 2.7 sets out the powers of sentencing.

Box 2.7 Sentencing in the Crown Court

Absolute/conditional discharge
Bindover
Fine (and compensation)
Community orders coupled with conditions such as unpaid work, supervision, attendance at a programme, residence and curfew which can be electronically monitored
Suspended sentence with or without conditions, the maximum length of sentence is 2 years with a suspension of up to 2 years.
Restraining order
Prison sentence
Hospital order, Section 37 Mental Health Act 1983
Hospital order and restriction order, Sections 37 and 41 Mental Health Act 1983
For offences since October 2012 a victim's surcharge is also imposed
The courts are required to take account of Sentencing Guidelines, unless it would be unjust so to do
Credit is given for an early plea of guilty and the credit reduces with time.

Crown Court trials without a jury

The Criminal Justice Act 2003 allows for trial by a judge sitting alone when there is a danger of jury tampering. The first such case of a trial without a jury occurred in April 2010 when four men were

found guilty of a £1.75 million armed robbery at Heathrow in 2004 after three previous trials failed. The Court of Appeal had supported the prosecution's application for a trial without jury in June 2009.[11] A trial without a jury could also take place in cases involving fraud.

The staff nurse has the right to appeal against the finding of guilt on the grounds that the conviction is unsafe. She also has the right to appeal against the sentence imposed. The prosecution can appeal against sentencing by way of a reference by the Attorney General and it has the right to appeal on a point of law. Guidelines on sentencing are issued by the Sentencing Guidelines Council[12] and courts are required to follow relevant guidelines unless it is contrary to the interests of justice to do so.

In October 2013 the Court of Appeal held that a false statement to the media claiming that the assertions of the victims were spurious was a seriously aggravating feature to be taken into account when sentencing.[13] The Attorney General was given leave to appeal the unduly lenient sentence of Stuart Hall of 15 months imprisonment for 14 counts of indecent assault.

The Court of Appeal gave guidance on non-mandatory life sentences in June 2013.[14]

Elements of a crime

In order to establish guilt, the prosecution must be able to show that each element of the crime charged is proved so that the jury is sure. Each crime thus has its ingredients that make up that particular offence. Examples are given of the elements of some crimes in Box 2.8.

Box 2.8 Examples of the definition of certain crimes

1 **Assault** (common law offence):
   actus reus: an act that causes the victim to fear the immediate application of force against him
   mens rea: an unlawful intention to cause the victim to apprehend the immediate application of force, or recklessness as to whether the victim might apprehend immediate force.
2 **Battery** (common law offence):
   actus reus: an act that results in the application of force to the person of another
   mens rea: an unlawful intention to apply force, or recklessness as to whether force might be applied.
3 Wounding or causing really serious harm, Section 18 Offences Against the Person Act 1861:
   actus reus: wound or cause any really serious harm to any person
   mens rea: unlawfully with intent to do really serious harm or an intent to resist or prevent lawful apprehension or detaining of any person.
4 Wounding or inflicting really serious harm, Section 20 Offences Against the Person Act 1861:
   actus reus: to wound or inflict any really serious harm on any other person, either with or without any weapon or instrument
   mens rea: unlawfully and maliciously (intentional or recklessly and without lawful justification).
5 Theft, Section 1(1) Theft Act 1968:
   actus reus: appropriate property that belongs to another
   mens rea: dishonest with the unlawful intention of permanently depriving the true owner of that property.

Mental and physical elements

There is a further breakdown of the elements that have to be established to prove that a crime has taken place, i.e. between the *actus reus* and the *mens rea*. The *mens rea*, or mental element, includes all those elements that relate to the mind of the accused. The *actus reus* is everything else. There are some crimes where there is no requirement to show a mental element. For example, the sale of medicine by a person who was not qualified and while unsupervised by a pharmacist and which was contrary to section 52

of the Medicines Act 1968 was held to be an absolute offence.[15] The law has now been changed to require a mental element to be proved.

If there were no requirement for the prosecution to establish a mental element in the crime of theft, Staff Nurse Jarvis could be successfully prosecuted for theft in circumstances where someone had accidentally dropped a bottle of tablets in the staff nurse's open bag and she had therefore taken them home inadvertently. In order to secure a conviction, whether the prosecution takes place in the magistrates' court or in the Crown Court, all the elements, mental and physical, must be shown to have existed at the time it was alleged that the crime was committed.

Several cases where health professionals have been convicted of criminal offences are now discussed.

Case of Dr Nigel Cox[16]

Dr Nigel Cox, a rheumatologist in Winchester, was convicted of attempted murder of a patient to whom he had administered potassium chloride, after repeated doses of heroin failed to control her pain. (The prosecution conceded that the patient might have died anyway even if Cox had not administered the drugs, so he was only charged with attempted murder.) He was given a prison sentence of 1 year suspended for 12 months. The patient was 70 years old, terminally ill with rheumatoid arthritis, with gastric ulcer and gangrene and in considerable pain. Her relatives were concerned at her condition. Dr Cox was also brought before his employers, the Wessex Regional Health Authority, to face disciplinary proceedings, but retained his post. He was also brought before professional conduct proceedings of the General Medical Council, which admonished him but noted that he acted in good faith and allowed him to stay on the Register.

The Cox case contrasts with that of Dr Bodkin Adams,[17] who was charged with the murder of an elderly patient in Eastbourne. The judge directed the jury that a doctor was not guilty of murder if he prescribed medication for pain relief appropriate to a person's needs, even if, incidentally, the medication shortened that person's life. (See chapter 29.)

Case of Dr Adomako

Gross professional negligence can constitute both a criminal offence of manslaughter and also grounds for an action for compensation in the tort of negligence, as the case of Dr Adomako shows (see Case 2.1). Dr Adomako was an anaesthetist who failed to realise during an operation that a tube had become disconnected, as a result of which the patient died. He was prosecuted in the criminal courts and convicted of manslaughter.

Case 2.1 *R* v. *Adomako* (1995)

Manslaughter by an anaesthetist[18]

At approximately 11.05 a.m. a disconnection occurred at the endotracheal tube connection. The supply of oxygen to the patient ceased and led to a cardiac arrest at 11.14 a.m. During this period, the defendant failed to notice or remedy the disconnection. He first became aware that something was amiss when an alarm sounded on the Dinamap machine, which monitors the patient's blood pressure. From the evidence it appeared that some four and a half minutes had elapsed between the disconnection and the sounding of the alarm. When the alarm sounded, the defendant responded in various ways, checking the equipment and administering atropine to raise the patient's pulse. But at no stage before the cardiac arrest did he check the integrity of the endotracheal tube connection. The disconnection was not discovered until after resuscitation measures had been commenced.

He accepted at his criminal trial that he had been negligent. The issue was whether his conduct was criminal, i.e. whether there was gross negligence. He was convicted of involuntary manslaughter, but appealed against conviction. He lost his appeal in the Court of Appeal and then appealed to the House of Lords.

The House of Lords clarified the legal situation.[19] The stages that the House of Lords suggested should be followed are set out in Box 2.9.

Box 2.9 House of Lords ruling in Adomako case

1 The ordinary principles of the law of negligence should be applied to ascertain whether or not the defendant had been in breach of a duty of care towards the victim who had died.
2 If such a breach of duty was established, the next question was whether that breach caused the death of the victim.
3 If so, the jury had to go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. That would depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred.
4 The jury would have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent on him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.

The judge was required to give the jury a direction on the meaning of gross negligence as had been given in the present case by the Court of Appeal.

The jury might properly find gross negligence on proof of:

(a) indifference to an obvious risk of injury to health or of
(b) actual foresight of the risk coupled either
  (i) with a determination nevertheless to run it or
  (ii) with an intention to avoid it but involving such a high degree of negligence in the attempted avoidance as the jury considered justified conviction or
(c) of inattention or failure to avert a serious risk going beyond mere inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address.

[Lettering and numbering are the author's.]

The House of Lords held that the Court of Appeal had applied the correct test and the appeal was dismissed.

There would also be vicarious liability on his employers in the civil courts for his negligence in causing the death of the patient.

Further information on murder and manslaughter can be found on the CPS website.[20]

The Corporate Manslaughter and Corporate Homicide Act 2007

The Law Commission[21] recommended that the law should be changed to enable it to be made easier for corporations and statutory bodies to be prosecuted for manslaughter. The government accepted the recommendations and the Corporate Manslaughter and Corporate Homicide Act was enacted in 2007. The Act abolishes the common law offence of corporate manslaughter by gross negligence and replaces it with statutory offences which can be committed by a specified organisation if its activities are managed or organised in a way which (a) causes a person's death, and (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased. An organisation is guilty of an

offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach of the duty of care. The organisations specified include 'corporations' and also the Department of Health. The duty of care is defined widely and includes duties to a detained patient, but excludes any duty of care owed by a public authority in respect of a decision as to matters of public policy (including in particular the allocation of public resources or the weighing of competing public interests). Duty of care also excludes emergency responses carried out by an NHS body or ambulance service (see chapter 12 on the link with health and safety legislation).

Alarmist fears that the Act would lead to the end of corporate team-building activities when it came into force on 6 April 2008 were rejected by the Chief Executive of the Royal Society for the Prevention of Accidents in a letter to *The Times* on 6 December 2007. He pointed out that the Act is there to strengthen the sanctions against negligent employers who, by ignoring good safety practice and necessary regulation, kill their staff and members of the public. It is not designed to undermine a spirit of enterprise, nor to inhibit a creative, fun atmosphere that can be so valuable in welding work colleagues into a team.[22] The first case of a prosecution under the Corporate Manslaughter and Corporate Homicide Act was that of Peter Eaton, a director of Cotswold Geotechnical Holdings, which was accused of gross negligence leading to the death of a geologist who died while taking soil samples when the pit he was working on collapsed on him.[23] The trial was adjourned to October 2010 to be preceded by a pre-trial assessment of Eaton's mental condition. The case against Peter Eaton was dropped; the company was fined £385,000 under the Corporate Manslaughter and Homicide Act. Guidelines for sentencing for corporate manslaughter were published by the Sentencing Guidelines Council in February 2010.[24] A flower firm in Norfolk was found not guilty of corporate manslaughter in April 2014 following the death of a worker who was electrocuted when his trailer made contact with overhead power cables. It was, however, found guilty of failing to ensure the safety of an employee.[25] A leisure company was fined £135,000 for the death of a girl who died after being hit by a speedboat towing the inflatable in which she was riding. The company pleaded guilty to corporate manslaughter.[26] There has been a 40 per cent increase in prosecutions for corporate manslaughter brought by the CPS since 2011.

Case of Dr Shipman

On 31 January 2000 Dr Shipman, a general practitioner, was found guilty of the murder of 15 patients and was suspected of having killed many more. The atrocious offences raised serious concerns about the inadequacy of professional regulation and control. An inquiry set up by the Secretary of State published six reports together with reforms to the coronial system (discussed in chapter 29).[27]

Case of Beverley Allitt

Following the deaths and injuries to children caused by the nurse Beverley Allitt, an independent inquiry was set up. (Its recommendations are considered in chapter 5.)

Case of Kevin Cobb

Kevin Cobb was found guilty of the manslaughter of a nurse and also convicted of drugging three female patients and raping two of them.[28]

The case of Rodney Ledward who was struck off the medical register after being found guilty of bungling 13 gynaecological operations is considered in chapter 5.[29] He did not face criminal proceedings.

Administration of drug by epidural instead of intravenous injection

In 2003 a junior doctor in Nottingham pleaded guilty to the manslaughter of a patient suffering from leukaemia. Instead of administering the anti-drug intravenously, he administered it epidurally and the patient died. The doctor was given a prison sentence. The National Patient Safety Agency is tasked with preventing the recurrence of such mistakes (see chapters 12 and 28).

Offence of ill-treatment or wilful neglect

Section 44 of the Mental Capacity Act 2005 introduced a new offence of ill-treatment or wilful neglect of a person who lacks mental capacity (see chapter 17). Following the Francis Report on Mid Staffordshire NHS Trust a new statutory offence of ill-treatment or willful neglect was recommended. This is discussed in chapter 5.

Failure to call medical assistance

A husband was charged with manslaughter because he had failed to call medical assistance for his wife following a home birth when the baby was stillborn. The wife refused to allow him to call for help and she died. The judge directed the jury that because the wife was mentally competent and had refused assistance, the husband's duty of care to seek assistance was removed. He could not therefore be guilty of manslaughter.[30]

Defences

The main defences to a criminal act are shown in Box 2.10. They are all given here for completeness, but not all of them are relevant to Staff Nurse Jarvis's case.

Box 2.10 Main defences to a criminal offence

1 Absence of any of the elements making up the offence: *actus reus* or *mens rea*.
2 Infancy:
below 10 years no crime. (In Scotland the age is being raised from 8 to 12 years.)
3 Insanity:
(a) unfit to plead and stand trial;
(b) not guilty by reason of insanity at the time of the crime.
4 Diminished responsibility and loss of control (which reduce murder to manslaughter).
5 Mistake. (Sometimes this is a statutory defence but usually only where the defendant has taken all reasonable steps. Normally the statute places the burden of proof on the defendant on a balance of probabilities.)
6 Necessity (now known as 'duress of circumstances').
7 Duress.
8 Superior orders.
9 Self-defence.

Absence of any of the elements making up the offence

It will be apparent from what has been said thus far that if the accused can show that any of the required elements, either *actus reus* or *mens rea*, as defined in the Act of Parliament or the common

law definition of the crime, are missing, then there should be an acquittal. Even though it is usually for the prosecution to show they exist rather than for the defence to prove their absence, it would clearly be an advantage for the defence to show their absence. Thus, for example, in the offence of theft, one of the elements is that the property that has been taken belonged to another. If the defence can show that the property did not belong to anyone but had, in fact, been abandoned, then that would be a successful defence. A state of automatism by the defendant was accepted by the prosecution when it withdrew charges against a man who had strangled his wife while having a nightmare. Brian Thomas dreamt that intruders had broken into their camper van and he woke up to find his wife dead beside him. It was accepted that he was not in control of his actions at the time of the killing and the prosecution accepted the evidence of three psychiatrists that detention in a mental hospital would serve no useful purpose.[31]

Infancy

Children under 10 years are exempt from criminal responsibility and cannot be found guilty of a crime. The infant is known as *doli incapax*.

Minors over 10 years are presumed to be responsible for their actions but there are considerable procedural differences from the way in which an adult is proceeded against. The UK was criticised by the European Court of Human Rights for its handling of child criminals following the conviction of two boys for the killing of Jamie Bulger.[32] The Court held that Article 6 had been breached by the way the trial had been conducted. However, the court did not find that there was a breach of Article 3 (inhuman or degrading treatment). In March 2010 the Children's Commissioner called for the age of criminal responsibility to be raised from 10 to 12 years. Dr Maggie Atkinson pointed out that in some European countries the age of criminal responsibility was 14 years.[33] Her call was rejected by the Ministry of Justice. Scotland is raising the age of criminal responsibility from 8 years to 12 years. In England the defence of *doli incapax* for a child over 10 was abolished by the Crime and Disorder Act 1998 section 34 as interpreted by the House of Lords.[34]

The Supreme Court has held that under Articles 6 and 8 it was permissible for a child to testify in family proceedings, but the considerations of the advantages of the child giving evidence to determine the truth had to be balanced against the damage it might do to the child.[35] The Youth Justice and Criminal Evidence Act 1999 introduced a range of measures that can be used to facilitate the gathering and giving of evidence by vulnerable (which includes all those under 18) and intimidated witnesses. These are known as 'special measures' and include screens, the removal of wigs and gowns, live links, evidence given in private and video recorded interviews.[36]

Insanity

Insanity can be pleaded before or when the trial takes place so that the accused is held unable by reason of insanity to stand trial. Alternatively, it can be pleaded as a defence to the crime on the basis that at the time the crime was committed the accused was insane. The definition of insanity as a defence is based on the M'Naghten Rules, which were laid down in 1843. The basic propositions are:

> **[E]very man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved.**
>
> **[To] establish a defence on ground of insanity, it must be clearly proved that at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.**

Since 1843 there have been many interpretations and refinements of this definition, but the substance has survived.

Diminished responsibility and loss of control

These statutory defences provided by the Homicide Act 1957, as amended by the Coroners and Justice Act 2009, apply only to murder and have the effect of enabling the accused charged with murder to be found guilty of manslaughter on grounds of diminished responsibility or loss of control. (The former common law defence of provocation has been replaced by a new defence of loss of control.) The Law Commission published a consultation paper in 2006 which set out proposals for a new Homicide Act.[37] Some of its recommendations were included in the Coroners and Justice Act 2009. The Amendments to the Homicide Act 1957 by the Coroners and Justice Act 2009 are shown in Box 2.11.

Box 2.11 Amendments to the Homicide Act 1957

The Homicide Act 1957 is amended:

1 A person ('D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which:
   (a) arose from a recognised medical condition;
   (b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A); and
   (c) provides an explanation for D's acts and omissions in doing or being a party to the killing.

1A Those things are:
   (a) to understand the nature of D's conduct;
   (b) to form a rational judgment;
   (c) to exercise self-control.

1B For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.

Loss of control

Section 54 of the Coroners and Justice Act 2009 provides a new partial defence to murder known as loss of control, which is shown in Box 2.12.

Box 2.12 Loss of Control section 54 of the Coroners and Justice Act 2009

Section 54

1 Where a person ('D') kills or is a party to the killing of another ('V'), D is not to be convicted of murder if:
   (a) D's acts and omissions in doing or being a party to the killing resulted from D's loss of self-control;
   (b) the loss of self-control had a qualifying trigger; and
   (c) a person of D's sex and age, with a normal degree of tolerance and self-restraint and in the circumstances of D, might have reacted in the same or in a similar way to D.

2 For the purposes of subsection (1)(a), it does not matter whether or not the loss of control was sudden.

3 In subsection (1)(c) the reference to 'the circumstances of D' is a reference to all of D's circumstances other than those whose only relevance to D's conduct is that they bear on D's general capacity for tolerance or self-restraint.

4 Subsection (1) does not apply if, in doing or being a party to the killing, D acted in a considered desire for revenge.

5 On a charge of murder, if sufficient evidence is adduced to raise an issue with respect to the defence under subsection (1), the jury must assume that the defence is satisfied unless the prosecution proves beyond reasonable doubt that it is not.
6 For the purposes of subsection (5), sufficient evidence is adduced to raise an issue with respect to the defence if evidence is adduced on which, in the opinion of the trial judge, a jury, properly directed, could reasonably conclude that the defence might apply.
7 A person who, but for this section, would be liable to be convicted of murder is liable instead to be convicted of manslaughter.
8 The fact that one party to a killing is by virtue of this section not liable to be convicted of murder does not affect the question whether the killing amounted to murder in the case of any other party to it.

The meaning of qualifying trigger is defined in section 55.

Section 55 Meaning of 'qualifying trigger'

1 This section applies for the purposes of section 54.
2 A loss of self-control had a qualifying trigger if subsection (3), (4) or (5) applies.
3 This subsection applies if D's loss of self-control was attributable to D's fear of serious violence from V against D or another identified person.
4 This subsection applies if D's loss of self-control was attributable to a thing or things done or said (or both) which:
   (a) constituted circumstances of an extremely grave character; and
   (b) caused D to have a justifiable sense of being seriously wronged.
5 This subsection applies if D's loss of self-control was attributable to a combination of the matters mentioned in subsections (3) and (4).
6 In determining whether a loss of self-control had a qualifying trigger:
   (a) D's fear of serious violence is to be disregarded to the extent that it was caused by a thing which D incited to be done or said for the purpose of providing an excuse to use violence;
   (b) a sense of being seriously wronged by a thing done or said is not justifiable if D incited the thing to be done or said for the purpose of providing an excuse to use violence;
   (c) the fact that a thing done or said constituted sexual infidelity is to be disregarded.
7 In this section references to 'D' and 'V' are to be construed in accordance with section 54.

The Court of Appeal (Criminal Division) has held that on a charge of murder, where the defence of loss of self-control is raised, then whether the circumstances were extremely grave and whether the defendant's sense of being seriously wronged by them was justifiable required an objective assessment by the judge at the end of the evidence and by the jury.[38]

A man who caused fractures, when fighting two burglars of his premises, was acquitted of causing grievous bodily harm by the jury after 20 minutes' deliberation.[39]

Mistake

A defendant can argue self-defence if he honestly but mistakenly believed he was under attack. This can be an effective defence where it prevents the accused from being able to form the required mental element (i.e. *mens rea*) to be guilty of the offence charged. For example, a defendant to a charge of theft could argue that he honestly but mistakenly believed that he had permission to take the goods, i.e. mistake negatives dishonesty. Mistake of law is not sufficient, for knowledge that an act is a crime is not usually a necessary ingredient of the *mens rea*.

Necessity

There is no recognised principle that necessity is a valid defence to any crime.

Duress

This will be a valid defence where it can be established that the force or compulsion was such that the accused had no choice. There must be an immediate threat of death or serious harm. It is unlikely to be accepted as a defence to a charge of murder, but has been invoked in other lesser crimes.

Superior orders

It is not a defence for the accused to argue that the crime was committed in obedience to the orders of a superior. However, it might be possible for a defendant to show that as a result of the orders she lacked the required mental element for the crime and that she was acting reasonably in all the circumstances. The issue of obeying orders as a defence in the civil courts is considered in chapter 4.

Self-defence

Reasonable force can be used to defend oneself or another person against an attack. However, greater force than is reasonable would result in the possibility of the defender being liable to prosecution for assault or, in the event of the assailant dying, murder or manslaughter. (This is considered further in chapter 12.)

Criminal injuries compensation

A scheme to compensate those who have suffered personal injuries as the result of criminal action has been in existence since 1964. A new scheme for compensation following injuries or death as a result of a crime was established on 1 April 1996 under the Criminal Injuries Compensation Act 1995, based on a statutory scale of awards known as the 'tariff'. Details of the scheme,[40] which was revised in 2008, and again in 2012[41] are available from the Criminal Injuries Compensation Authority (CICA) headquarters in Glasgow[42] and can be downloaded from the internet.[43] The 2012 scheme excludes some injuries originally recognised as the subject of compensation and payments for other injuries are reduced. Claims are processed by the CICA and claims officers, and adjudicators on a panel determine whether a claim can be met. Evidence is obtained from applicants, the police medical bodies and others such as witnesses to the incident. The CICA determines whether payments are to be made to victims of criminal acts. Those eligible (and these include the victims of crime as well as the dependants of homicide victims) must have reported the crime to the police as soon as possible. The application should be made within two years of the incident, but exceptions can be made to both these requirements. Payments are made against a tariff system up to a maximum of £500,000 (see Annexe E of the scheme) and include the following items:

- medical expenses
- mental health expenses
- lost wages for disabled victims (but not for the first 28 full weeks of lost earnings or earning capacity)
- lost support for dependants of homicide victims
- funerals
- travel
- rehabilitation for disabled victims
- pain and suffering
- bereavement
- loss of parental services.

Claims below £2,500 are excluded from the new scheme. (Previously the minimum payment was £1,000).

A crime must be established for compensation to be payable and a cyclist was stripped of his award of £500,000 for injuries he sustained when a dog chased him into the path of a car. The Court of Appeal held that he had not been the victim of a crime and was not entitled to the money.[44]

Procedure for claiming

The procedure is for an application form (available from CICA, local victim support schemes, Crown Court witness service, local police stations or local citizens' advice bureaux and can be downloaded from the website) to be completed and sent to CICA. Claims officers at CICA initially consider the claim to determine whether it comes within the scheme's eligibility criteria. The claim will either be rejected or an offer will be made to the claimant. Once CICA is notified that the offer has been accepted, the compensation will be paid. In certain circumstances an interim award may be made with the final award awaiting further details, for example of the victim's prognosis. Claimants may be asked to attend a centre for medical examination. A claimant has the right to apply for a review which would be held by a claims officer other than the officer making the original decision. A claimant may contest the award or the result of the review by appealing to the Criminal Injuries Compensation Appeals Tribunal.

Information relating to CICA can be obtained from its website[45] and should be available to all NHS staff, who should ensure that, if they are injured at work, they can check on their eligibility to receive compensation.

The Court of Appeal held that an unborn child (for those born before 2012), who suffered fetal alcohol disorder because the mother drank whilst pregnant, could not be a victim of a crime and therefore no criminal injury compensation was payable (see Chapters 2 and 14). The fetus was not any other person for the purposes of Section 23 of the Offences Against the Person Act 1861. The CICA scheme was changed in 2012 specifically to exclude damage done in utero by ingestion of harmful substances as being a crime of violence for the purposes of compensation.

Withholding of compensation

The scheme permits compensation to be refused if the claimant has a criminal record or their conduct led to their being injured. In addition, people who fail to cooperate in bringing an offender to justice may be refused compensation. The CICA has discretion to withhold or reduce an award on these grounds. Paragraphs 22–29 set out the grounds for withholding or reducing an award including failure to report to the police and character of claimant.

The fact that the aggressor is a mentally disturbed patient against whom a prosecution may not succeed on the grounds of insanity will be left out of the account in deciding whether compensation should be paid. The Supreme Court held that where a person who had committed suicide had been reckless as to whether his action would also cause injury to some other person so as to constitute an offence of inflicting grievous bodily harm contrary to section 20 of the Offences against the Person Act 1861, that was a crime of violence entitling the other person to claim under the Criminal Injuries Compensation Scheme.[46] However, on the actual facts of the case (where a driver of a lorry had swerved to avoid a would be suicide and hit a gritter vehicle driven by the claimant who was severely injured) it was for the First Tier Tribunal to determine the facts and the Tribunal was not satisfied that the deceased had the necessary *mens rea* of intending to cause harm and had ruled against the claimant. The decision of the First Tribunal was restored and the claimant failed in his claim.

Order that the convicted defendant make a compensation payment to the victim

Judges and magistrates also have the power to order a defendant to make a payment to the victim of the offence of which they have been convicted. Before making the order, the judge has to take into account the defendant's ability to pay the amount ordered.

The government is considering giving victims a legal right to have a personal statement about their ordeal read out in court as part of a package of reforms which could make up the first ever 'victims' law'.[47]

Conclusions

Significant changes have taken place in criminal law and procedure in recent years. The introduction of an offence of corporate manslaughter does not yet appear to have influenced the attitudes of senior management within the NHS, athough the organisation can now be held to account for a death caused by gross negligence, and rules relating to health and safety of both staff and patients are likely to be strictly enforced. It is unlikely that the individual nurse will be involved in criminal law issues but she should be aware that any successful prosecution of a registered practitioner will be notified to the NMC (see chapter 11). There is increasing concern about the mistreatment of the vulnerable witnesses and bereaved families and a new Victims' Commissioner, Baroness Newlove of Warrington, has asked for powers to safeguard the rights of victims.[48] Her annual report for 2013/14 set out her achievements for the first year in office and identified her priorities for 2014/15 including monitoring compliance with the victim's code and improving complaints handling and giving victims a voice.

Legal aid has been cut for criminal court hearings. Changes announced in September 2013 by the Justice Secretary Chris Grayling include removing legal aid in 11,000 cases brought by prisoners each year, a 30 per cent cut in the cost of long-running criminal cases; a staged 17.5 per cent cut in legal fees; a new system for contracts for legal aid work to come into force in 2015. However, these contracts will no longer be awarded to the lowest bidder (ridiculed as supermarket justice by the barristers) with no cap on the number of firms to be awarded contracts.[49] In addition, a working party will look at how thousands of short hearings can be avoided and handled by email or video-link.

The Court of Appeal overruled the Crown Court which had held that because of a refusal by barristers to accept the lower level of fees paid in criminal cases the defendants could not be properly represented and therefore the cases adjourned or dismissed. The Court of Appeal decision has been criticised since it means that the prosecution with well-paid top barristers will be facing inexperienced junior barristers paid for out of the public defender service.[50]

Reflection questions

In the case of Staff Nurse Jarvis, trace the course that would be followed if:

(a) she were tried in a magistrates' court

(b) she were tried in the Crown Court

(c) she pleaded guilty in the magistrates' court

(d) she pleaded guilty in the Crown Court.

Further exercises

1 What do you consider are the advantages and disadvantages of trial before magistrates compared with a jury trial for an offence that is triable either way?

2 What evidence do you consider the prosecution would require in a case similar to that of Staff Nurse Jarvis and what evidence would the defence seek?

3 Visit your local magistrates' court and Crown Court and analyse the difference between the two in terms of formality, procedure and justice to the accused.

4 Ascertain whether there have been any prosecutions for corporate manslaughter or corporate homicide in the NHS and identify the implications of this offence for your own organisation.

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Chapter 3

Liability in a civil court case for negligence

This chapter discusses

- Duty of care
- Standard of care
- Causation
- Liable for what?
- Harm

Introduction

Litigation to obtain compensation in the civil courts is one of the growth areas of recent years. In 2014 the NHS Litigation Authority stated[1] it had made provision for nearly £25.6 billion for future compensation payouts with clinical claims against the NHS being at a record high. Total negligence claims jumped 18 per cent to 11,945 which officials said was the result of new legal firms entering the market and cases being brought before the rules on no win, no fee were changed. Of the £1.2 billion paid out in 2013 almost a quarter (£259 million) was paid to claimants' solicitors. Figures published by NHS England in October 2013 showed that more than 300 patients die each month as a result of medical errors.[2] The National Patient Safety Agency[3] (NPSA) (now incorporated in the NHS Commissioning Board Special Health Authority) publishes detailed figures relating to the incident reports it has received, including deaths of patients. These figures are available on its website.

If harm has occurred to a patient, then the patient or his/her representatives can seek compensation. However, not all harm is compensatable. Accidents to patients are infinite: they include incidents where

the patient falls out of bed, pressure sores develop, the wrong dose of medicine is given, it is given at the wrong time or at the wrong site by the wrong method or the expiry date is passed, the wrong limb is amputated, the treatment is given to the wrong patient, the patient dies as the result of a mistake. Some of these are the result of negligence and the victims may receive compensation. Not all accidents, however, will result in the payment of compensation to the patient or relatives. In some circumstances the defendant may pay a sum of money to the claimant without admitting liability. This is known as an ex gratia payment and may have the effect of resolving the issue and reducing the potential costs of further proceedings. For example, Camden and Islington Mental Health and Social Care Trust agreed to pay £400,000, without admitting liability, to a mental patient who leapt under an Underground train. The patient had walked out of the psychiatric department of the Whittington Hospital nine days before. The patient claimed that the trust failed to protect him from himself.[4] In a case where a woman aged 64 was told to suck ice cubes for a persistent cough and after being seen by five doctors over two years was found to be suffering from cancer and died, the husband accepted an undisclosed sum from the GP who originally treated her, but with no admission of liability.[5]

In contrast liability was admitted by the Barking, Havering and Redbridge Hospital NHS Trust in 2013 when it was reported that a mother died after two trainee surgeons took out an ovary instead of her appendix.[6] In any subsequent court case the only issue would be over **quantum**, i.e how much compensation was payable (if this could not be agreed between the parties) and not liability.

This chapter looks at the circumstances that must exist for compensation to be payable and the type of harm for which compensation will be paid. The personal liability of the nurse and the liability of her employer are considered in chapter 4. The calculation of compensation is considered in chapter 6.

The elements that must be established by the claimant in a case of negligence before the civil courts are set out in Box 1.2 (see chapter 1). In this section we are concerned with four basic questions:

1 What is meant by the term 'duty of care'; when does the nurse owe a duty of care; and to whom is it owed?
2 What is the appropriate standard of care and what criteria determine whether the nurse is in breach of that duty?
3 What is meant by 'reasonably foreseeably caused' and why and how must the claimant prove this in an action for negligence?
4 What type of harm do the courts recognise as capable of being compensated?

This chapter will answer these questions by providing examples where patients have been harmed. The next chapter will consider some specific problems of liability in relation to inexperienced staff, team responsibility, limits on resources and also the liability of the NHS trust.

Duty of care

Difficulties can arise as to whether a duty of care exists, especially outside the immediate employment situation. A duty of care is not owed universally and the claimant bringing the action has to show that a duty of care was owed to him or her personally.

The legal test of whether a duty of care exists was laid down in the case of *Donoghue* v. *Stevenson*.[7] In this case, manufacturers were held to owe a duty of care to the ultimate consumer. The facts of this case were that a person who was bought a bottle of ginger beer discovered the decomposed remains of a snail when half the beer had been drunk and sued the manufacturer, arguing that the manufacturer owed a duty of care to the consumer. In the case, Lord Atkin stated that:

> **You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.**

In other words, a duty of care can be said to exist if one can see that one's actions are reasonably likely to cause harm to another person.

In recent years, there have been several cases on whether a duty of care is owed to an individual by different public services: the ambulance service, social services, the police and the fire service. In one case, the Court of Appeal held that although the ambulance service owed no duty to the public at large to respond to a telephone call for help, once a 999 call had been accepted, it was arguable that the ambulance service did have an obligation to provide the service for a named individual at a specified address. Subsequently the Court of Appeal dismissed an appeal by the London Ambulance Authority that it should pay the victim £362,377. The facts of the case are shown in Case 3.1.

Case 3.1 *Kent v. Griffiths and Others* (2000)

Ambulance slow to arrive[8]

A doctor called an ambulance for a woman who was asthmatic at 4.27 p.m. on 16 February 1991. The standards recommended were that the ambulance should come within 14 minutes. The husband phoned again at 4.39 p.m. and was told they would be there within 7 to 8 minutes. The doctor phoned at 4.55 p.m. and was told it would be a couple of minutes. The ambulance arrived at 5.05 p.m., 38 minutes after the first call. (A record prepared by a member of the crew indicated that it had arrived after 22 minutes.) During the journey, the claimant was given oxygen, but on the way suffered a respiratory arrest with tragic consequences, including serious memory impairment, change of personality and miscarriage. The judge found that the record of the ambulance's arrival had been falsified. The Court of Appeal refused to strike out the case as disclosing no reasonable cause of action for negligence, but held that the case should continue to trial.

The Court of Appeal held that a duty of care could be owed by the ambulance service which was comparable to hospital services rather than to the police or fire services.

In the second appeal, the Court of Appeal held that the acceptance of the call in the present case established the duty of care. It was delay that caused the further injuries. If wrong information had not been given about the arrival of the ambulance, other means of transport could have been used.

In another case, in June 2014 a scientist who was brain damaged after waiting more than 100 minutes for an ambulance won compensation of £5 million. The ambulance service had given the call a high-risk register which required a police escort because of potential risks to the safety of staff.[9]

Educational psychologist

In the case of *Phelps* v. *Hillingdon London Borough Council*,[10] the Court of Appeal held that an educational psychologist, employed by a local education authority to give advice to it in respect of children in its schools suffering from learning difficulties, did not owe a duty of care to such a child, unless he or she had assumed responsibility for that child. The House of Lords, however, allowed the appeal.[11] It held that a local education authority is liable for the negligent actions of a teacher or educational psychologist and can be sued for a failure to provide an education commensurate with a child's needs. The House of Lords gave a judgment on four cases: the Phelps case against London Borough of Hillingdon; Marcus Jarvis against Hampshire County Council (failing to diagnose dyslexia); G against Bromley (failure to provide him with computer technology and suitable training to help him deal with a muscular problem); and Rhiannon Anderton against Clwyd County Council (she sought pre-action disclosure of educational records: to succeed she had to show that she was suffering from personal injury).

The House of Lords emphasised that liability for negligence by a council would require exceptional circumstances. It held that a failure to improve a condition from which a child suffered could count as personal injury. It rejected the argument that providing psychological advice was part of a multidisciplinary approach that, in the past, has justified immunity from negligence in care claims.

Placing of foster child

In the case of *W and Others* v. *Essex County Council and Another*,[12] the local authority (LA) placed a foster child with a couple, having given an assurance that he was not a known sex abuser. In fact, the LA knew that the boy had been cautioned three years previously for indecent assault on his sister. The boy subsequently sexually abused three of the claimants' children. The foster parents' claim for psychiatric shock failed in the High Court and the Court of Appeal on the grounds that the court held that no duty of care was owed to them at common law. The children succeeded since they were not subject to any statutory duty by the LA, but were living at home with their parents and express assurances had been given that a sexual abuser would not be placed in that home. The House of Lords[13] allowed the parents' appeal on the grounds that the parents should not be barred from pursuing their claim: the parents could be seen as victims of the situation, the psychiatric injury they suffered could be seen as within the range of psychiatric injury recognised by law and it could be argued that the LA owed a duty of care to the parents. They should therefore be allowed to pursue their claim.

In a similar case, the House of Lords[14] allowed the claim by a boy who had been in LA care all his life to pursue an action against the LA for psychiatric damage he had suffered as a result of the authority's breach of statutory duty and negligence in failing to place him for adoption or place him in suitable foster homes.

Where there has been clinical negligence by a hospital, a legal action arises, not because of the statutory duty on the NHS to provide a service, but because of what it has done in accepting a patient for treatment.[15]

The High Court held that a local authority had a duty of care to its teachers to take such precautions as were reasonable to prevent or minimise the risk of injury that might occur as a result of mischievous or malicious behaviour on the part of the pupils. On the facts of the case, where a pupil had poisoned a teacher by putting whiteboard fluid into her drinking water, the court held that there was a duty of care but the Council were not in breach since, while it should be a policy to prevent unsupervised access by pupils to classrooms, it was impractical to suggest that teachers should not have a discretion to ask a pupil to get something from another classroom.[16]

In a case where a head teacher suffered clinical depression and eventually stopped work through ill health and retired as a consequence of disputes with a parent governor, the Court of Appeal held that the local education authority had a statutory duty to take reasonable steps to protect the psychiatric health of the head teacher and should have appointed an interim executive board and replaced the Board of Governors. This statutory duty ran alongside the duty of care at common law and the head teacher was entitled to claim **damages** for negligence.[17]

It was reported that the family of a schoolgirl who was murdered by her former boyfriend after they had warned police that he should be arrested were to bring a negligence action against the police.[18] To succeed they will have to show that the police owed the victim a duty of care: a claim which failed in the case of the relatives of one of the Yorkshire Ripper's victims (*Hill* v. *Chief Constable of West Yorkshire*).[19] Hill was followed in a more recent case where a woman, Robinson, was caught up in the arrest of a drug dealer when she was walking down a busy high street. She was knocked down and injured. The judge held that there was negligence by the police officers but not outrageous negligence and that the immunity from suit for officers engaged in the apprehension of criminals applied. Her appeal to the Court of Appeal failed. The Court held that the Hill principle was designed to prevent defensive policing and better protect the public.[20]

Chapter 13 discusses child protection cases where the European Court of Human Rights has found that a duty of care is owed to parents where a child has been removed as a result of abuse being wrongly

suspected, thus overruling earlier decisions in the UK domestic courts. The duty of care owed to an informal patient is considered in chapter 20.[21] In chapter 17 the ruling of the Supreme Court in the case of the duty of care owed to vulnerable people with dementia and other disabilities is considered.[22]

Does a nurse have a duty to volunteer help?

Practical Dilemma 3.1 Volunteering help

A nurse on her way to work passes a road accident. She sees that a man is still trapped in a vehicle. Does she have an obligation to stop and render first aid? If she does stop and help and something goes wrong, would she be liable?

Unless there is a pre-existing relationship between the parties (for example, if the nurse has caused the accident or if she is employed to assist people in such circumstances), she has no duty in law to stop and render first aid. So if, for example, someone saw her drive past and, knowing that she was a nurse, believed that she could have saved the victim, and she was consequently sued, the action would fail. Her failure to help is not actionable. There is in law no duty to volunteer help. There must be a pre-existing duty. However, once the nurse undertakes the duty of care, she is then bound to follow the standard of care that would be expected of a reasonable person. So, for example, imagine that she moves the victim and causes spinal injury. If it can be shown that she should have anticipated the dangers of moving a person when a spinal injury was possible, and if there were no immediate danger in leaving the man where he was, then she could be sued for any further injuries she had caused him.

While there is no legal duty, the Nursing and Midwifery Council (NMC) had made it clear in its Code of Professional Conduct,[23] published in 2004, that there is a professional duty upon the registered practitioner at all times. Paragraph 8.5 stated:

> **In an emergency, in or outside the work setting, you have a professional duty to provide care. The care provided would be judged against what could reasonably be expected from someone with your knowledge, skills and abilities when placed in those particular circumstances.**

This paragraph has not been included in the 2008 edition of the Code,[24] but such a duty could be interpreted from the general duty of maintaining the reputation of the profession at all times. In 2014 the NMC was consulting on a draft new Code of Practice.

The nurse who failed to volunteer help could therefore not be held legally liable in the civil courts for failing to act; she could, however, face professional conduct proceedings (see chapter 11). Where the nurse has volunteered help in such a situation, it is unlikely that her employer would accept any responsibility for her actions (i.e. would not be vicariously liable (see page 77)) and therefore the nurse would have to rely on personal insurance cover in the event of any action being brought against her. This cover, known as cover for Samaritan actions, is provided by some professional associations and such professional indemnity covered is recommended by the NMC. Professional indemnity cover is now required by all health professionals (see chapter 4). Lord Young's[25] review of health and safety laws recommends clarification of the laws relating to the liability of a volunteer because of fears that concern over liability is preventing people from volunteering help.

> **Clarify (through legislation if necessary) that people will not be held liable for any consequences due to well-intentioned voluntary acts on their part.**

The Social Action, Responsibility and Heroism Bill 2014, if passed and enacted, will protect volunteers, teachers and organisations from legal action if they act in an emergency or take reasonable steps in organising school trips (see chapter 12):

Practical Dilemma 3.2 A fall in the night

Mary Smith is in the postoperative ward following a gall bladder operation. She becomes very disturbed during the night and Staff Nurse Janice Parker hears a crash and rushes to the ward. She finds Mrs Smith on the floor.

How is the civil liability of the staff nurse determined? The questions to be answered are:

1 Does Staff Nurse Parker owe a duty of care to Mrs Smith?
2 Is she in breach of the duty of care?
3 Has her breach of care led to reasonably foreseeable harm?
4 Has the patient suffered compensatable harm?

To win compensation in a civil case, Mary Smith would have to show that the staff nurse failed to follow the approved accepted practice without good reason in carrying out her duty of care towards her and that, as a reasonably foreseeable result, she suffered harm.

Does a duty of care arise?

A nurse, by virtue of the nurse/patient relationship, does owe a duty of care to her patients. Whether a duty of care exists will be decided by established legal principles. There is no doubt that, in these circumstances, the nurse does owe a duty of care to the patient. The duty of care in relation to independent contractors is considered in chapter 4. Once it is decided that a duty of care is owed, the next question is: has there been a breach of this duty? Before this can be answered, the nature of the standard of care owed must be established.

Standard of care

Approved practice

Case 3.2 *Whitehouse* v. *Jordan* (1981)

Birth traumas[26]

Stuart Whitehouse was born on 7 January 1970 with severe brain damage. His mother alleged that the brain damage was caused because the doctor pulled too hard and too long with forceps, as a consequence of which the baby was severely disabled. The doctor denied the allegations.

The House of Lords stated that whether an error of judgement was negligence or not depended on the facts of the situation. The test to be applied to determine if there was negligence was the Bolam Test (from an earlier case in 1957).[27] In applying this test in this case, the House of Lords decided that Mr Jordan had not been negligent. The Bolam Test is as follows:

> **When you get a situation that involves the use of some special skill or competence, then the test as to whether there has been negligence or not is . . . the standard of the ordinary skilled man exercising and professing to have that special skill. If a surgeon failed to measure up to that in any respect ('clinical judgement' or otherwise), he had been negligent and should be so adjudged.**

[redacted]

[redacted]

[redacted]

[redacted] approved practice

[redacted]

Case 33 [redacted]

Bolam

[redacted]

[redacted]

[redacted]

While this decision might seem very hard for the patient, it is only fair to the professional staff where a decision has been made carefully and with great consideration and is supported by substantial professional opinion, even if not everyone would have followed the same practice. In applying this to nursing staff, it can be said that in most circumstances the nurse will be expected to follow the standards of practice laid down by her profession or the local policy of her employer, but there may be very exceptional circumstances where it is justifiable not to follow the accepted practice. In a more recent case, the Court of Appeal has suggested that, where there was more than one acceptable standard, competence should be gauged by the lowest of them.[30] The Bolam Test applied where there was a conscious choice of available courses made by a trained professional. It was inappropriate where the alleged neglect lay in an oversight.

The wording of the Congenital Disabilities (Civil Liability) Act 1976 (which gives a right of action in cases of prenatal infliction of harm) puts the point very clearly. (This Act is considered in detail in chapter 14.)

Statute 3.1 Congenital Disabilities (Civil Liability) Act 1976 Section 1(5)

The defendant is not answerable to the child, for anything he did or omitted to do when responsible in a professional capacity for treating or advising the parent, if he took reasonable care having due regard to then received professional opinion applicable to the particular class of case; but that does not mean that he is answerable only because he departed from received opinion.

The courts rely on expert evidence to decide on what is a reasonable standard of care and the House of Lords in the Bolitho case emphasised that such expert opinion must flow logically and reasonably from the specific circumstances:

> **The use of the adjectives 'responsible, reasonable and respectable' (in the Bolam case) all showed that the court had to be satisfied that the exponents of the body of opinion relied upon could demonstrate that such opinion had a logical basis.[31]**

It will be rare for a court to hold a school of medical opinion as irresponsible[32]

Following the changes to the civil procedure as a result of the Woolf Reforms, parties to a civil action are required, if possible, to agree on experts who are to give evidence of the required standards and the extent to which what actually happened measured up to that standard.

The application of the Bolam Test was considered in the work of the laboratory screeners who read the slides for cervical cytology.[33] The High Court and Court of Appeal held that the Bolam Test did not apply where no professional judgement was required by the employee. The evidence of expert witnesses that the Standards of the Cervical Screening Programme, which required an absolute confidence test, had not been complied with was accepted by the judge. (The full facts of the case are given in chapter 23.) In a case which followed a skiing accident, the Court of Appeal held that the implementation of a duty of care never to allow skiing pupils to take risks beyond their capabilities depended on local standards.[34] An inquest in 2010 heard that a teenager suffering from meningococcal septicaemia died after she was moved to two incorrect wards rather than to intensive care. The coroner ruled that there was a lack of direction and urgency over her treatment which was characterised by seven errors. He was unable to say whether these failures had contributed to her death.

Policies, protocol, procedures, guidelines, benchmarks and their effect

The questions arise: when must I follow a procedure and when should I not follow it? Is there any difference in law between a policy, a procedure and a guideline and their effect? In the main, guidance

issued by an employer, by a professional association or by the registration body should as far as is reasonable be followed. However, there may be specific circumstances that make the following of a particular procedure inappropriate and therefore any reasonable practitioner would modify compliance with the procedure accordingly. Clearly, advice from others would be required to ascertain whether rigid compliance with the procedure would be justified. The courts require a reasonable standard to be followed, a standard that would be supported by competent professional opinion and practice. Where the practitioner decides that circumstances justify a modification of the usual procedure, it is essential that she record exactly why the usual practice was not followed.

Procedures, policies, protocols, benchmarks and guidelines do not have a recognised **hierarchy** in courts of law. The same principles would apply to them all. In general, they should be followed, if it would be reasonable to do so. If a policy etc. is issued by an NHS trust that is not acceptable in the light of professional practice, it should be challenged as soon as possible and a revised policy that does accord with reasonable standards of care issued. Reference should be made to the work by Brian Hurwitz where this issue is considered in detail.[35] The significance of protocols has become more important as the work of the National Institute for Health and Care Excellence (NICE) has expanded (see chapter 5). Eventually, NICE guidelines are likely to be incorporated into the Bolam Test of reasonable practice, but it will be open for a health professional to argue that the guidelines were not appropriate in the particular circumstances of the patient for whom she was caring. In the case of *Early* v. *Newham HA*,[36] the judge accepted that guidelines drafted locally by consultants on intubation could be seen as satisfying the Bolam Test. In a case in 2005[37] where a ventouse delivery was attempted at 9 cm of dilation and led to spastic tetraplegia and cerebral palsy in the baby, the court held that the clinician had failed to follow both the guidelines of the Royal College of Obstetricians and Gynaecologists and also the hospital's own guidelines, and held the defendant NHS trust liable.

The Bolam Test was applied in a case where a patient alleged that, had her general practitioner referred her for orthopaedic surgery the same day as she was seen by him, she would not have suffered from the severe side effects of the loss of function of her bowels and bladder. She failed since it was established that her GP's views were in accordance with the practice accepted as proper and there was no evidence that had there been a same-day referral, she would have had an operation immediately.[38] John Tingle and Charles Foster have edited a useful book showing the interlink between law, policy and practice on clinical guidelines.[39] The Department of Health has updated the essence of care benchmarks which were first published in 2001 and following a consultation in 2009 were revised.[40] Twelve fundamental areas of patient care were identified and provide benchmarks for determining if the essential standards have been met. The areas include: bladder, bowel and continence care; care environment; communication; food and drink; prevention and management of pain; personal hygiene; prevention and management of pressure ulcers; promoting health and well-being; record keeping; respect and dignity; safety and self-care. The guide on how to employ the benchmarks shows how versatile they are for use in audit, education, checklists, and for use by the Care Quality Commission (CQC) and other regulators to ascertain compliance with recognised standards of care. Many professional bodies, including the RCN, have provided guidelines on clinical practice which could become absorbed within the Bolam Test of approved practice. For example, the RCN has published guidelines on the assessment and prevention of falls in older people,[41] venous leg ulcers,[42] irritable bowel syndrome,[43] pressure ulcer assessment and equipment,[44] recognition of acute pain in children,[45] management of violence in inpatient psychiatric services and emergency departments,[46] contingency management and delivery of critical care in a post anaesthesia care unit,[47] monitoring standards of care,[48] national standards and guidance in diabetes care,[49] and dementia.[50] They, and others, can be found on the RCN website.[51] (See also chapter 24 on the scope of professional practice and clinical guidelines.)

NICE published guidance on the use of intravenous drips in December 2013 pointing out that tens of thousands of patients were harmed every year because doctors and nurses made basic mistakes when using intravenous drips. The guidance emphasised that all doctors and nurses must be trained in how

to use drips. They should also use new formulas to calculate what patients need, and the cost of this will be more than outweighed by savings from patients having fewer complications as a result.[52]

In 2014 NICE was given a new role to develop evidence-based guidelines which set out safe staffing levels for the NHS, focusing on nursing and midwifery staffing levels (see chapter 4). Further information on forthcoming NICE publications on staffing can be found on its website.[53]

Recent examples of possible negligence include:

An inquest was told that a GP was visited four times by a 16-year-old girl with complaints of headaches and failed to diagnose a non-lethal brain tumour. He refused the mother's request to arrange an MRI scan.[54]

Paramedics told a dying woman that she had a stomach bug and refused to take her to hospital. They failed to check her vital signs, including pulse, breathing and blood oxygenation. They then colluded to fabricate a patient record. The panel of the Health and Care Professions Council held that there was established failure to conduct a proper assessment. The subsequent dishonest fabrication and collusion were very serious, representing a disregard for fundamental and core duties.[55]

An ambulance NHS trust was found liable for the negligence of paramedics who failed to take a proper history from the patient or to make a proper assessment of the symptoms and signs they did find, had insufficient training and knowledge of the potential consequences of her high blood pressure and had over reliance on ECGs. They did not advise the patient to attend hospital that day and she died five days later.[56]

A liver surgeon was suspended after a review of 32 of his patients found that 10 later died and 8 of those deaths were avoidable.[57] He was reported to the GMC and the Cardiff and Vale University Health Board set up an emergency line for patients.

A patient was found dead in the hospital fire exit.[58]

A girl died when the paramedics went to the wrong RAF base.[59]

A girl died from pneumonia after being sent home from an out-of-hours GP who gave her less than optimal treatment.[60]

A girl died from an infection because a junior doctor with only four weeks in the post failed to spot a fatal infection. The junior doctor was left in charge overnight of 130 patients and the coroner stated that the medical records were a shambles.[61]

A 6-year-old girl who was prescribed Calpol when she was taken to A&E was later found to have a fractured arm.[62] The fracture was picked up eight weeks later when she was taken to the same hospital with a new break in the same arm.

An inquest heard that doctors at Basildon Hospital failed to carry out tests of a girl, Amie Miller, with a swollen brain. The duty doctor admitted that he had not taken regular neurological observations and the nurses had not noticed that she was floppy because of her sedation. One nurse stated that an increase in urine (a sign of brain damage) had not been reported immediately because she could not find a nurse in charge who would be the one to inform the doctor.[63] In a narrative verdict the inquest jury found that staff had missed a string of opportunities to save her life.[64] The family was taking legal advice to pursue regulatory, disciplinary and criminal action.

The coroner recorded a narrative verdict in a case where a 64-year-old man died after apparently being ignored by staff who did not give him the necessary fluids for his kidney condition and were too busy to provide care at the Queens Medical Centre in Nottingham.[65]

In many of these cases, the inquest finding will be followed by either civil action to obtain compensation or an offer of an ex gratia payment by the hospital to settle the case.

The Court of Appeal refused to allow an appeal against the finding that there was no negligence by a GP who failed to refer a baby to hospital. Colic had been diagnosed. The baby was subsequently diagnosed with meningitis which left him with moderate learning difficulties, double incontinence and right hemiplegic cerebral palsy. It held that the experienced judge had come to a clear conclusion about the consultation with the GP and there was no material error in his approach or findings.[66]

The legal situation is thus as follows:

1 There is no breach of the standard of care if the professional has acted in accordance with the practice accepted as proper by a responsible body of professionals skilled in that particular art and this was appropriate in the circumstances of the case.
2 There is no breach of the standard of care if there is no acceptable body of opinion covering that situation, but what the professional did was considered reasonable in all the circumstances.
3 There is no breach of the standard of care if the professional did not follow the accepted practice, but his/her actions were reasonable in all the circumstances and would be supported by competent professional opinion.

Reasonable foreseeability

Other criteria are considered in determining if the professional has been negligent. One of the basic principles of the law of negligence is that precautions can be taken only against reasonably known risks.

Case 3.4 *Roe* v. *Ministry of Health* (1954)

Ampoules in phenol[67]

A local anaesthetic was given by injection in a hospital. The ampoule, which was stored in phenol to sterilise it, contained invisible cracks caused by some mishandling in the hospital, through which the phenol seeped into the ampoule. The injection caused paralysis.

The patient sued the anaesthetist and nurses and their employer. The patient, however, lost the case. The possibility of seepage through invisible cracks was not known at that time and precautions against an unforeseeable possibility are not required of the defendant. However, successful defence may, of course, mean that the next claimant has a greater chance of winning since such risks are now known. The standard of care thus increases.

The judge, Lord Denning, said in this case:

> **It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors like the rest of us have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right . . . We must not look at the 1947 accident with 1954 spectacles.**

Exactly the same could be said of practice today and of nurses as well as doctors. There may be many occasions when one looks back and says, 'I would do things differently if I were to do it again', but that does not mean the professional has been negligent.

Keeping up to date

When one looks at the many professional journals that exist, the question must arise as to what extent the professional can be expected to master all this knowledge. How up to date is one expected to be?

Case 3.5 *Crawford* v. *Charing Cross Hospital* (1953)

A recent article[68]

A patient developed brachial palsy during a blood transfusion. An article had appeared in the *Lancet* six months previously describing this hazard.

The patient lost the case on the grounds that, provided the professional staff were following the accepted approved practice at that time, it could not be said that they were negligent in failing to apply or be aware of recent knowledge.

Articles in magazines and journals can be of very different status. Some are pure research articles, the lessons from which have not yet been absorbed into current accepted practice; others are controversial and their conclusions may never become part of recognised procedure. Other instructions, however, should have immediate effect. Thus, if a directive from the Medicines and Healthcare Products Regulatory Agency warned against prescribing a particular drug to a patient, to ignore that instruction might well be evidence of negligence. Nursing staff who had received comparable instructions from their profession or senior nurse management would be expected to be aware of these orders and to comply. The instructions would become part of the accepted practice.

Balancing the risks

As the earlier quotation from Lord Denning points out, there are hazards in modern medicine, and much of professional discretion is concerned with balancing the risks of taking action A compared with action B or compared with taking no action at all.

Practical Dilemma 3.3 Meningitis

A patient is admitted with a provisional diagnosis of meningitis. She was immediately barrier nursed in a single room, even though that meant moving a very sick patient on to a four-bed ward. The patient who was moved died in the night. There was criticism from relatives that the patient should not have been moved and also a suggestion that the death was accelerated. Was the nurse at fault if, the next day, it is discovered that the suspected meningitis patient was only suffering from a non-fatal virus?

Provided the nurse used her professional judgement in making the decision to give the single room to that particular patient, with the knowledge available to her at that time, then there should be no finding of negligence. In fact, if meningitis had been confirmed, then the nurse may well have been negligent in not taking precautions to prevent any danger of staff or patients being infected. She has to use her judgement in determining the degree of risk to both patients.

Causation

The third element in the claimant's case against the NHS trust or the nurse is to establish that there is a causal link between the breach of the duty of care by the nurse and the harm suffered by the claimant.

It is possible for the nurse to fail in her duty of care to the patient and for the patient to suffer harm, yet for the nurse or her employer not to be liable in civil law. This is because one of the essential elements that the claimant must establish in an action for negligence is that there is a causal link between the failure of the defendant to follow the approved practice and the harm suffered by the patient. The possibility that this harm could occur must be reasonably foreseeable and must also take place.

Factual causation

Case 3.6 *Barnett v. Chelsea HMC* (1968)

Causation[69]

A patient attended the casualty department after drinking tea that, unknown to him, had been contaminated with arsenic and that caused prolonged vomiting. The doctor did not examine him, but sent a message that he should see his own doctor. He died a few hours later.

The widow failed in her action because it was established that the patient would have died even if properly examined and treated. In this case, the pathological evidence on the progress of arsenic poisoning and the projected timetable of events had the patient been examined and admitted was of vital importance.

Similarly, the claimant lost where a doctor had been negligent in making a wrong diagnosis but nothing could have been done had the correct diagnosis been made.[70] In another case although there were breaches of care by doctors in the care of a patient following rectal surgery, the high court held that these breaches had not caused the death from compartment syndrome.[71]

In such circumstances, although a civil action fails there are likely to be professional and disciplinary proceedings by the professional body and the employer.

Barnett's case (Case 3.6) was an example of a lack of factual connection between the breach of duty of care and the harm suffered by the patient.

Another example of a case that has been before the House of Lords is the following.

Case 3.7 *Wilsher v. Essex AHA* (1988)

Blindness, but how caused?[72]

In the Wilsher case (considered on page 72, Case 4.3), the House of Lords decided that the case should be reheard by a new High Court judge on the issue of whether it was the defendant's negligence that had caused the harm to the child. In this case, it was agreed that there were several different factors that could have caused the child to become blind, and the negligence by the defendant was only one of these. The trial judge had failed to make a relevant finding of fact and could not presume that it was the defendant's negligence that had caused the harm.

Following the House of Lords' ruling, the parties came to a settlement and compensation was paid to the parents for the child.

In a case heard in 2008, the Court of Appeal held that weakness to the patient following the hospital's negligence in failing to resuscitate her properly after an operation combined with weakness caused by her pancreatitis led to her overall weakened state which resulted in her aspirating her vomit and suffering brain damage. It was not possible to determine the causative effects of each form of weakness, but the

Ministry of Defence (in their role as managers of the Royal Haslar Hospital – the first hospital to which she was admitted) was held liable for the harm the patient suffered.[73]

In July 2009, the High Court held that Corby Borough Council was potentially liable for disabilities to young children whose mothers had been exposed to toxic materials when the former steelworks were reclaimed. The Council had argued that there was no link between the deformities and the removal of waste to a quarry.[74] The deformities included missing fingers, heart and eye defects and skin conditions.

Case 3.8 *Kay v. Ayrshire and Arran Health Board* (1987)

The cause of deafness[75]

A child suffering from meningitis was given 300,000 units of penicillin instead of 10,000 units. The mistake was discovered and remedial action taken. The health authority admitted liability and made an offer to the parents for the additional pain and suffering that the negligence caused the boy. However, the parents argued that the overdose had caused the boy to become deaf and they rejected the board's offer, claiming instead many thousands of pounds more because they held the health authority liable for the deafness.

The House of Lords decided that the parents had not made out the factual causation between the overdose and the deafness, and thus that the boy was not entitled to the larger amount. It is a well-known fact that meningitis itself can cause deafness.

Reasonably foreseeable consequence

In a civil case for negligence, the claimant also has to establish that the harm that occurred was a reasonably foreseeable consequence of breach of duty by the defendant.

Practical Dilemma 3.4 Reasonable foreseeability

In breach of her duty of care, a nurse failed to dispose properly of contaminated dressings, which were left on a stainless steel trolley in the treatment area. By chance, two boys broke into the room looking for syringes and needles. When they heard footsteps approaching, they grabbed as much as they could from the trolley and ran off, taking a dressing with them. Subsequently, an outbreak of disease attributable to the dressing occurred in the neighbourhood. Was the nurse responsible in law for this?

The nurse was certainly at fault for not disposing correctly of the dressings. However, it could be argued that the subsequent events were not reasonably foreseeable and, in any event, the chain of causation between the nurse's action and the outbreak of the disease was broken by the action of the boys. This is sometimes known as a *novus actus interveniens* (i.e. a new act intervening).

Taking one's claimant as one finds him

There is one important exception to the rule that the harm resulting from the breach of duty is reasonably foreseeable, known as the thin skull rule or 'you take your claimant as you find him'.

Practical Dilemma 3.5 The thin skull rule

A nurse puts some drops in the wrong eye. They were meant to dilate the pupil in the other eye. They would not normally have caused any harm, but because of an existing defect in that eye the patient became blind.

The nurse in this case is clearly negligent. However, in the majority of patients her error would have caused no, or very little, harm. In this case, however, even though she could not have predicted the outcome, she would be liable for the harm that has occurred on the basis of the doctrine 'you take your claimant as you find him'.

Case 3.9 *Smith* v. *Leech Brain* (1961)

The thin skull rule[76]

An accident occurred at work when a labourer was splashed with a piece of molten metal and his lower lip was burnt. The burn was treated and the labourer thought nothing more about it. However, the place where the burn had been began to ulcerate and get larger. He consulted his general practitioner who sent him to hospital where cancer was diagnosed. Treatment by radium needles enabled the lip to heal and destroyed the primary growth. Subsequently, however, secondary growths were observed. He had six operations and died of cancer just over three years after the accident. His widow claimed compensation from the employers.

They admitted liability for the original accident, but denied that they were responsible for the man's death. Lord Parker in the Queen's Bench Division held that the test was not whether the defendants could reasonably have foreseen that a burn would cause cancer and that Mr Smith would die. The test was whether these defendants could reasonably foresee the type of injury that he suffered, namely the burn. The amount of damage that he suffers as a result of that burn depends on the characteristics and constitution of the victim. The widow therefore won her case.

In a case involving harm to a child who was playing about on a boat,[77] the House of Lords held that ingenuity of children in finding unexpected ways of doing mischief to themselves and others should not be underestimated. Reasonable foreseeability was not a fixed point on the scale of probability and the child won his case against the local authority as occupiers. (The case is discussed in chapter 12 Case 12.3.)

Loss of a chance

Case 3.10 *Hotson* v. *Berkshire* AHA (1987)

A lost chance[78]

A 13-year-old boy fell out of a tree and suffered a slipped femoral epiphysis. He attended the A&E department, but the doctor failed to carry out an X-ray of the hip. The boy suffered considerable pain and returned to hospital five days later, when the fracture was diagnosed. He developed avascular necrosis of the femoral head which medical evidence suggested occurred in 75 per cent of patients.

Expert evidence for the claimant was that as a result of the delay in diagnosis he lost a 25 per cent chance of avoiding this complication. The judge awarded the boy £150 damages for the pain suffered by him for the five days, which he would have been spared by prompt diagnosis and treatment. In addition, the boy was awarded 25 per cent of the damages that would have been awarded had the entire injury been attributable to negligence (i.e. 25 per cent of £45,000), for the loss of the chance of recovery.

The House of Lords allowed the health authority's appeal, holding that the claimant had not established that the defendant's negligence had caused the avascular necrosis. The question of causation was to be determined on the balance of probabilities with the onus on the claimant. The cause of his injuries was the non-negligent falling out of the tree and that injury would on balance of probabilities have occurred anyway.

The loss of a chance argument by a claimant is particularly difficult in cases where there has been failure to diagnose a condition such as a malignancy. In such a case the patient may have died even had the correct diagnosis been made, but would attempt to argue that had the correct diagnosis been made, then he would have been in that category which would have obtained remission following the appropriate treatment. In order to obtain compensation when there has been negligence in diagnosis, the claimant may have to rely on the specific consequences of delayed diagnosis such as further protracted treatment, additional pain and suffering, or other harm, rather than being able to claim that he or she would have been cured.

The House of Lords, in a majority judgment (*Gregg* v. *Scott*),[79] reaffirmed the use of the balance of probabilities test of causation in a 'lost chance' case and dismissed the claimant's appeal. The claimant alleged that negligent misdiagnosis of his tumour had caused a nine-month delay in the start of treatment. The trial judge held that this delay had reduced the claimant's chance of a cure from 42 per cent to 25 per cent. *Gregg* v. *Scott* was applied in another case of failure to detect cancer, where the claimant partially succeeded in his claim. The GP admitted breach of her duty of care in failing to diagnose a malignant melanoma in 2006. A correct diagnosis was made seven months later by another doctor. The judge held that the tumour had already become ulcerated in 2006 and his chances of surviving a further 10 years were less than 50 per cent. The judge found that failure to diagnose the tumour in 2006 had caused his life expectancy to be reduced by three years[80].

Hotson was applied in a case where Cauda Equina Syndrome (CES) was not diagnosed but the court held that on the balance of probabilities the prospects of the claimant making a good recovery if surgery had been undertaken earlier were less than 50 per cent and his claim that earlier surgery might have resulted in some general improvement in his condition was entirely speculative and impressionistic.[81]

Liable for what?

A victim of the Ladbrooke Grove rail crash who suffered depression which led to his killing someone, was unable to recover damages for the loss of his earnings after the manslaughter from the defendants who admitted liability for negligence up to the date of the manslaughter.[82] While his physical injuries were minor, the accident had a major psychological impact on him. He suffered post-traumatic stress disorder (see below) with a marked depressive component and a significant personality change. In August 2001, he stabbed a stranger to death. The Court of Appeal held that his claim was not founded on an illegal act. The manslaughter was not inextricably bound up with the claim for loss of earnings before and after the manslaughter, which resulted from the defendant's negligence. It was for the court to determine to what extent the manslaughter was the claimant's fault and therefore could be viewed as contributory negligence under the 1945 Act (see below).

However, the House of Lords allowed the defendant's appeal and held that the claimant could not recover damages for loss of earnings following his detention in prison and in mental hospital following the killing on the basis that a person cannot benefit from his own wrong (*ex turpi causa non oritur actio*). The defendants had accepted liability in negligence up to the date the claimant had committed the manslaughter.[83]

Harm

Not all forms of harm are compensatable by the civil courts. Grief itself is not a ground for a claim, although there is now a statutory right for compensation for bereavement where the death has resulted from negligence. This is considered in chapter 6 where the basis for the amount of compensation is discussed. The court recognises that harm that involves personal injury or death or loss or damage of property should be compensated if the other elements of negligence can be proved. However, the harm must be a reasonably foreseeable consequence of the breach of duty; it must not be too remote. This is a particularly difficult question when economic loss has occurred and the courts have limited the liability of the defendants to reasonably foreseeable economic loss. Similar difficulties arise over determining the liability for causing nervous shock, or post-traumatic stress as it is now termed.

Post-traumatic stress

Case 3.11 *McLoughlin* v. *O'Brian* (1982)

Post-traumatic stress syndrome (nervous shock)[84]

Mr Thomas McLoughlin and his three children, George (aged 17), Kathleen (aged 7) and Gillian (aged 3), were in a motorcar driven by George when it was in collision with a lorry. George was not at fault. Mrs McLoughlin, who was not in the vehicle, was told by a friend who was in the car behind (with Michael, another McLoughlin child, aged 11, who was a passenger) that George had probably died and that he was uncertain of the condition of the husband or the other children. She was driven to the hospital and saw Michael, who told her that Gillian was dead. She was taken down the corridor and, through a window, she saw Kathleen, crying with her face cut and begrimed with dirt and oil. She could hear George shouting and screaming. She was taken to her husband, who was sitting with his head in his hands. His shirt was hanging off him and he was covered in mud and oil. He saw his wife and started sobbing. She was then taken to see George. The whole of the left face and left side were covered. He appeared to recognise her and then lapsed into unconsciousness. Finally, she was taken to see Kathleen, who by now had been cleaned up. The child was too upset to speak and simply clung to her mother. As a result of this experience Mrs McLoughlin suffered from severe shock, organic depression and a change of personality. She was normally a person of reasonable fortitude.

Obviously, in a case like this, damages would be payable to the husband and the children for the harm that they had suffered, but in addition to that, compensation was claimed by Mrs McLoughlin for nervous shock. The defendants argued that she was too remote from the defendants' negligence: she was not herself a direct victim of the accident, neither was she a bystander witnessing what happened. The House of Lords decided that she was entitled to receive compensation since she was so closely related to those injured and the nervous shock that she suffered was close in both space and time.

Lord Wilberforce said:

> **It is necessary to consider three elements inherent in any claim: the class of persons whose claims should be recognised; the proximity of such persons to the accident; and the means by which the shock is caused. As regards the class of persons the possible range is between the closest possible of family ties, of parent and child or husband and wife, and the ordinary bystander. Existing law recognises the claims of the first; it denies that of the second, either on the basis that such persons must be assumed to be possessed of fortitude sufficient to enable them to endure the calamities of modern life or that defendants cannot be expected to compensate the world at large.**

Any persons wishing to claim compensation for nervous shock (now referred to as post-traumatic stress syndrome) would have to show that they were actually suffering from a mental illness and not simply grief, and that they were sufficiently closely related to the objects of the defendant's negligence and also in time and space.

The law has been further clarified by the House of Lords in the case of *Alcock* v. *Chief Constable of the South Yorkshire Police*.[85] In this case, people who were present at or who watched the disaster at Hillsborough, where 95 people died (as a result of overcrowding in the stadium, allegedly due to negligence by the police), brought a claim in respect of post-traumatic stress syndrome. The House of Lords held that in order to establish a claim in respect of psychiatric illness resulting from shock it was necessary to show not only that such injury was reasonably foreseeable, but also that the relationship between the claimant and the defendant was sufficiently proximate. Proximity could include not only blood ties, but also ties of love and affection. The closeness would have to be proved in each individual case. The claimant would also have to show propinquity in time and space to the accident or its immediate aftermath. It was held that those claimants who viewed the disaster on television could not be said to be equivalent to being within sight and hearing of the event or its immediate aftermath.

In March 2014 the Association for Personal Injury lawyers pressed for the law to be reformed so that compensation for mental harm suffered by those who witness the death of a loved one is no longer based on the principles set down in the Alcock case but should be revised. The Alcock principles were held to be archaic, inflexible, unfair and needed to be changed as a matter of urgency.[86]

In *White and Others* v. *Chief Constable of the South Yorkshire Police and Others*,[87] police officers sued for post-traumatic stress syndrome following the same disaster. The House of Lords decided that merely being an employee of the person/organisation responsible for the negligence did not automatically create sufficient proximity for the claimant to succeed in obtaining compensation for post-traumatic stress syndrome. The employee had to satisfy the usual rules of establishing proximity. To obtain compensation for psychiatric illness, a rescuer would have to show that he had objectively exposed himself to danger or reasonably believed that he was doing so. Rescuers were not entitled to claim compensation when they were not within the range of foreseeable physical injury and their psychiatric injury was caused by witnessing or participating in the aftermath of accidents that caused death or injury to others. The police therefore failed in their claim.

Both the McLoughlin and Alcock cases were referred to in a case in 1998,[88] where a mother failed in her case to obtain compensation for psychiatric illness following the abduction and death of her daughter by a mentally ill outpatient. The Court of Appeal held that the judge was correct to find that there was no proximity between the mother, the daughter and the Tees Health Authority. It was also relevant to consider how the offences could have been avoided even if sufficient proximity were established, having regard to the difficulty in identifying and protecting potential victims and to the limited effectiveness of the health authority's powers under the Mental Health Act 1983.[89]

The High Court[90] applied these House of Lords' cases in a situation where a fire officer sued his son, claiming damages for psychiatric harm suffered as a result of attending the scene of an accident in which the son had suffered head injuries. The accident occurred as a result of the son driving a car negligently after drinking. The court held that a victim of self-inflicted injuries owed no duty of care to a secondary party who, after witnessing the event from which the injuries resulted or its aftermath,

suffered psychiatric injury. In addition, in the circumstances of the case, to allow one family member to sue another would potentially result in an objectionable form of intra-family litigation.

An event may, in practice, cover a period of time, as the following case shows.

Case 3.12 *North Glamorgan NHS Trust v. Walters* (2003)

Delayed transfer[91]

A 10-month-old boy was admitted to hospital suspected of suffering from hepatitis. The doctors failed to diagnose that this was acute and accepted that, had it been properly diagnosed and treated by means of a liver transplant, he may have lived. During the night he suffered a fit and the mother was told by the nurse that it was unlikely that he had suffered any brain damage. In fact, there had been a major epileptic seizure that led to a coma and irreparable brain damage. A scan was carried out and the mother was told incorrectly that it showed no brain damage. He was transferred to a London hospital where he was placed on a life support machine. A further scan showed that he had suffered severe brain damage and the parents agreed that it was in the boy's best interests for the life support to be turned off. He died in his mother's arms. She was subsequently told that had he been transferred earlier he would have had a far better chance of survival.

It was agreed that the mother was suffering from a pathological grief reaction, which was a result of witnessing, experiencing and participating in the events described. The judge found that the mother was a secondary victim and her psychiatric injury was caused by sight and sound of a horrifying event that had covered a period of time. The defendants appealed to the Court of Appeal on the grounds that the 36-hour period could not be regarded in law as one horrifying event, but the claimant's appreciation was not sudden. The Court of Appeal held that the 36-hour period could be viewed as a single horrifying event and the judge was correct to find that the claimant's appreciation of the events was sudden as opposed to an accumulation of gradual assaults on her mind.

A similar decision is seen in another Court of Appeal case[92] where the claimant suffered post-traumatic stress syndrome after her daughter was killed in a road accident when a car mounted the pavement. The claimant rushed to the scene of the accident, which was cordoned off, and she was prevented from crossing the tape. She was told that her daughter was dead and she screamed hysterically and collapsed to the ground. Subsequently, at the mortuary, while the worst of the injuries on the girl's lower part were covered by a blanket, the mother saw that the daughter's face and head were disfigured. She cradled the daughter, saying she was cold. She lost her case on the grounds that the judge could not accept that what happened in the mortuary could be said to be part of the aftermath. The shock from which she suffered was a result of what she had been told by the police. The Court of Appeal allowed the claimant's appeal, holding that the immediate aftermath extended from the moment of the accident until the moment that the claimant left the mortuary. The judge had artificially separated out the mortuary visit from what was an uninterrupted sequence of events.

A woman received more than £500,000 after paramedics arrived 17 minutes late to tend her dislocated knee. Her knee dislocated on a bus and she was trapped between two chairs. It took 50 minutes for the paramedics to arrive. The kneecap was manipulated back into place but she suffered immense psychological damages and she has been left house-bound.[93] In 2012 the High court warned against the dangers of allowing claims for mental distress to creep into the forum of clinical negligence. In the case, parents failed in their claim for damages for psychiatric injury following the stillbirth of a child as a result of the hypercoiling of the umbilical cord. There had been negligence by the consultant in failing to advise a second meeting in relation to conception but this breach did not lead to the stillbirth.[94]

This topic of post-traumatic stress syndrome relates to the nurse in two ways. First, she may herself be the victim of post-traumatic stress arising from another person's negligence, in which case she needs to know whether she is likely to obtain compensation. Second, in her own work she should be aware of the dangers of causing stress shock in others and the possibility of claims for compensation arising out of this.

Conclusions

Claims in respect of clinical negligence are increasing in the NHS, and the nurse needs to be aware of the basic legal provisions which apply so that she can protect both the patient and herself. The NHS Redress Act, which has only been introduced in Wales (see chapter 6), would have introduced an alternative scheme for compensation has not been implemented in England but following the Francis Report into the Mid Staffordshire NHS Trust scandal a duty of candour on organisations has been introduced together with a more effective complaints procedure. (See chapter 5 for the Francis Report and chapter 27 for complaints handling.) Identification and implementation of the appropriate standards is essential together with quality record keeping (see chapter 9) to ensure litigation is reduced.

Reflection questions

1 Consider the duty of care possibly owed by the nurse of an NHS trust and discuss whether and on what grounds you think a duty would be owed in the following circumstances:
   - **a.** an informal psychiatric patient who wanders away from the hospital and damages cars in the vicinity of the hospital
   - **b.** a patient detained under the Mental Health Act who does likewise
   - **c.** a patient in the A&E department who, after an attempted suicide, insists on taking his own discharge and is shortly afterwards found dead on a railway line
   - **d.** a doctor in a cinema who gives a person having a cardiac arrest the wrong treatment
   - **e** a community nurse who is caring for a neighbour, not on her list, and who accidentally leaves the door open. The neighbour is mugged and the house burgled.
2 If there has been a negligent act but no harm has occurred to the patient, what remedies are available (if any) for the patient to obtain compensation?
3 How would you determine the standard of care that should be adopted in carrying out the following procedures:
   - **a.** lifting
   - **b.** administering medication
   - **c.** informing patients of their rights
   - **d.** advising relatives on the procedures to be followed in dealing with death?
4 A man of 60 was told that he had terminal cancer and was unlikely to survive more than six months. He bought a car for a friend, had an expensive holiday and spent most of his savings. A year later he was informed that there had been a mistake in diagnosis and the growth was benign, and he could live to the usual age of life expectancy. He wishes to sue the trust for negligence. Analyse how such an action would proceed and what he would have to prove.

Further exercises

1 Why do you consider that causation is an important element in an action for negligence? Would it be fairer to the claimant if causation did not need to be proved?

2 New Zealand and Finland have a system of no-fault liability for personal injury claims. What are the advantages and disadvantages of introducing such a scheme into the UK?

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Chapter 4

Specific problem areas in civil liability:

personal liability of the nurse, vicarious liability of the employer and managerial issues

This chapter discusses

- Negligence in communication
- Inexperience
- Team liability and apportionment of responsibility
- Taking instructions: refusal to obey
- Nurse as manager
- Vicarious liability of employer
- In the course of employment
- Liability for negligence of volunteers
- Duty of care and liability for independent contractors
- Direct liability of employer
- Indemnity from the employee at fault
- Pressure from inadequate resources
- Public Interest Disclosure Act 1998 and whistleblowing

Introduction

In this chapter, we explore some of the particular difficulties that can arise in determining the liability of a professional in some specific situations, beginning with liability for negligence in communicating. In addition, we consider the problems that can arise from inadequate resources; the nurse as a manager; and the liability of the employer. (The scope of professional practice and the role of the clinical nurse specialist and consultant nurse are considered in chapter 24.)

Negligence in communication

It is possible to be negligent in failing to communicate with the appropriate person at the correct time and in the proper way.

Case 4.1 *Coles v. Reading HMC* (1963)

Crushed fingers[1]

Mr Coles suffered a crush injury to his finger. He went to the cottage hospital where the nurse cleaned the wound of dust and dirt and told him to go to a proper hospital where he would have an anti-tetanus injection. But neither she nor anyone else impressed on him the purpose and importance of the visit and so he did not go. He later saw his general practitioner who believed that he had had the injection and so he did not give him one. He subsequently died of tetanus.

In this case, there was negligence by all those professional staff (including the nurse) who had failed to communicate adequately with other professionals and with the patient. Failure to communicate, if it falls short of the required professional standard, can be regarded as negligence and is actionable if it causes reasonably foreseeable harm to the patient.

Failure to communicate rarely causes such devastating harm as in this tetanus case, but there are other well-known examples where it is vital that the patient receives certain information and it cannot be assumed that the patient is aware of the dangers. For example, in head injury cases there may be no detectable sign of head injury when the patient is seen in the A&E department. However, it is essential that the patient be warned to return if certain symptoms appear. Comparable instructions must be given after plastering and in many other situations. In such circumstances, it is advisable for a strict procedure to be implemented to ensure that the correct information is given both by word of mouth and in writing. If there is likely to be any dispute as to whether the information was given and/or where there are considerable dangers if the patient is not informed, it is possible to ask the patient to acknowledge in writing his receipt of that information. This procedure has the added advantage of making the patient aware of the importance of the information or instructions. A report of the National Patient Safety Agency in 2010[2] into delayed diagnoses of cancer revealed appalling faults in communication between GP, hospitals and diagnostic departments such as radiology and pathology. For example, a chest X-ray suggesting lung cancer taken on 1 November 2007 and reported on 23 days later was not delivered until 1 February 2008. There were severe failures in communication at all stages between GPs and hospitals and between departments within a hospital.

Negligence in instructing others is considered in further detail in chapter 18, which deals with the law and the nurse educator. Liability for a negligent misstatement was found when a local authority recommended a registered childminder to a mother despite an earlier case of non-accidental injury by the minder.[3]

Inexperience

Does a newly qualified nurse have to follow the same standard of care as an experienced nurse?

In practical terms, it is, of course, impossible to expect the same standard of care from the junior nurse as from the experienced senior nurse. However, in law that is what the patient is entitled to expect. You cannot say in defence to a patient, 'The reason that you were given the wrong drug is that

nurse X administered it and she has only just qualified.' The patient is entitled to receive the accepted standard of care whoever provides it. It is, however, essential that staff work within their field of competence and that work requiring greater experience is performed by those with the appropriate skills or that those lacking in experience have adequate supervision to ensure the task is safely undertaken. This point is discussed in the Wilsher case (considered on page 72).

Case 4.2 *Nettleship v. Weston* (1971)

A learner driver[4]

Mr Nettleship was teaching Mrs Weston to drive in her husband's car. On the third lesson, he was helping her by moving the gear lever, applying the handbrake and occasionally helping with the steering. In the course of the lesson, they made a slow left-hand turn after stopping at a halt sign. However, Mrs Weston did not straighten up the wheel and panicked. Mr Nettleship got hold of the handbrake with one hand and tried to get hold of the steering wheel with the other. The car hit a lamp standard. Mr Nettleship broke his kneecap. He claimed compensation and succeeded before the Court of Appeal.

The crucial question in the case was: since Mrs Weston was not a qualified driver, was the standard of care that she owed to the instructor lower than would otherwise have been the case? The court decided not. They preferred to have one standard of driving, not a variable standard depending on the characteristics of the individual driver. 'The certainties of a general standard are preferable to the vagaries of a fluctuating standard' (Lord Justice Megaw).

This might seem irrelevant to the standard of the nurse but Lord Justice Megaw, in discussing the issue, used the example of the young surgeon:

> **Suppose that to the knowledge of the patient, a young surgeon, whom the patient has chosen to operate on him, has only just qualified. If the operation goes wrong because of the surgeon's inexperience, is there a defence on the basis that the standard of care and skill was lower than the standard of a competent and experienced surgeon? In cases such as the present it is preferable that there should be a reasonably certain and reasonably ascertainable standard of care, even if on occasion that may appear to work hardly against an inexperienced driver.**

Mr Nettleship obtained his compensation, subject to a reduction for contributory negligence.

Practical Dilemma 4.1 No experience

Ruth Evans is recently qualified and is a staff nurse at Roger Park Hospital. She is asked to work initially on the orthopaedic ward until a vacancy occurs on the children's ward, which is her chosen specialty. The orthopaedic consultant suggests that Fred Timms, who has recently been taken off traction, could start some mobility exercises. Ruth, following this advice, approaches Fred's bed with a nursing auxiliary and with a pair of crutches. She suggests that Fred should manoeuvre himself to the side of the bed and gently put his sound leg on the floor. Then, when he feels steady enough, he should take the crutches and start to walk. Fred shifts to the side of the bed, puts his sound leg on the floor, but, as he stands up holding on to the crutches, they slide away from him and he falls heavily to the ground. Subsequently, X-rays reveal a further fracture of the injured leg and a fresh fracture in the other leg. Where does Ruth stand as far as liability is concerned? Is the fact that she has only just commenced on the orthopaedic ward and has never specialised in it a good defence for her personally against any potential court action that Fred might bring?

It is quite likely that if this case were investigated it would be established that there was a recognised procedure for mobilisation of orthopaedic patients, which would most likely involve the physiotherapist, and that Ruth had failed to follow this and probably was not even aware of its existence. This would be no defence against Fred. If he can establish the four elements of negligence – (a) a duty of care was owed to him, (b) Ruth was in breach of that duty by failing to follow the accepted approved practice and that (c) as a reasonably foreseeable consequence, he has (d) been caused harm – then he would succeed in his action. Ruth would be held to be negligent. Fred is, however, more likely to sue the NHS trust as Ruth's employer on the grounds that it is vicariously liable for her negligence (see below) and is also directly liable for failing to ensure a system of supervision of inexperienced staff. Other staff may also be held negligent. For example, who should have ensured that Ruth had the requisite training, that she was made aware of ward procedures and that she had adequate support? Someone else should have ensured that she was aware of the role of the physiotherapist.

In practice, of course, the experience of individual staff varies greatly and even where staff have had the same experience and training, their level of skill and manual dexterity may also vary greatly. However, the patient should be assured that the recognised approved standard of care will be given. Occasionally, a patient may require a higher standard.

For example, Mr Links may have held himself up as a specialist in a complex ear operation that is not often performed because of its particular hazards and difficulties. A GP might refer a patient to Mr Links because of his particular skill. If Mr Links then fails to perform the operation carefully and the patient suffers harm, it is no defence for Mr Links to claim that he knows he did not perform it correctly, but no other ear surgeon could have done it. He has held himself up as having that particular skill. Of course, it would have to be shown that he had failed to perform the operation with the required level of care and skill. The fact that things go wrong does not in itself mean that there has been negligence.

Team liability and apportionment of responsibility

Team liability

If harm is caused by another member of the team, is the nurse responsible?

Work in the health service is, above all, team-oriented. Very few tasks are performed entirely on one's own. In the community, particular tasks are often allocated not purely on a professional basis, but on a key worker basis, which enables one person to take responsibility for a wide range of tasks.

Practical Dilemma 4.2 The team

Jane is a third-year student who, together with other members of staff on the ward, is caring for orthopaedic patients. The nursing process is in operation. One day Jane is asked to work in the plaster unit where it is her task to bind the plaster bandage around the patients' limbs. One of the patients, a young boy called Sam, has a broken wrist and Jane is told to strap it up. She bandages the wrist and then calls the sister to look at it. The sister glances at it, but does not touch it and the boy's mother is asked to bring him back in three weeks' time. No instructions are given about checking the tightness of the bandage or moving the hand. Three weeks later the boy returns with his mother and it is noticed that the bandage has been put on too tightly and it appears that permanent damage has been done to the boy's hand. What is Jane's responsibility?

Jane is, of course, the person who actually bandaged his wrist. Whether the trust is vicariously responsible for her actions will depend on any memorandum of agreement between her college of nurse training and the NHS trust offering clinical placements. Jane's personal liability will depend on such questions as: Had Jane been trained to plaster? Was such a task entirely within her competence? Should she have refused to undertake an activity for which she was not competent? Was her level of expertise such that the sister should have checked her work? If, for example, it should have been quite clear that Jane was too inexperienced to undertake the task without supervision, the fact that she asked the sister to check over the work might be sufficient to relieve her of personal responsibility. The failure to communicate to the parent the need to check on the plaster is also a breach of duty, and liability will depend on who had the responsibility of ensuring that this was done. As has been noted in the first section of this chapter, failure to communicate can itself be grounds for an allegation of negligence.

The team may be a group of nurses working together – it might be a multidisciplinary group. In the following case, the team was made up of doctors and nurses working under one consultant.

Case 4.3 *Wilsher* v. *Essex AHA* (1986)

No team liability[5]

A premature baby was placed in a special care baby unit staffed by a medical team consisting of two consultants, a senior registrar, several junior doctors and trained nurses. A junior doctor, while monitoring the oxygen intake, inadvertently put the catheter in a vein rather than in an artery. He asked the senior registrar to check what he had done. The registrar failed to see the mistake and several hours later made exactly the same mistake himself. As a result, the catheter failed to monitor the oxygen correctly and it was alleged that the child suffered from an incurable condition of the retina resulting in near blindness.

At the trial, the judge awarded £116,199 to the child. The health authority appealed to the Court of Appeal on the grounds that: (1) there had been no breach of duty of care owed to the child because the standard of care required of doctors in the unit was only that reasonably required of doctors having the same formal qualifications and practical experience as the doctors in the unit; and (2) the child had failed to show that the health authority's actions had caused or contributed to his condition since excess oxygen was merely one of several different factors, any one of which could have caused or contributed to the eye condition from which the child suffered. (This last point is known as causation and is discussed in chapter 3, page 56.)

On the point of the standard of care, the Court of Appeal held that there was no concept of team negligence, in the sense that each individual team member was required to observe standards demanded of the unit as a whole, because it could not be right, for example, to expose a student nurse to an action for negligence for her failure to possess the experience of a consultant. The standard of care required was that of the ordinary skilled person exercising and professing to have that special skill, but that standard was to be determined in the context of the particular posts in the unit rather than according to the general rank or status of the people filling the posts, since the duty ought to be tailored to the acts which the doctor had elected to perform rather than to the doctor himself. It followed that inexperience was no defence to an action for negligence. One judge, however, stated that an inexperienced doctor who was called on to exercise a specialist skill and who made a mistake nevertheless satisfied the necessary standard of care if he had sought the advice and help of his superior when necessary. The court in this case applied the same standard as the court in the Whitehouse and Jordan case (see page 50), i.e. the Bolam Test. The judges held that the junior doctor had not been negligent and had upheld the relevant standard of care by consulting his superior. His superior had, however, been negligent in failing to notice that the catheter had been mistakenly inserted in a vein rather than an artery and, accordingly, the health authority was vicariously liable for the registrar's negligence.

An additional finding was that there was no reason why, in certain circumstances, a health authority could not be directly liable to a claimant if it failed to provide sufficient or properly qualified and competent medical staff for the unit (see page 83 on direct liability). The House of Lords subsequently ordered a new trial on the issue of causation and the parties then settled the case (see chapter 3).

Apportioning responsibility

Although there is no concept of team negligence in law, each person is individually responsible for his/her negligence; it does not follow that there are no occasions of multiple liability, i.e. in a given situation several different professionals might be individually responsible for their own individual negligence. An example of this is given in chapter 28 on the prescribing of medicines.[6] Under the Civil Liability (Contribution) Act 1978, if there are several defendants, a successful claimant can recover damages from any one of the defendants. That defendant may then sue the other defendants to recover a sum that represents their responsibility for the harm which has occurred.

Taking instructions: refusal to obey

General principles

When we look at the scope of professional practice (see chapter 24), we will consider the possibility that the nurse might have to refuse to undertake a task where, for example, she was not trained to perform it or where she had insufficient time to undertake it safely. In this section, we look at the wider field of obeying orders.

Practical Dilemma 4.3 Orders are orders

A registrar decides that Margaret Brown should be prescribed a new drug that has only just been released on to the market and writes her up for it. The staff nurse on that ward is not familiar with the drug and says that she would like to check it with the pharmacist before she administers it. The doctor is furious with this insolence and says that if he has written it up then she should administer it without questioning his competence. The nurse says that she needs some understanding of the drug before she gives it to the patient. The doctor insists she gives it. Where does the nurse stand?

This is a simplified version of situations that often confront the nurse. This particular example raises the issue of what the nurse's responsibility is in relation to the administration of drugs, but examples could be given from other fields such as obeying the order 'not for resuscitation', not passing certain information on to a patient, etc.

It is impossible to give an answer that would apply to every situation. In an emergency, for example, certain risks have to be taken which would not be appropriate in non-urgent circumstances. In Practical Dilemma 4.3, the nurse would be quite correct in obtaining further information about the drug in question. When she administers a drug she must be sure that she is administering the right drug, at the right time, in the right place, at the right dosage, in the right way, to the right patient. She should not administer a drug of which she has no knowledge without taking all reasonable steps to ascertain that it is appropriate for that particular patient. If in this situation she were to go ahead and administer the drug on the orders of the doctor and the patient were to die or suffer harm as a result, she could be held to be negligent in any civil action (for which her employers would be held vicariously liable) since she failed to follow the reasonable standards of care expected of a nurse. She could also face professional

disciplinary proceedings before the Conduct and Competence Committee (CCC) of the NMC and disciplinary proceedings before her own line manager because she failed to use all care and skill in carrying out her contract of employment. If the patient died, the nurse might have to appear in the coroner's court and there might also be criminal proceedings brought against both her and the doctor. See the NMC Code of Professional Conduct: standards for conduct, performance and ethics,[7] which states that:

> The people in your care must be able to trust you with their health and well-being.
>
> To justify that trust, you must:
> - make the care of people your first concern, treating them as individuals and respecting their dignity;
> - work with others to protect and promote the health and well-being of those in your care, their families and carers, and the wider community;
> - provide a high standard of practice and care at all times.

In all these courts and hearings, saying, 'I was only carrying out orders' will not be sufficient defence on its own. In the civil courts, the fitness to practise proceedings of the NMC and the employer's disciplinary proceedings, the nurse would have to show that what she did was reasonable, having regard to the approved accepted practice to be expected from any qualified nurse. In the criminal courts, she would have to show that her acts did not constitute the ingredients of the particular charge and/or that she lacked the required mental state (see chapter 2).

Obeying orders in an emergency

In certain circumstances, time does not permit the usual practice to be followed, but the risks taken must be balanced against the risk of the patient dying.

Practical Dilemma 4.4 Emergency

A patient has been brought into the A&E department with severe bleeding. A blood sample is taken for cross-matching and he is immediately put on an intravenous infusion of plasma. The doctor places the cannula in the patient's arm for the intravenous infusion and asks the nurse to set up a saline solution for administration straight away. Staff Nurse Bryant takes the bag that the doctor is holding out to her and attaches it to the IV line. She does not check the bag. The patient's condition worsens and he eventually dies. It is then discovered that the doctor inadvertently gave the nurse a bag containing a substance other than saline. What is the nurse's liability?

It is clear that a quick check of the label on the bag would not have delayed the patient's treatment and could have been done by the nurse without any difficulty. It is most likely that she would be found personally negligent in these circumstances (although her employer would have to pay compensation because of its vicarious liability for her negligence) and any defence of 'but that was the bag the doctor gave me' would be unlikely to succeed. There could be other circumstances where emergency life-saving measures are required and the nurse would be unable to make the same checks. Very rarely, however, would the defence of 'obeying orders' succeed, since as a professionally qualified person the nurse would be expected to act responsibly and carefully and to ensure that her own personal actions are safe.

Nurses sometimes complain that the misgivings they express to doctors are ignored. What do they do then? Obviously, it depends on the circumstances. Where her misgivings concern treatment that could be harmful to the patient and if one doctor ignored her concern, then the nurse should express her misgivings to her own line manager and, if necessary, the advice of a more senior doctor should be

sought. Much depends on the approach made by the nurse and the nature of the relationship and understanding that exists between the nurse and the doctor. Undoubtedly, encouragement of a team approach to patient care could prevent many unnecessary confrontations of this kind. It should, of course, be stressed that a nurse should not disobey the instructions of a doctor lightly; she should have compelling reasons from the patient's point of view. She should ensure that she keeps detailed records indicating the reasons for her actions and that her nurse manager is brought in at the earliest opportunity. If it should happen that the nurse's attitude was unreasonable then she would, of course, face disciplinary action and, if the patient has been harmed as a result of the nurse's action, civil proceedings and professional misconduct proceedings. (See the discussion of whistleblowing later in this chapter.)

In a case heard by the Court of Appeal in 1942,[8] Lord Goddard said:

> **If a doctor in a moment of carelessness, perhaps by the use of a wrong symbol in a prescription, ordered a dose which to an experienced ward sister was obviously incorrect and dangerous, I think it might well be held to be negligence if she administered it without obtaining confirmation from the doctor or higher authority. In the stress of an operation, however, I should suppose that the first thing required of a nurse would be an unhesitating obedience to the orders of the surgeon.**

Since 1942, as the recognition of the nurse's personal professional accountability has strengthened, the number of occasions on which a nurse would be expected to obey orders without question has clearly diminished.

Nurse as manager

Delegation and supervision

As the scope of professional practice develops (see chapter 24), more and more work that is currently undertaken by registered staff will have to be delegated to healthcare support workers under the supervision of registered practitioners. Delegation may take place to other trained staff, learners and nursing assistants and also volunteers. On some occasions, these volunteers may be very unwilling helpers as, for example, where youth training schemes include an attachment to a hospital. If such persons are assigned to work on a ward or department and the nurse manager is responsible for them, then she would have to ensure that their training and the tasks delegated to them are appropriate and that adequate supervision is provided. (This topic is further considered in chapter 24.)

As a manager, the nurse would be responsible for ensuring that the resources were effectively used and were sufficient for treating patients according to the approved standard of care. If harm is caused by inadequate resources and it is established that she failed to take the appropriate measures to prevent unreasonable risks arising, then she may well be liable (see below and page 86). Delegation to support workers and the recommendations of the Francis Inquiry on the training and registration of support workers are considered in chapter 24.

Pressure on the manager

Practical Dilemma 4.5 Manager's nightmare

Nursing Officer Janice Clarke is on duty and is informed by the staff in the surgical ward that, although they are on intake and have three empty beds, owing to illness and the failure to fill vacancies they are so far below their establishment that the situation is dangerous and the present staff cannot cope with any more patients.

Obviously, the nursing officer would ensure that the facts are correct and that the nurses on that ward are using their time appropriately and not undertaking tasks that could safely be left, in order to give priority to the work that is most important. Having assured herself that the situation is critical, she would then look internally at other wards and decide whether staff could be transferred. She might also have to consider bringing in bank or agency nurses. If necessary, she would consider the situation on a district basis, which might mean that she would have to discuss the possibility of another hospital taking over the intake at the present. Ultimately, she might have to bring in other districts or at least refer the problems to a more senior manager. The decision might be made that waiting list admissions are cancelled for the time being. Clearly, at all stages in this decision the evidence of the individual ward staff on the dangers and hazards is vital for informed decisions to be made. Like the ward sister or staff nurse, the nursing officer herself should keep records of the reasons behind the actions she has taken since this information may well be relevant to a court or CCC hearing. (Whistleblowing is considered below.)

Practical Dilemma 4.6 On holiday

Marion is ward sister of an acute surgical ward of 30 patients. While she is on holiday, a patient is given a pre-medication prior to the form of consent for his operation being signed. The mistake is discovered and because it was felt that there was no doubt that the patient wanted to have the operation he was still asked to sign the form. He was then taken to theatre. Subsequently, he disputed the extent of his operation, as he had understood that the operation was only exploratory, but he received radical surgery including the provision of a colostomy. He argued that had he known that this was a possibility he would not have agreed to have the operation and he could not remember signing any form of consent. The circumstances of his signature were then discovered. Since the ward sister was on holiday at the time, is there any possibility of her being liable?

It would be cheering for ward sisters and managers if the question could be answered with a definite 'no'. However, this is not possible. A manager has a continuing responsibility to ensure that procedures and policies are designed and implemented to prevent any likelihood of harm to the patient. A vital question to be answered would be: had a procedure been established to ensure that the nursing staff checked that the consent form had been signed before administration of pre-medication? It would be the ward sister's responsibility to ensure that those procedures that come under the responsibility of the nursing staff are carried out competently and diligently, even when she is not there. In this example, the doctor would be liable for failing to obtain consent. In addition, as far as the immediate responsibility is concerned, the manager in charge of the ward at the time would also share liability for the events, but if, for example, it were established that there was no clear system for ensuring a correct procedure in relation to the checking of consent forms prior to the pre-medication being given, then the ward sister who should have implemented and supervised such a procedure would share some responsibility for the events. It is likely, too, that evidence of similar events in the past would be used to show the deficiencies in overall ward management in this particular context. In these circumstances, the ward sister's liability is not vicarious (see next section), i.e. it does not concern taking responsibility for the fault of others. It is directly her own personal liability for failing in her management role. If, of course, it can be shown that a sound practice had been implemented and was not followed on that occasion owing to the negligence of the staff on duty at that time, then there is less likelihood that the ward sister would be held liable.

Her failings in her responsibilities as manager could result in her having to give evidence in the civil courts, if her employer were to be sued for its vicarious liability for her negligence and, in addition, it could result in her facing a hearing for professional misconduct before the CCC of the NMC. The definition of unfitness to practise by reason of conduct unworthy of a nurse, which may justify removal from the Register, is sufficiently wide to cover mismanagement by a nurse. Nurse managers may appear

before the CCC to answer the charge of misconduct in failing to take responsibility for the situation and having shown a failure in management. A nurse manager who was aware that a nurse was on drugs or under the influence of drink at work and who failed to take appropriate action would be in breach of the NMC Code of Practice and could face a fitness to practise hearing.

The Royal College of Nursing has provided guidance on the principles of good management practice,[9] covering the topics of: vision and strategy; leadership; managing people; managing financial resources; management of care; and quality and risk management. Its aim is to provide a template for managers to develop their own performance standards. It emphasises the importance of regular updating. Subsequently the RCN has published guidance on the role of the ward sister and charge nurse.[10] It hosts an A to Z website providing guidance on many areas of practice and management. (The implications of clinical governance are considered in chapter 5.)

The Francis Report of the Mid Staffs Inquiry[11] made the following recommendation in relation to ward nurse managers:

> **Recommendation 195: Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.**

Vicarious liability of employer

Vicarious liability

The NHS trust or employer has two forms of liability in negligence: one is known as direct liability, i.e. the trust itself is at fault; the other is known as vicarious liability or indirect liability, i.e. the trust is responsible for the faults of others, mainly its employees. In this first section, we look at the vicarious liability of the employer, which could be an NHS trust, a clinical commissioning group, a private hospital, a company or even a GP who employs his own staff.

Practical Dilemma 4.7 Assault on behalf of the employer

Kate was a staff nurse in casualty where, at weekends, there tended to be a problem with drunks. The hospital was close to the town centre and to several pubs and, not infrequently, people needing some assistance were accompanied by friends who were incoherent and abusive. One evening Kate was very busy and therefore extremely annoyed to find some very obstreperous men accompanying another man who had a cut head. She asked them to leave him and wait outside. They refused to go. She said she would have to summon the police if they did not leave quietly. One particularly aggressive visitor moved towards the treatment trolley and Kate, fearing that he would knock it over, raised her arm to prevent him. He was taken by surprise at her actions and fell heavily to the ground, catching his head on the side of the trolley. Kate has subsequently learnt that he intends to sue her and her employer.

In a personal action against her for assault, Kate would have to prove that she took reasonable action in self-defence or in protecting her employer's property or in evicting on behalf of the occupier a trespasser who refused to go. In such cases, it is more likely that the claimant would sue the NHS trust responsible for the wrongs of its employees. The claimant does not have to choose whether to sue the employer or the employee. He can sue both. The obvious advantage of suing the employer is that funds

will be available to pay him should he win the case. To win against the employer, he has to establish the following:

1 Kate was negligent or was liable for a civil wrong (see chapter 3).
2 Kate was an employee (see pages 81–2).
3 Kate was acting in the course of her employment (see below).

There is no problem with the second element in this case. Kate was an employee, but there may be cases where this is not so clear; for example, if Kate were an agency nurse it might not always be obvious whether Kate is considered to be an employee of the authority to which she is sent or whether she continues to be an employee of the agency.

In practice, the first element could cause some considerable difficulty. Much would depend on the circumstances of the assault: whether she had lost her temper, the level of provocation she was subjected to, etc. Let us assume, for the purpose of this discussion, that it was established as a matter of fact that Kate had acted unlawfully and that personal action against her would therefore succeed.

In the course of employment

In the employer's interests

The third element now needs to be considered. Was the nurse acting in the course of her employment when she assaulted the visitor? The test used to answer this question is as follows: what was she employed to do and when she carried out that act was she acting for the benefit of her employer? In this case, she was clearly not employed as a bouncer, but she was trying to prevent a trolley from being upset by an obstreperous visitor (or even trespasser). This could certainly be seen as being in the interests of the employer's business. Even if there were a clear policy that nursing staff should not attempt to deal with aggressive visitors on their own, this should not necessarily prevent the act from being in the course of employment. The performance of a prohibited act does not on its own mean that the employee has ceased to be acting in the course of employment. All the facts have to be considered. If it can be shown that all three elements were present (i.e. Kate was liable for a civil wrong, was an employee and was acting in the course of employment), the NHS trust could be held vicariously liable for the harm caused by the nurse.

There have been difficulties in establishing whether an act is in the course of employment, and Box 4.1 sets out the criteria which have been used by the courts to decide if an act is in the course of employment.

Box 4.1

The term may cover:

1 Acts authorised by employer.
2 Acts not authorised by employer, but
   (a) performed for the purpose of the employer's business
   (b) prohibited acts, but the prohibition does not take the conduct outside the sphere of employment[12]
   (c) acts incidental to the employment, undertaken for the employee's benefit while the employee is working on the employer's business (e.g. smoking on duty)[13]
   (d) acts for the protection of the employer's property and business[14]
   (e) dishonest or fraudulent acts of the employee, if the employer is under a duty to the person suffering the loss[15]

Outside the job description

Practical Dilemma 4.8 Helping others

Ann Barrett was a staff nurse on a medical ward and was concerned that the kitchen had not sent up the diets. She telephoned for them and was told that she would have to wait since there were no porters available. Rather than wait, she decided to fetch them herself. She went to the kitchen, passing the notice saying: 'No admission, kitchen staff only.' She went across to the diet bay and as she did so she knocked into a cook who was removing a pan of gravy from the stove. The gravy splashed over the cook and also over Ann. What remedies do the cook and Ann have in this situation and is the employer vicariously liable for Ann's negligence?

The cook could, of course, sue Ann personally. Ann owed a duty of care to the cook and, by her carelessness, she caused reasonably foreseeable harm to the cook. However, is the employer vicariously liable for Ann's actions? There is no doubt that she is an employee. There is also no doubt that she was negligent in knocking into the cook. However, is the third element satisfied, i.e. was she acting in the course of employment when she went to the kitchens and when she knocked into the cook? She was employed as a nurse, not as a kitchen porter, but she was acting in the care of the patients (her employer's business) when she went to the kitchens. Even if there were a clear prohibition on non-kitchen staff entering the kitchens, this would not in itself remove the act from the course of employment. The crucial point would be whether she was acting on the employer's business when she entered the kitchen and the answer to that in this case is yes. It would be very different if she entered the kitchen to have a chat on non-hospital business with a friend of hers who worked there.

It is not, of course, uncommon for staff in the health service to step outside the strict confines of their job descriptions. If the employer is aware of this and turns a blind eye to it, then it could be said that he condones it and accepts that the employee's duties have been expanded to include the additional tasks. In such cases, if the employee acts negligently while carrying out these duties, it could be argued that he or she is acting within the course of his or her employment. In addition, particularly during times of industrial action, employers specifically authorise staff to cover for the strikers or those working to rule. In such cases, the employees are acting in the course of their employment: they have the express authorisation of the employer.

Activities incidental to the work

Practical Dilemma 4.9 Smoking on duty

There was a clear and enforced policy at Roger Park Hospital that there was no smoking anywhere. One of the nurses ignored these instructions and regularly smoked with the patients in the ward area. On one such occasion, she accidentally dropped the cigarette and burned a patient's foot. He threatened to sue the NHS trust. Was the nurse acting in the course of employment?

The answer is probably yes, based on the following case.

Case 4.4 *Century Insurance Co. Ltd* v. *Northern Ireland Road Transport Board* (1942)

Lighting up[16]

A tanker driver ignored his instructions not to light matches when loading or unloading his vehicle and, as a result, the tanker, a vehicle belonging to the garage and several nearby houses were destroyed.

In this case, the court held that even though the act of lighting a cigarette is for the employee's own comfort and even though it is prohibited, the act could not be separated from the circumstances of his employment. The driver was held to be negligent in the course of performing his authorised work and the employers (and therefore their insurers) were liable.

In our example of the smoking nurse, it is highly likely that she will face disciplinary proceedings and possibly even dismissal, yet she may still be held to be acting in the course of employment and therefore the employer is liable for any harm which her negligence has caused.

In Case 4.5 the House of Lords held that school owners were vicariously liable for acts of sexual abuse committed by the school warden against pupils – the abusive acts were sufficiently connected with his work as to be in the course of employment.

Case 4.5 *Lister* v. *Hesley Hall* (2001)

Sexual abuse by warden[17]

The board of governors were sued by the victims of abuse by the warden at Hesley Hall, a children's home, because of its vicarious liability for his actions. The Home denied liability on the grounds that the abuse was not committed in the course of his employment. The House of Lords held that it was vicariously liable for the acts of the warden in abusing the claimants: the Home had undertaken the care of the children and entrusted the performance of that duty to the warden and there was therefore sufficiently close connection between his employment and the acts committed by him.

The House of Lords stated that the approach which was best when determining whether a wrongful act was to be deemed to be done by the employee in the course of his employment was to concentrate on the relative closeness of the connection between the nature of the employment and the particular wrongdoing. The defendant undertook to care for the claimants through the services of a warden, so there was a very close connection between the torts of the warden and the defendant. The torts were also committed at a time and place when the warden was busy caring for the claimants. The warden was carrying out his duties though in an unauthorised and improper mode.

The Lister case was followed by the Court of Appeal when an archdiocese of the Catholic Church was held vicariously liable for the abuse of a boy by a priest. It was held that sufficient connection existed between what a priest with special responsibility for youth work was employed to do and his sexual abuse of a non-Catholic boy to hold the Church vicariously liable for his abuse.[18]

The House of Lords held that an employer could be vicariously liable for harassment by an employee which was contrary to the Protection from Harassment Act 1997[19] (see chapter 12). In *Weir* v. *Chief Constable of Merseyside Police*,[20] a policeman was helping his girlfriend to move house when he assaulted a man who was rummaging through his girlfriend's possessions. He was held to be acting in the course of employment because he had identified himself to the victim as a policeman and told him he was taking him to the police station. In contrast, in *N* v. *Chief Constable of Merseyside Police*,[21]

a policeman who raped a woman and made a video film of the assault was held not to be acting in the course of employment even though he was in his uniform and displayed his warrant card. In *Gravil* v. *Redruth Rugby Football Club*,[22] the Court of Appeal held that the club was vicariously liable for a player who punched an opponent, causing serious injuries. The punch was thrown in the course of the game and could be fairly regarded as a reasonably incidental risk to the playing of rugby.

What if a nurse is off duty?

There can be no easy answer. It depends entirely on what she is doing and in what way she has been negligent. In one case, the Court of Appeal allowed an appeal with costs against the decision of the Professional Conduct Committee (PCC), who found that a nurse was guilty of misconduct when she refused to answer a heart patient's call for help because she was having her tea break. The decision was based on the fact that it had not been established that the nurse knew it was an emergency. However, this case was before the PCC and different principles might apply in a civil case.

In one case, for example, some employees in their employer's van left the authorised route and went to a café to have a snack. On the way back, they had an accident and the court held that they were not acting in the course of employment.[23] It might have been different had they deviated from their route to collect goods for the employer.

Non-employees

It will be recalled that, in order to establish vicarious liability, it must be established that the negligent person is an employee of the defendant. Box 4.2 shows some of the criteria used by the courts to decide if an individual is an employee. Case 4.6 illustrates this principle.

Box 4.2

1. The employee agrees that in consideration of a wage or other remuneration he will provide his own work and skill in performance of some service for the employer.
2. He agrees, expressly or impliedly, that in the performance of that service he will be subject to the other's control in a sufficient degree to make that other the employer.
3. The other provisions of the contract are consistent with its being a contract of service. 'Control in itself is not always conclusive', *Ready-Mixed Concrete (South-East) Ltd* v. *Ministry of Pensions and National Insurance* [1968] 1 All ER 433.

Case 4.6 *Watkins* v. *Birmingham City Council* (1975)

Classroom chaos[24]

A deputy headmistress was injured when she fell over a tricycle that had been negligently placed near a classroom door by a 10-year-old boy in the course of carrying out his assigned task of distributing milk in the classrooms. There was a strict rule that tricycles were not to be removed from their safe position in the middle of the assembly hall.

The Court of Appeal held that the boy was not an employee of the authority, that he was doing those duties as part of his education and that the authority was therefore not vicariously liable.

In a case in 1999,[25] the Court of Appeal held that it was necessary for a contract of employment to contain an obligation on the part of the employee to provide services personally. A contract that allowed services to be provided by another person was a contract for services and not a contract of service.

Liability for negligence of volunteers

What about volunteers? Do the same principles apply? Is the NHS trust liable for the negligent acts of the volunteer? If we follow the basic principles of vicarious liability, it could be argued that since the volunteer is not an employee, then the NHS trust should not be liable. However, the philosophy that underlies the concept of vicarious liability is one of public policy, i.e. the person or organisation that has set in motion a particular activity that has caused harm should bear the loss rather than an innocent victim. In addition, one of the essential elements in the principle of vicarious liability is that the master is in control of the servant's activity. Whether or not an NHS trust would be liable to a third person for the negligence of a volunteer would, of course, depend on the circumstances of the volunteer's negligence. It may be that the NHS trust or its staff are themselves at fault in failing to provide adequate training or supervision, or have delegated an entirely inappropriate task to the volunteer.

Duty of care and liability for independent contractors

Practical Dilemma 4.10 Agency liability

Mary Downs is employed by a nursing agency and is often sent to work in NHS hospitals that call on the agency for additional staff to cover any crises. While she is assisting on the ITU, she fails to notice that one of the monitoring machines has ceased to function and she then discovers that the patient has died. The relatives wish to bring a complaint or even take the NHS trust or the agency to court.

In a case like this, there may well be direct responsibility of the NHS trust for failing to provide a machine that had an effective alarm system or had been satisfactorily maintained. If there is also negligence on the part of the agency nurse, does it make any difference that she is not an employee of the NHS trust, but is employed by the agency? Could the NHS trust still be liable for her negligence? The answer would depend to a considerable extent on the agreement between the NHS trust and the agency on the terms of employment of their staff. In the unlikely event that this has not been predetermined, the control test would be applied. The general or permanent employer has to shift the presumption of responsibility for the negligence of the employee on to the hirer. He can do this by showing that the control of the employee has passed to the hirer. In a health service context, this should be relatively easy since an agency staff nurse sent to help out at an NHS hospital would automatically become part of the ward/department, would be under the control of the ward sister or departmental head and would be subject to their supervision. In most cases, unless there is a clear agreement to the contrary, the NHS trust would probably be vicariously liable for the negligence of the agency staff.

In a significant decision with wide implications, the Supreme Court ruled in October 2013 that a school had a duty of care to a pupil who was severely brain damaged during a swimming lesson run by an independent swimming instructor in a council-run pool in Essex.[26] It was alleged that the swimming instructor's negligence had caused the injuries. The Supreme Court ruled that the school had a non-delegateable duty of care towards its pupils – not merely to take reasonable care of them but also to provide that reasonable care is taken of them by third parties, even while outside the premises of the school. It stated that 'the duty extends beyond being careful, to procuring the careful performance of

work delegated to others'. Five defining features justified departure from the established principle of the delegation of the duty of care:

1 The claimant is a child or vulnerable person.
2 There is a pre-existing duty owed by the defendant to the claimant with a positive obligation to protect the claimant from harm.
3 The claimant has no control over the defendant's performance of that obligation.
4 The defendant has delegated some part of its function to a third party.
5 The third party has been negligent.

This ruling has significant implications for both health and local authorities as they delegate services to be performed by outside organisations. Having established this principle, the victim now has to establish that there was negligence which led to her brain injuries in order to obtain the £3 million compensation.

In 1947 the House of Lords[27] held that any written agreement between the parties was not conclusive and the actual facts of the case were more significant: the firm which paid the employee and hired out a crane was vicariously liable for personal injury caused by the crane operator. In *Hawley* v. *Luminar Leisure Ltd* a night club was held vicariously liable for injuries caused by a door steward, even though he was employed by another company with whom the night club contracted.[28] The issue of which of several organisations is vicariously liable for harm caused by negligence is likely to arise more frequently as diverse arrangements between the public and private sector operate in the NHS following the Health and Social Care Act 2012 (see chapters 5 and 10).

Direct liability of employer

The Secretary of State has a statutory duty (i.e. one laid down by Act of Parliament) under the NHS Act 1977 (now re-enacted in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012) to provide medical services throughout England and Wales and to direct the appropriate health service bodies to exercise these functions on his behalf. It has been argued that if any employee or independent contractor or agency person is negligent, then there is a breach of duty under the Act and the NHS trust is primarily liable, without having to establish all the elements of vicarious liability. This was the opinion of Lord Denning in the case now described.

Case 4.7 *Cassidy* v. *Ministry of Health* (1939)

A hand operation[29]

The patient lost the use of his left hand and had severe pain and suffering as a result of negligent treatment following an operation on his hand. The evidence showed a *prima facie* case of negligence on the part of the persons in whose care the plaintiff was, although it was not clear whether this was to be imputed to Dr Fahrni, the full-time assistant medical officer, to the house surgeon or to one of the nurses.

The Court of Appeal held that the hospital authority was liable. Lord Denning said:

Whenever (hospital authorities) accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves. They have no ears to listen through the stethoscope, and no hands to hold the knife. They must do it by the staff which they employ, and, if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him . . . I decline

> to enter into the question whether any of the surgeons were employed only under a contract for services, as distinct from a contract of service. The evidence is meagre enough in all conscience on that point, but the liability of the hospital authorities should not, and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff. All he knew was that he was treated in the hospital by people whom the hospital authorities appointed, and the hospital authorities must be answerable for the way in which he was treated.

This suggests that the NHS trust cannot delegate its duty by providing competent trained staff. It will always be primarily responsible for any negligence to the patients whether the negligent person is an employee, a volunteer, an independent contractor or an agency employee.

A case on this point is that of *Wilsher* v. *Essex Area Health Authority*,[30] discussed earlier. In this case, it was held that there was no reason why, in certain circumstances, a health authority could not be directly liable to a plaintiff (claimant) if it failed to provide sufficient or properly qualified and competent medical staff for the unit. In a case where the Ministry of Defence ceased to arrange direct care for British forces in Germany, their families entered into an arrangement whereby an English NHS trust procured services in Germany and a baby was brain damaged. The High Court held that there was no negligence by the NHS trust and there was no appeal against that finding. The Court of Appeal held that the Ministry of Defence was not liable.[31] It considered that there was no non-delegable duty which made the Ministry liable for acts of negligence by the provider. This must be contrasted with the recent judgment of the Supreme Court which held that an education authority was liable for injuries to a pupil in a swimming pool even though the swimming lessons had been contracted out to an independent contractor.[32]

It must be pointed out, however, that even where it is possible to hold the NHS trust directly liable for the harm caused to the patient under the principle set out by Lord Denning, those individuals who were negligent could still face an action for their personal liability. In addition, if the NHS trust pays out compensation as a result of an employee's negligence, it would be possible for it to seek an indemnity from the negligent person. At present, this indemnity is rarely sought.

Indemnity from the employee at fault

This indemnity arises as a result of an implied term in the contract of employment, that the employee will indemnify the employer as a result of any losses caused by a breach of contract by the employee. In these circumstances, this would be a breach of the term 'to use all reasonable care and skill'.

Case 4.8 *Lister* v. *Romford Ice and Cold Storage Co. Ltd* (1957)

Family trouble[33]

Lister was employed as a lorry driver who worked with his father. He negligently ran down his father while backing the lorry in a yard. The father recovered damages from the employers on the grounds of their vicarious liability for the negligence of their employee. The employers' insurers then brought an action against the son for damages for breach of an implied term in his contract of employment that he would exercise reasonable care and skill in his driving. The son in his defence claimed that he was entitled to the benefit of any insurance that his employer either had or should have taken out. Therefore, they could not claim an indemnity from him.

The House of Lords held by a majority decision that they could claim an indemnity from the employee and they refused to imply a term in the contract of employment that the employer would not seek to claim an indemnity from the negligent employee.

Case 4.9 *Jones v. Manchester Corporation* (1952)

Anaesthetic[34]

The widow of a patient who died as a result of negligent hospital treatment sued for damages. The hospital board claimed an indemnity from Dr Wilkes, an inexperienced physician, who had administered the fatal anaesthetic under the instructions of Dr Sejrup, a house surgeon.

The Court of Appeal rejected this claim for an indemnity partly because the hospital itself was at fault.

Claims brought against NHS organisations are handled by the NHS Litigation Authority (NHSLA). Trusts have joined in a clinical negligence scheme (CNST) whereby resources are pooled and claims over a certain amount are met from the pool. (This is discussed further in chapter 6.)

Professional indemnity insurance cover

A new clause 9 was included in the amended Code of Professional Conduct in 2004, and the 2008 edition is as follows:

> **The NMC recommends that a registered nurse, midwife or specialist community public health nurse, in advising, treating and caring for patients/clients, has professional indemnity insurance. This is in the interests of clients, patients and registrants in the event of claims of professional negligence.**
>
> **Although employers have vicarious liability for the negligent acts and/or omissions of their employees, such cover does not normally extend to activities undertaken outside the registrant's employment. Independent practice would not be covered by vicarious liability. It is the individual registrant's responsibility to establish their insurance status and take appropriate action.**
>
> **In situations where an employer does not have vicarious liability, the NMC recommends that registrants obtain adequate professional indemnity insurance. If unable to secure professional indemnity insurance, a registrant will need to demonstrate that all their clients/patients are fully informed of this fact and the implications this might have in the event of a claim for professional negligence.**

This compromise is not now possible as a result of the European Directive on cross-border healthcare.

European Directive and professional indemnity[35]

This Directive came into force on 25 October 2013 and sets shared operating principles for healthcare systems throughout the European Union. Each member state must:

- have national contact points that supply patients with standards and guidelines on quality and safety in healthcare, the regulation of registered health professionals and hospital accessibility for the disabled;
- have information on charges for health services;
- ensure access to health services is free from discrimination based on nationality;
- have in place a transparent complaints procedure;
- uphold the right to privacy with respect to personal data and health records;
- put in place a system of professional indemnity insurance or a similar arrangement.

Further information on the working of the EU Directive can be found on the NHS choices website.[36] For employees who are covered by the employer's vicarious liability, the need for personal public indemnity cover will only become necessary if they work outside the course of employment and therefore the employer does not accept vicarious liability – for example, if they undertake Good Samaritan acts.

Professional associations often provide cover for such actions by their members. However, the implementation of the Directive has clear implications for all those who undertake private practice. They now require personal public indemnity cover for their private work. Independent midwives who have found that professional indemnity cover is too costly can no longer practice without such cover. The impact of this has been spelt out by Richard Griffith.[37]

The NMC requires all its registrants to sign a self-declaration when registering and renewing stating that they have (or will have prior to commencing any practice) appropriate indemnity arrangements. Legislation requiring registrants to have professional indemnity insurance cover came into force on 17 July 2014. More information on professional indemnity insurance can be found on the NMC website[38] and from the NHS Employers website.[39]

The Health and Care Professions Council issued for consultation draft guidance on professional indemnity cover and registration in June 2013 and requires all its registrants to make a declaration that they have the appropriate professional indemnity cover in place.[40]

Pressure from inadequate resources

Unfortunately, harm to the patient can occur because of shortage of staff, inadequate equipment and unsafe premises. This section deals with the liability of those concerned. The NMC Code of Professional Conduct[41] sets out clearly the practitioner's duty in relation to managing risk and the environment of care:

Manage risk

- You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk
- You must inform someone in authority if you experience problems that prevent you working within this Code or other nationally agreed standards
- You must report your concerns in writing if problems in the environment of care are putting people at risk.

General principles

Practical Dilemma 4.11 Resources

Pauline Cross is working on a busy geriatric ward with only two staff. The patients are severely confused and can do little for themselves. As she is transferring a patient from a wheelchair into bed, the patient falls to the floor and breaks her hip bone. Is Pauline likely to be held responsible in law for the patient's injuries?

It could be argued that this incident took place because there was inadequate staffing. However, there are many factors to be considered. Were they so short-staffed that even when priorities were set it would have been impossible for another member of the staff to help Pauline? Had the staff been trained in manual handling and was a risk assessment carried out? Was such an incident reasonably foreseeable such that additional precautions should have been taken or was it an inevitable accident? If the conclusion is that the accident was avoidable and another nurse should have been assigned to assist Pauline, then this will not automatically relieve Pauline of responsibility, especially if she were in charge of the ward. The question arises whether it would not have been possible to have transferred the patient

to bed later when more help would have been available. Alternatively, could the tasks that were occupying the other nurses have been given a lower priority?

Even if all the questions could be answered negatively, i.e. they were so short-staffed that they could not take the necessary foreseeable precautions to ensure the patient was put to bed safely, Pauline may still be responsible. If she was in charge of the ward, had she warned her senior nurse management of the staffing difficulties and suggested remedial action such as discharging patients to other wards or home or suggesting the use of agency nurses if nurses could not be transferred from other wards? Failure to take such action where her management role requires it would mean that Pauline would have to share some measure of responsibility for the occurrence (see the section on the nurse as manager on page 75).

Employer's responsibility

If a patient is harmed because of an accident that would not have occurred had reasonable resources been available, then the patient would have a valid action to recover compensation in the civil courts. It is no defence to say to a patient, 'We are sorry we amputated the wrong leg, but Wednesday is our busiest day and we had a lot of staff off with influenza.' A patient is entitled to the approved standard of care. Even in an emergency situation, staff would be expected to take additional precautions to prevent further harm arising on the basis of a clear order of priorities. In such circumstances, the patient would be able to sue the NHS trust for its vicarious liability for the negligence of the staff. However, it is probable, too, that an action of direct liability also might succeed against the trust because harm was caused to the patient as a result of inadequate resources. If there has been a failure to provide a reasonable standard according to the Bolam Test, it does not matter what the cause was: staffing shortages, lack of equipment, or inexperience, there will either be direct liability of the organisation or vicarious liability for the negligence of its staff.[42] The claimant must, of course, be able to show that there is a causal link between the failure to maintain the reasonable standard of care and the harm which has occurred.[43]

Case 4.10 *McCormack* v. *Redpath Brown* (1961)

Inadequate resources (1)[44]

A casualty officer, through pressure of work, made only a brief examination and treated a major head injury on the assumption that it was a minor one.

Both he and the health authority were held liable. The judge held that pressure of work was no defence to the patient's claim.

Case 4.11 *Deacon* v. *McVicar and Another* (1984)

Inadequate resources (2)[45]

Several allegations were made by a patient that she was not treated with proper professional care and skill during the delivery of her first child. A Shirodkar suture had been fitted at an earlier stage because of an incompetent cervix. It was important that the suture should be removed promptly once labour had commenced, otherwise there was a danger that the cervix could be damaged. The patient claimed that the staff had failed to act speedily and as a consequence her cervix was damaged. The defendants claimed that the ward was very busy that night and the patient received appropriate care.

At the defendants' request, the judge directed that the notes of the other patients should be made available to show what was going on in the labour ward that evening. He did so with reluctance because he did not wish a breach of the duty of confidentiality owed to the patients and the defendants had not pleaded any special emergency that prevented speedier attention to the patient. These patients were referred to by code names. Their notes were exhaustively examined in the course of the evidence. 'In summary they showed that the doctors were busy and that the patient bringing the action was not the only patient who presented problems. But they did not show there was anything to prevent the doctors performing a vaginal examination or removing the suture sooner than they did.'

One of the criticisms was that the doctors had failed to give the patient sufficient priority. The doctor in his defence said that on a busy labour ward the doctors do not sit down and work out a list of priorities. The judge, however, had to decide if the patient had been kept waiting too long. He said: 'I appreciate that one must not be too critical of what goes on in a busy ward but it is difficult to understand why the patient did not have a vaginal examination until two hours after admission. Other ladies were admitted at about the same time as she was and whose cases were of no greater urgency had their examinations far sooner.'

Commenting on the statement of one of the experts for the defence who had said, 'I think the time scale is within the pattern of what occurs in a busy ward', the judge said:

> **That may well be, but it does not resolve the question whether this particular patient was given proper care . . . I do not pinpoint any particular moment when a particular doctor did something wrong. It was rather a case where there was a lack of sufficient sense of urgency on all sides. In these circumstances I hold that the second defendants (Leicester Health Authority) did not treat the patient with proper professional care and skill.**

The patient was awarded £1,500.

Several important points emerge from this case:

1. The assessment of priorities can be carried out negligently or not at all and can itself form the basis of a claim for compensation.
2. To ascertain the workload and other demands, it is possible with the approval of the judge for the records of other patients to be made available. It is essential that comprehensive records are always kept.

Coping under pressure

One question often asked by nursing staff in relation to shortage of resources is, 'What happens if we are dangerously short of staff and yet we cope? What is the situation then?' This is a frequent situation. Yet if no person suffers harm as a result of the inadequate levels, then there can be no action for negligence, since harm must be established. However, it would be part of the duties of the nurse, both in her professional duties and as a manager, to ensure that senior levels are notified of any dangers or hazards so that harm does not eventually occur. An inadequate number of trained staff in proportion to the demands of patients could lead to inexperienced people administering drugs, using specialised equipment or assisting doctors in complex treatments, and patients could therefore suffer overdoses or other forms of harm. In extreme situations, where it is impossible to obtain sufficient numbers of staff to run a service safely or to run a service with the correct skill mix, then the provision of that service may have to be transferred to other providers.

Legal requirements on staffing

Another question that is raised is: 'What are the legal staffing levels or of what legal significance is a particular staffing ratio that has been recommended by different researchers?' Minimum staffing levels or ratios are unlikely to be laid down by Act of Parliament or by the courts. (Note, however, guidance

by NICE in 2014 discussed below). Under the principles relating to liability in negligence, sufficient resources must be provided to ensure that the patients being cared for are provided with the approved accepted standard of care, i.e. the Bolam Test (see page 50). All circumstances must be taken into account in determining whether this has been provided in respect of a given patient who has suffered harm. Obviously, evidence could be given of the extent to which the staffing levels had fallen below the levels considered by experts in the field to be the minimum consistent with good practice, but this is evidence, not law.

One of the recommendations from the Francis Inquiry on Mid Staffordshire Hospital related to the need to prioritise nurse staffing levels. It was, however, pointed out in a letter to *The Times* that 'there is a danger that mandated staffing levels will be perceived as an optimum staffing level, when in our experience, the number of staff required may differ according to patient need and may be in excess of the mandated level'. The correspondent recommended the use of the Safer Nursing Care Tool to determine optimal nurse staffing levels for inpatient wards.[46]

In May 2014 NICE stated that it planned to develop guidance on staffing levels for doctors following guidance it had given for nurse staffing. Numbers of nurses must be set and monitored on a shift-by-shift basis. Death rates rose if each nurse was looking after more than eight patients. In July 2014 NICE suggested the following red alerts/flags to indicate that wards were short-staffed:

patients not receiving medication when they should;
delays of more than 30 minutes in providing pain relief;
patients not asked about their pain levels;
patients not helped to use the lavatory;
food or other items out of reach;
patients left uncomfortable and at risk of pressure sores; and
only one registered nurse on duty on a shift.

Guidance was issued on calculating the number of nurses required on each shift in relation to the needs of patients and activities to be performed. The deputy CEO of NICE estimated that an extra 5 per cent of current nursing costs would be required to implement the guidance.[47] Further information on NICE publications on staffing guidance can be found on its website.[48]

Failures by management

What does the nurse do if she has drawn the attention of management to a situation that she considers dangerous and nothing is done about it? Whatever the situation, whether it is concerned with inadequate resources or incompetent staff, the nurse should not give up if she feels her concern about a dangerous situation is being ignored. She has a duty to ensure that the patients are cared for appropriately. She should therefore put her concerns in writing with evidence of hazards that have occurred. Her report would need to be a detailed account that is meaningful to management of the levels of staffing and the needs of the patients. If nothing is done, she should then be prepared to refer the matter to a higher level of management. Eventually, if she is still concerned that the dangers are being ignored, she should take the matter to her NHS trust or the NMC and utilise the procedure set up under the Public Interest Disclosure Act 1998. This is preferable to bringing the local or national press into a field that should be sorted out internally.

Public Interest Disclosure Act 1998 and whistleblowing

Nurses are required under the Code of Professional Conduct (quoted above) to report concerns in writing if problems in the environment of care are putting people at risk. Practitioners whose fitness to practise is doubted must also be reported to the NMC.[49] Many nurses have feared victimisation (see report on Rodney Ledward, chapter 5, page 124). To allay such fears and prevent victimisation, the NHS

Management Executive issued Guidelines for Staff on Relations with the Public and the Media (1993). This emphasised that under no circumstances are employees who express their views about health service issues in accordance with this guidance to be penalised in any way for doing so (paragraph 6). Each NHS employer has a duty to establish a procedure for employees to raise concerns. Statutory provision was made in the Public Interest Disclosure Act 1998 to ensure that a procedure is set up to ensure that staff who raise justifiable concerns are protected from victimisation. Justifiable concerns are shown in Box 4.3. (Guidance has been issued by the Department of Health (HSC (99)198, followed by a policy pack[50] and by the RCN.[51,52]) The charity Public Concern at Work provides a helpline and information service for the promotion and protection of responsible whistleblowing.[53] A claim by an employee of the North Glamorgan NHS trust that he had been unfairly dismissed because he had made allegations of fraud against other employees was allowed to proceed on the grounds that in a fact-sensitive situation such as a whistleblowing claim a full hearing was necessary to resolve the dispute.[54]

The Employment Rights Act 1996 provides protection for workers who suffer a detriment or are dismissed as a result of blowing the whistle by making a qualified **disclosure** in accordance with sections 43C to 43H (as amended by the Enterprise and Regulatory Reform Act 2013). Qualifying disclosure has the meaning given in section 43B of the Act. Section 43F provides that a qualifying disclosure will be protected if it is made to a prescribed person and relates to matters in respect of which that person is protected. Amendments made by the Enterprise and Regulatory Reform Act 2013 include the provision that disclosures (after 25 June 2013) are not protected unless the worker reasonably believes that the disclosure is in the public interest. The tribunal is given the power to reduce the compensation where the disclosure is not made in good faith. In addition a worker is protected if he is subjected to detriment by co-worker or agent of employer. (See section 19 Enterprise and Regulatory Reform Act 2013.)

The Schedule of the 1999 Public Interest Disclosure (Prescribed Persons) Order[55] sets out the list of prescribed persons and the matters in respect of which they are prescribed for the purposes of section 43F. The list has subsequently been amended in 2003, 2009, 2010 and 2013 to include the General Social Care Council, the Health and Safety Executive, local authorities responsible for enforcing health and safety legislation, the Information Commissioner and the Pensions Regulator. The worker must reasonably believe that the relevant failure is within the concern of that person and the information is substantially true.

The protected disclosures in Box 4.3 are extensive and would cover most of the situations in which a registered practitioner would have a professional duty to inform an appropriate person or authority under the Code of Professional Conduct.

Box 4.3 Protected disclosures under the Public Interest Disclosure Act 1998

1. That a criminal offence has been, is being or is likely to be committed.
2. That a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject.
3. That a miscarriage of justice has occurred, is occurring or is likely to occur.
4. That the health or safety of any individual has been, is being or is likely to be endangered.
5. That the environment has been, is being or is likely to be damaged.
6. That information tending to show any matter falling within any of the above paragraphs has been, is being or is likely to be deliberately concealed.

Under the Act, as amended, the disclosure is only protected if certain conditions are satisfied. If bad faith is found to exist, damages can be reduced by up to 25 per cent. Disclosure is also protected if it is made in the course of obtaining legal advice; or if the employer is a body any of whose members are appointed by a minister of the Crown, then the disclosure can be made to a minister of the Crown.

This would cover disclosures by employees working within the NHS. The employee must believe the disclosure to be in the public interest. Disclosures to prescribed persons are protected if made in good faith to a person prescribed by the Secretary of State (see above page 90). Other disclosures are protected if the conditions set out in Box 4.4 are satisfied.

Box 4.4 Conditions for other protected disclosures

1 He reasonably believes that the information disclosed, and any allegations contained in it, are substantially true.
2 The disclosure is made in the public interest (added by Section 17 of the Enterprise and Regulatory Reform Act 2013)
3 He does not make the disclosure for personal gain.
4 Any of the conditions in subsection 2 is met (see below).
5 In all the circumstances of the case, it is reasonable for him to make the disclosure.

The subsection 2 conditions referred to in Box 4.4 include the reasonable belief that the employee would be subjected to detriment by his employer if he makes the disclosure. Factors determining the reasonableness of the disclosure include the identity of the person to whom it is made; the seriousness of the failure; whether it is continuing or likely to occur in future; whether the disclosure is made in breach of a duty of confidentiality; previous disclosures to the employer or to another person prescribed by the Secretary of State; and compliance with any procedure specified for making disclosures.

Disclosures relating to exceptionally serious failures

Special provisions apply to a disclosure of an exceptionally serious failure. Such a disclosure is protected if the employee makes the disclosure in good faith, reasonably believing the allegations to be true, not making the disclosure for personal gain and in all the circumstances it is reasonable to make the disclosure and to that particular person.

Gagging of an employee

The Act states that any provision in an agreement is void in so far as it purports to preclude an employee from making a protected disclosure. Thus, if a trust attempts to introduce a term into a contract of employment that prevents an employee making a disclosure that comes under the protection of the Act, that term is void.

Before the Public Interest Disclosure Act, a student nurse reported a Rampton Hospital nurse for ill-treating and assaulting patients.[56] The abuser was subsequently convicted in the criminal courts and struck off the UKCC Register. The student nurse, however, suffered considerable abuse after blowing the whistle. Such victimisation should now lead to compensation for the whistleblower. Under section 19 of the Enterprise and Regulatory Reform Act a worker (W) has the right not to be subjected to any detriment by any act, or any deliberate failure to act, done (a) by another worker of W's employer in the course of that other worker's employment, or (b) by an agent of W's employer with the employer's authority, on the ground that W has made a protected disclosure. Where a worker is subjected to such detriment then that is treated as also done by the worker's employer. It is immaterial whether the thing is done with the knowledge or approval of the worker's employer. However, it is a defence for the employer to show that the employer took all reasonable steps to prevent the other worker so acting. This fills the gap highlighted in the case of *NHS Manchester* v. *Fecitt and others*.[57]

In 2013 the employment charity Public Concern at Work[58] set up a commission to look into whistleblowing. It recommended that a statutory code of practice should be created which can be taken into account when courts and tribunals are considering whistleblowing cases.

A consultant cardiologist Raj Mattu won a landmark tribunal ruling for unfair dismissal against Walsgrave Hospital in Coventry in the longest-running and most expensive whistleblowing case in NHS history. He first blew the whistle in 1998 about concerns on patient safety. The tribunal judgment was given in April 2014 and held that he suffered a detriment as a whistleblower and was found to have been unfairly dismissed. He claimed that he had been harassed by senior management when he drew attention to the need for reforms. His whistleblowing attempts were dismissed by Sir David Nicholson as an employment matter in 2010. He is to meet the new head of the NHS Simon Stevens who has called for a new culture of openness in the NHS.[59] Documents released under the Freedom of Information Act revealed that officials from various national health bodies joined meetings to discuss the case without his knowledge. He is said to be claiming £6.5 million damages.

The following case is reported by Public Concern at Work.

Case 4.12 *Kay v. Northumberland Healthcare NHS Trust* (2001)

A protected disclosure bid[60]

Kay managed a ward for the elderly. Kay internally raised concerns about bed shortage but was told there were no resources. The problem worsened and some elderly patients were moved to a gynaecological ward. Kay wrote a satirical open letter to the Prime Minister for his local paper. With the trust's agreement, Kay was photographed for the local press. When the letter was published, the trust gave a final written warning for totally unprofessional and unacceptable conduct. Kay won the case as the disclosure was protected because (a) disclosure under 43G of the 1998 Act was balanced with Article 10 and freedom of expression in the European Convention on Human Rights, (b) Kay did not know of the trust's whistleblowing policy, (c) there was no reasonable expectation of action following earlier concerns, and (d) it was a serious public concern.

Margaret Haywood, a registered nurse, was struck off the Register by the NMC as a consequence of her breach of confidentiality in participating in a TV programme which highlighted abuse of elderly residents in a care home. She appealed to the High Court against the decision. A joint NMC and RCN statement was made in December 2009 as follows:

> **The NMC and the Royal College of Nursing (RCN) are pleased to announce a settlement in the case of nurse Margaret Haywood.**
>
> **This was an extremely difficult and complex case in which the NMC panel had to balance Ms Haywood's duty to protect patient confidentiality with her duty to raise concerns about poor standards of care.**
>
> **The NMC and RCN put forward terms of settlement for the Court's consideration and the Court approved those terms which led to the replacement of the striking off order with a 12 month caution.**

Subsequently, Kathy George, Chief Executive and Registrar, NMC said:

> **Raising concerns about poor standards of care is a difficult and brave step for any nurse or midwife to take and is vitally important in driving improvements in patient care. One of the lessons of Margaret Haywood's case is that nurses and midwives need clearer information about how to appropriately raise and escalate concerns in a way that is safe for patients and in a way that will not bring them into conflict with their code of conduct.**

The NMC worked with the RCN, RCM, Unison, UNITE and other groups to prepare draft guidance on raising and escalating concerns which was published in November 2010 and updated in 2013. The

document gives guidance to all practitioners registered with the NMC on how they should raise concerns about a patient's care. It explains the process of raising concerns, offers information about legislation and indicates where staff can get confidential support and advice.[61] It can be accessed on the NMC website. The NMC is also taking steps to remind employers to develop clear reporting procedures for staff. Paragraphs 63–67 of the new draft Code of Practice issued by the NMC for consultation explicitly details of raising concerns ('whistleblowing'). Further guidance on raising concerns, and the duty of candour is to be published by the NMC.

In the NHS an associate A&E specialist who had reported clinical failings by a colleague was ostracised by senior management, refused access to important meetings and offered a £96,000 pay-off with a gagging clause which she turned down.[62] Enquiries using the Freedom of Information Act found that 71 NHS trusts admitted reaching settlements with doctors over the past decade. Forty admitted making pay-offs totalling £3 million.

In 2014 the Supreme Court held on the preliminary issue of the definition of a worker for the purposes of bringing a whistleblowing case that a partner was eligible to bring a case. The action was then remitted to the employment tribunal to determine whether the applicant had been the victim of discrimination on the grounds of sex and whistleblowing.[63]

Kennedy Report

The Kennedy Report,[64] following the inquiry into children's heart surgery at Bristol Royal Infirmary, recommended that there should be openness and honesty in the NHS and a partnership between patients and professionals. It set out the principles which should be recognised within NHS management.

In considering the topic of 'respect and honesty', the Report recommended that:

> **Patients in their journey through the healthcare system are entitled to be treated with respect and honesty and to be involved, wherever possible, in decisions about their care.**

To achieve this aim the Report makes recommendations on achieving a partnership between healthcare professionals and the patient, whereby the patient and the professional meet as equals with different expertise. Patients must be kept informed about their treatment and care. Communications must be improved, including the use of tape-recording facilities to enable patients, should they so wish, to make a tape-recording of a discussion with a healthcare professional when a diagnosis, course of treatment or prognosis is being discussed. Support services should be provided for patients, including counselling and a professional bereavement service. Voluntary organisations that provide care and support for patients should, where they meet the appropriate standards, receive state funding to contribute their services. Consent to treatment should be seen as a process and not simply the signing of a form. Feedback from patients should be encouraged. There should be a duty of candour, to tell a patient if adverse events have occurred, and patients should receive an acknowledgement, an explanation and an apology. Complaints should be dealt with swiftly and thoroughly, keeping the patient informed, and the present system of compensation should be reviewed.

The Department of Health announced its response to the Report in 2002 and both the full response and an executive summary are available from the Department of Health website.[65]

Subsequently many of the recommendations in the Kennedy Report on Bristol have been repeated in the Francis Report on Mid Staffordshire Hospital (see chapter 5). A duty of candour was one of the recommendations put forward by the Francis Inquiry and section 81 of the Care Act 2014 enables regulations to be drawn up to place such a duty on health service organisations (see chapter 5).

Kay Sheldon, a whistleblower on the board of the CQC, was threatened with losing her post following the failure of the CQC adequately to inspect baby deaths at Morecambe Bay NHS Trust.[66] Subsequently, Health Secretary Jeremy Hunt stated that he had approved a CQC recommendation that she be reappointed to the Board when her five-year term expired.[67]

Amanda Pollard an inspector for the CQC brought an action for constructive dismissal claiming that she was vilified, bullied, ridiculed and ostracized when she tried to blow the whistle on the organisation.

The employment tribunal found that her resignation, some 14 months after the Public Inquiry, was not protected by the whistleblowing law.

Two whistleblowers in South Devon, Penny Gates and Clare Sandari, won a tribunal ruling that they suffered by making whistleblowing allegations but an allegation of unfair dismissal was dismissed. They alleged that the Chief Executive was guilty of nepotism by hiring her daughter's boyfriend for a role for which he had little experience. The tribunal ruled that South Devon Healthcare NHS Foundation Trust made a dishonest attempt to suppress the findings of an internal investigation.[68]

In evidence given to the Commons Health Select Committee in March 2013 Sir David Nicholson, Chief Executive of the NHS, denied that he had tried to silence whistleblowers and pledged that no one in the NHS would be asked to sign gagging clauses banning them from talking about patient safety.[69] Great Ormond Street Hospital was accused of changing the report it submitted to the Baby P inquiry as part of a cover-up. It denied this saying that the 2007 report was amended on legal advice. The Secretary of State for Health Jeremy Hunt has asked the hospital for a response to the allegations.[70]

Criticism was made by the Public Accounts Committee in January 2014 of the fact that public sector bodies may have handed whistleblowers generous payoffs to keep quiet in a series of 'shocking' cover-ups.[71] It recommends that the Cabinet Office should require public sector organisations to secure its agreement for all special severance payments. (See also chapter 5 and the Stafford Report.)

In June 2014 the Secretary of State for Health announced an independent review into whistleblowing in the NHS to be led by Sir Robert Francis QC who chaired the Mid Staffs Inquiry, to ensure that where NHS whistleblowers are mistreated there are appropriate remedies for staff and accountability for those mistreating them. On 7 August 2014 he urged doctors and nurses to tell him what is going wrong and pledged to prise open an NHS 'closed ranks culture' that harms patient care.

Conclusions

This chapter has covered a wide range of topics relating to the role of the nurse in communicating, delegating, managing and dealing with inadequate resources. It has also considered the direct and vicarious liability of the employer. Nurses and employers, however, work within the wider scope of the NHS and it is the structure and management of the NHS to which we now turn.

Reflection questions

1 There can be liability for failure to communicate. Apply this principle to your particular post and consider how and to what extent communication with the patient could be improved.

2 Consider any work you undertake as a member of a team and assess the extent to which it is clear where the boundaries of individual responsibility lie.

3 There are times when it is essential that a nurse obeys the orders of a doctor without question and others when it is imperative that she check that the instructions are appropriate. What distinguishing features would decide whether an order falls in the first category or in the second?

4 What is the difference between direct and vicarious liability?

5 In what way do you think that the liability of the NHS trust for the safety of the volunteer differs from its liability for the safety of staff (see, in addition, chapter 12)?

6 An employee can be liable for the negligent actions of another person if the employee should not have delegated a task to him or, having correctly delegated it, has failed to provide the appropriate level of supervision. Apply this principle to the role of the nurse manager in relation to junior registered staff, learners, volunteers and untrained assistants.

Further exercises

1 Obtain a copy of your NHS trust's policy on the use of volunteers and study in particular those parts that relate to liability for the negligence of volunteers.

2 Obtain a copy of your employer's policy on whistle blowing and familiarise yourself with its contents. Do you understand how the procedure would work in practice?

3 Obtain a copy of the Mid Staffs Inquiry Report and consider the extent to which your department could implement any of its recommendations that are not yet in place.

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Chapter 5

Statutory functions and management of the NHS

This chapter discusses

- National Health Service
- White Paper *Equity and Excellence: Liberating the NHS*
- Enforcement of statutory duties
- The National Health Service Commissioning Board (NHS England)
- The Mandate
- NHS foundation trusts
- Monitor
- National Health Service Trust Development Authority
- Clinical governance
- Duty of quality
- Care Quality Commission (replacing the Commission for Healthcare Audit and Inspection (CHAI) (Healthcare Commission))
- National Institute for Health and Care Excellence (NICE)
- National Service Frameworks (NSFs)
- NHS 111 and walk-in clinics
- NHS inquiries
- Mid Staffordshire NHS Foundation Trust Inquiry
- The NHS Constitution
- Healthy NHS Board
- Nursing initiatives
- NHS and the private sector

Introduction

This chapter considers the statutory background to the NHS and the functions of the Secretary of State. It looks at the present organisations which run the NHS following the Health and Social Care Act 2012 and considers the duty of quality, the Care Quality Commission and the National Institute for Health and Care Excellence. Issues of resource management and the Public Interest Disclosure Act 1998 are considered in relation to whistleblowing in chapter 4. The role of NHS professionals is considered in chapter 10. The administrative structure of the NHS in the four constituent countries of the UK is increasingly moving in different directions as can be seen from the analysis by Nicholas Timmins.[1] This chapter will focus on the changes which have taken place in England and readers are referred to the websites of the three assemblies for further details of health services in each country.

National Health Service

The National Health Service (NHS) was set up on 5 July 1948 as a result of the National Health Service Act 1946. It was based on the principle that services should be provided free at the point of delivery unless there was clear statutory authorisation for any charges. Charges for prescriptions were the first to be introduced. The duty to provide services was placed on the Secretary of State who delegated these functions to regional hospital boards, hospital management committees and other statutory organisations. Family practitioner services were administered by the executive councils, later superseded by the family practitioner committees. A major reorganisation of healthcare provision took place in 1973 and the statutory duties were re-enacted in the National Health Service Act 1977. Health Service legislation has since been consolidated in the National Health Service Act 2006 with the NHS Consequential Amendments Act 2006 and separate legislation for Wales and in the legislation of 2008 and 2012.

White Paper *Equity and Excellence: Liberating the NHS*

The White Paper *Equity and Excellence: Liberating the NHS* was published by the Coalition government in July 2010 on reforming the NHS.[2] It proposed a radical reorganisation of the NHS, abolishing strategic health authorities and primary care trusts and making all NHS trusts into foundation trusts. Monitor was to become an economic regulator with three key functions: to promote competition; to regulate prices; and to support continuity of services. The Care Quality Commission (CQC) would have enhanced powers to be an effective quality inspectorate across both health and social care. The majority of NHS funds would be passed to GP practices to commission services for patients. The executive summary of the White Paper can be found on the website of this book. Its themes were:

Putting patients and public first
Improving healthcare outcomes
Autonomy, accountability and democratic legitimacy
Cutting bureaucracy and improving efficiency
Making it happen.

Local authorities were to be given control over local health improvement budgets. The role of the Department of Health was to be reduced and an NHS Commissioning Board was to be established to promote equality and tackle inequalities in access to healthcare. The Board would allocate resources according to the needs of local areas, and lead specialised commissioning. The key roles of the Department of Health were to be:

Setting a formal mandate for the NHS Commissioning Board
Holding the NHS Commissioning Board to account

Arbitration
The legislative and policy framework
Accounting annually to Parliament.

Healthwatch would be established nationally and locally, based on local involvement networks to champion the needs of the public and patients at every level. The plan was to abolish 45 per cent of management costs within four years. The focus was on giving patients and the public more choice and involvement. Providers should respond to their needs. The internal market was not reintroduced but the concept of 'contestability' was envisaged.

Contestability means that there is the threat of competition, rather than there actually being competition. If the threat of competition exists, then providers in the market will respond as if they are in competition and act accordingly. This means that the benefits of competition can be achieved even in the absence of competition.[3]

The White Paper was accompanied by an analytical strategy which outlined the strategy for impact assessments for the policies announced in the proposals. Consultation was invited on the following areas:

- Commissioning for Patients
- Freeing Providers and Economic Regulation
- Local Democratic Legitimacy in Health
- The Review of Arm's-Length Bodies
- The NHS Outcomes Framework.

Further documents were published on the information strategy; workforce planning, education and training; accessing cancer drugs through a new fund; and how to extend and expand choice policy.

Health and Social Care Act 2012

The Health and Social Care Act 2012 put these White Paper proposals into law.

The duties placed on the Secretary of State are shown in the following Statute Box 5.1, which outlines how the 2006 Act was amended by the 2012 Act.

Statute 5.1 Duties of the Secretary of State under the National Health Service Act 2006 as amended by 2012 Act

Secretary of State's duty as to health service

Section 1(1)

The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement:

(a) in the physical and mental health of the people in England; and
(b) in the prevention, diagnosis and treatment of illness.

(2) For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.

(3) The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.

(4) The services provided as part of the health service in England must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.

1A Duty as to improvement in quality of services

(1) The Secretary of State must exercise the functions of the Secretary of State in relation to the health service with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with –
  (a) the prevention, diagnosis or treatment of illness, or
  (b) the protection or improvement of public health.

(2) In discharging the duty under subsection (1) the Secretary of State must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.

(3) The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show –
  (a) the effectiveness of the services,
  (b) the safety of the services, and
  (c) the quality of the experience undergone by patients.

(4) In discharging the duty under subsection (1), the Secretary of State must have regard to the quality standards prepared by NICE under section 234 of the Health and Social Care Act 2012.

1B Duty as to the NHS Constitution

In exercising functions in relation to the health service, the Secretary of State must have regard to the NHS Constitution.

1C Duty as to reducing inequalities

In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.

1D Duty as to promoting autonomy

(1) In exercising functions in relation to the health service, the Secretary of State must have regard to the desirability of securing, so far as consistent with the interests of the health service –
  (a) that any other person exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner that it considers most appropriate, and
  (b) that unnecessary burdens are not imposed on any such person.

(2) If, in the case of any exercise of functions, the Secretary of State considers that there is a conflict between the matters mentioned in subsection (1) and the discharge by the Secretary of State of the duties under section 1, the Secretary of State must give priority to the duties under that section.

1E Duty as to research

In exercising functions in relation to the health service, the Secretary of State must promote –
  (a) research on matters relevant to the health service, and
  (b) the use in the health service of evidence obtained from research.

1F Duty as to education and training

(1) The Secretary of State must exercise the functions of the Secretary of State under any relevant enactment so as to secure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England.

(2) Any arrangements made with a person under this Act for the provision of services as part of that health service must include arrangements for securing that the person co-operates with the Secretary of State in the discharge of the duty under subsection (1) (or, where a Special Health Authority is discharging that duty by virtue of a direction under section 7, with the Special Health Authority).

(3) In subsection (1), 'relevant enactment' means –
- (a) section 63 of the Health Services and Public Health Act 1968,
- (b) this Act,
- (c) the Health and Social Care Act 2008,
- (d) the Health Act 2009, and
- (e) the Health and Social Care Act 2012.

1G Secretary of State's duty as to reporting on and reviewing treatment of providers

(1) The Secretary of State must, within one year of the passing of the Health and Social Care Act 2012, lay a report before Parliament on the treatment of NHS health care providers as respects any matter, including taxation, which might affect their ability to provide health care services for the purposes of the NHS or the reward available to them for doing so.

(2) The report must include recommendations as to how any differences in the treatment of NHS health care providers identified in the report could be addressed.

(3) The Secretary of State must keep under review the treatment of NHS health care providers as respects any such matter as is mentioned in subsection (1).

(4) In this section –
- (a) 'NHS health care providers' means persons providing or intending to provide health care services for the purposes of the NHS, and
- (b) 'health care services for the purposes of the NHS' has the same meaning as in Part 3 of the Health and Social Care Act 2012.

Secretary of State's general power as to services

Section 2(1)

The Secretary of State may:
- (a) provide such services as he considers appropriate for the purpose of discharging any duty imposed on him by this Act; and
- (b) do any other thing which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty.

Section 2(2)

Subsection (1) does not affect:
- (a) the Secretary of State's powers apart from this section,
- (b) Chapter 1 of Part 7 [of this Act] (pharmaceutical services).

3B Secretary of State's power to require Board to commission services

(1) Regulations may require the Board to arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of –
- (a) dental services of a prescribed description;
- (b) services or facilities for members of the armed forces or their families;
- (c) services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description;
- (d) such other services or facilities as may be prescribed.

(2) A service or facility may be prescribed under subsection (1)(d) only if the Secretary of State considers that it would be appropriate for the Board (rather than clinical commissioning groups) to arrange for its provision as part of the health service.

(3) In deciding whether it would be so appropriate, the Secretary of State must have regard to –
- (a) the number of individuals who require the provision of the service or facility;
- (b) the cost of providing the service or facility;
- (c) the number of persons able to provide the service or facility;
- (d) the financial implications for clinical commissioning groups if they were required to arrange for the provision of the service or facility.

Other services which the Secretary of State has a duty to provide are set out in Schedule 1 of the NHS Act 2006 and include the medical inspection of pupils, contraceptive services, provision of vehicles for disabled persons, microbiological services and research activities.

Part 4 of the 2006 Act covers primary medical services; Part 5 the provision of dental services; Part 6 ophthalmic services; and Part 7 pharmaceutical services as amended by the Health and Social Care Act 2012.

The 2012 Act also saw the introduction of Healthwatch England and local Healthwatch organisations (see chapter 27).

The Health and Social Care Information Centre was set up under section 252 of the Health and Social Care Act 2012 (see chapter 8).

Enforcement of statutory duties

Failure to provide reasonable services continues to be a political issue and Section 1(3) of the 2006 Act (as amended by the 2012 Act) states that 'the Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England'. However, there have been several cases where patients who have waited a considerable time for operations or for other treatments have brought legal action to enforce the provision for them of health services. By and large, the courts have taken the view that it is not for the court to become involved in issues relating to resource allocation, unless there are clear failures in public duty (see Case 5.1). However, a decision of the Court of Appeal in 2004 held that the NHS should pay for a patient to have treatment abroad, if the patient had waited a significantly long time for NHS treatment.[4] (The case is considered later in this chapter on page 104.) Where a patient is kept waiting for treatment, there is an interesting distinction in the following three situations.

1. Where the treatment has commenced, it must be carried out according to the accepted approved standard. If a negligent act occurs that causes harm to the patient, then this is actionable by the patient (see chapters 3, 4 and 6).
2. Where treatment has not commenced and the patient has to wait on a waiting list, then even though the patient's condition might deteriorate this is not actionable provided the health service body has carried out its provision of health services rationally and determined priorities between patients appropriately. It may, of course, be the subject of a complaint since the provider has failed to comply with the standards set by the Department of Health, but these standards do not have any legal effect unless they are already incorporated in an Act of Parliament or a decided case or unless they infringe the European Convention on Human Rights. The Secretary of State has a duty under section 1A of the 2006 Act to secure continuous improvement in the quality of services and must have regard to the quality standards prepared by NICE under section 234 of the Health and Social Care Act 2012. However, it would appear that breach of this duty would give rise to a complaint rather than court action.
3. As a result of the *Watts* case,[5] where it is held that the patient has waited an unreasonable length of time for treatment, the NHS may be obliged to pay for treatment provided abroad.

Case 5.1 *R* v. *Secretary of State for Health* (1979)

Inadequate resources[6]

Orthopaedic patients at a hospital in Birmingham, who had waited for treatment for periods longer than was medically advisable, brought an action against the Secretary of State, the regional health authority and the area health authority. They were seeking a declaration that the defendants were in breach of their duty under Section 1 of the National Health Service Act 1977 to continue to promote a comprehensive health service designed to secure improvement in health and the prevention of illness, and under Section 3 to provide accommodation, facilities and services for those purposes.

The judge held that it was not the function of the court to direct Parliament as to what funds to make available to the health service and how to allocate them. The Secretary of State's duty under Section 3 to provide services 'to such extent as he considers necessary', gave him discretion as to the disposition of financial resources. The court could interfere only if the Secretary of State acted so as to frustrate the policy of the Act or as no reasonable minister could have acted. No such breach had been shown in the present case. The court could not grant **mandamus** or a declaration against area or regional authorities since specific remedies against them were available by Section 85 and Part V of the 1977 Act. Nor, if a breach were proved, did the Act admit of relief by way of damages. The application was therefore dismissed.

The reasoning behind the above ruling was confirmed in the following case.

Case 5.2 *In re Walker Application* (1987)

Postponed operation[7]

Mrs Walker's baby son required a heart operation and was on the waiting list. A date was fixed for the operation to be performed, but it was postponed by the Birmingham Health Authority. She applied to the court for a judicial review of the decision of the health authority. The High Court judge refused her application. She appealed to the Court of Appeal which upheld the earlier decision.

The health authority had accepted that the regional district health authorities could be subject to judicial review where there was reason to believe that they might be in breach of their public duties. There would always be individuals who believed that treatment was not provided quickly enough, but the financial resources were finite and always would be. The court held that it was not for the court to substitute its own judgment for that of those responsible for the allocation of resources. It would interfere only if there had been a failure to allocate funds in a way that was reasonable or where there had been breaches of public duties. Mrs Walker's application was refused.

Case 5.3 *R* v. *Cambridge HA* (1995)

Bone marrow transplant postponed operation[8]

A 10-year-old girl was suffering from acute myeloid leukaemia and required a further session of chemotherapy and a second bone marrow transplant to survive. It was estimated that the chance of success was between 10 per cent and 20 per cent. Costs of the drug and transplant were estimated as £15,000 and £60,000, respectively. The health authority refused to resource this and the father challenged its decision. The High Court upheld his application for judicial review. The health authority appealed to the Court of Appeal and the case was heard that same day. The Court of Appeal held that the four criticisms made by the trial judge of the health authority's decision were not acceptable. The court should confine itself to the lawfulness of the decision. It held that it was not in the best interests of the child to undergo further treatment and that resources had to be taken into account.

While the general principle that the courts will not intervene in resourcing issues of the NHS appears to continue to be accepted by the courts, there have been several cases where health authorities have been held liable for failure to provide services and in one case it was ruled that in certain circumstances the NHS should pay for treatment overseas.

In one case,[9] the health authority decided that it would not enable beta interferon to be prescribed for patients in its catchment area, since it was not yet proven to be clinically effective for the treatment of multiple sclerosis. A sufferer from multiple sclerosis challenged this refusal of the health authority and succeeded on the grounds that the health authority had failed to follow the guidance issued by the Department of Health.[10] A declaration was granted that the policy adopted by the health authority was unlawful and an order of mandamus was made requiring the defendants to formulate and implement a policy that took full and proper account of national policy as stated in the circular. In a later case the Court of Appeal held that the policy of a primary care trust on the availability of Herceptin for breast cancer was irrational since there were no clinical or personal considerations which led to one patient being preferred over another. It asked the primary care trust (PCT) to formulate a lawful policy upon which to base decisions in particular cases, including that of Mrs Rogers, in the future.[11] On 18 July 2007 the High Court ruled that, although the PCT policy on Avastin was entirely rational and sensible, the PCT had made a flawed and irrational decision when it refused to fund the drug Avastin for cancer treatment for a specific patient, Ms Otley.[12] As a consequence the PCT agreed to fund five cycles of treatment for her, the treatment being reviewed after those treatments and a CT scan. The guidance issued by NICE on drugs for Alzheimer's was challenged in a case in 2007.[13]

Another case concerned three transsexuals who wished to undergo gender reassignment.[14] The health authority refused to fund such treatment on the grounds that it had been assigned a low priority in its lists of procedures considered to be clinically ineffective in terms of health gain. Under this policy, gender reassignment surgery was listed among others as a procedure for which no treatment, apart from that provided by the authority's general psychiatric and psychology services, would be commissioned, save in the event of overriding clinical need or exceptional circumstances. The transsexuals sought judicial review of the health authority's refusal and the judge granted an order quashing the authority's decision and the policy on which it was based. The health authority then took the case to the Court of Appeal, but lost its appeal. The Court of Appeal held that:

1 While the precise allocation and weighting of priorities is a matter for the judgment of the authority and not for the court, it is vital for an authority:
   (a) to accurately assess the nature and seriousness of each type of illness;
   (b) to determine the effectiveness of various forms of treatment for it; and
   (c) to give proper effect to that assessment and that determination in the formulation and individual application of its policy.
2 The authority's policy was flawed in two respects:
   (a) it did not treat transsexualism as an illness, but as an attitude of mind which did not warrant medical treatment;
   (b) the ostensible provision that it made for exceptions in individual cases and its manner of considering them amounted to the operation of a 'blanket policy' against funding treatment for the condition because it did not believe in such treatment.
3 The authority were not genuinely applying the policy to the individual exceptions.
4 Article 3 and Article 8 of the European Convention on Human Rights (see Chapter 1) did not give a right to free healthcare and did not apply to this situation, where the challenge is to a health authority's allocation of finite funds. Neither were the patients victims of discrimination on the grounds of sex.

In another case,[15] a woman was waiting for a hip replacement operation and went abroad for treatment after being told that she would have to wait a year for the operation on the NHS. She asked her local hospital in Bedford to pay for the trip under the E112 certificate scheme, but Bedford PCT refused on the grounds that the wait was within the government's waiting times guidelines. She brought an action for judicial review of the PCT's refusal, claiming that its decision was unlawful and infringed her rights under Articles 3 and 8 of the European Convention on Human Rights.

The judge held, based on Article 49 of the EC Treaty[16] (which prohibited restrictions on freedom to provide services within the Community), that prior authorisation for treatment by an NHS patient in another member state of the European Union at the expense of the NHS could be refused on the ground

of lack of medical necessity only if the same or equally effective treatment could be obtained without undue delay at an NHS establishment. He also held that in assessing what amounted to undue delay, regard had to be had to all the circumstances of the specific case, including the patient's medical condition and, where appropriate, the degree of pain and the nature and extent of the patient's disability. Consideration of NHS waiting times and waiting lists were relevant, when having regard to all the circumstances. On the facts of the case, however, the claimant did not recover the money, since the local hospital had offered her an earlier operation. The Court of Appeal referred the case to the European Court of Justice (ECJ) for a preliminary ruling on the application of Article 49 and Article 22 of Regulation 1408/71. The ECJ held that under Article 22(1) the organisation was required to establish that the waiting list did not exceed an acceptable period; Article 49 did not preclude reimbursement of the cost of hospital treatment to be provided in another member state. A refusal to grant prior authorisation could not be based purely on the existence of waiting lists; the claimant was entitled to be reimbursed the cost of the healthcare received under Article 22(1)(c) and the cost of ancillary costs under Article 49.[17]

The EU Directive on cross-border healthcare (2011/24/EU) was incorporated into regulations[18] which came into force on 25 October 2013. A national contact point must be designated to make specified information accessible to patients including information about rights and entitlements to obtain a healthcare service in another member state available or accessible to NHS patients. There are also provisions for prior authorisation and reimbursement of expenditure. Regulation 13 makes provision for charges where certain NHS services are provided to a visiting patient. They can be seen on the book website.

It is inevitable that there will always be a gap between the demands that are made for healthcare and the resources to meet those demands. Decisions will therefore have to be made on priorities and who is refused treatment. New developments in technology, such as the identification of the human genome and the treatment possibilities for identified genetic diseases, are just one example of increasing pressures. The Human Rights Act 1998 has seldom been successfully relied upon in disputes over access to services. As we examine later in this chapter, NICE is tasked with determining priorities and quality standards. There is evidence that, in the current time of financial pressures, many elective or cosmetic treatments are ceasing to be provided on the NHS.[19] However, since the statutory duty on the clinical commissioning group (see Statute Box 5.4) is to 'arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility'; it is unlikely that any court action to enforce provision (for example of removal of tattoos, surgery to prevent snoring, hair transplantation) would succeed. In a poll commissioned by the NHS Confederation which reported in March 2014, half of the politicians surveyed in Britain think a free NHS could be consigned to history unless challenges are tackled to ensure that it meets future patient needs. The Chief Executive of the NHS Confederation expressed concern about how the NHS could make provision of services for an ageing population and an increase in long-term health conditions. See also the interim report of the King's Fund discussed below.[20] Another case where the claimant challenged a failure to provide services was that of Mr Condliff who alleged that failure to provide bariatric surgery for his obesity was a breach of his Article 8 rights. He failed: the court held that there had to be a balancing act between individual needs and the community as a whole and that the Trust had acted reasonably.[21] Where a health service body has been negligent in the performance of its duties, then a civil claim for compensation may be brought. (This is considered in chapters 3, 4 and 6.) Where a death has occurred as a result of gross negligence by the organisation then proceedings under the Corporate Manslaughter and Homicide Act in 2007 may be brought (see chapter 2).

Distinction between statutory duties and guidance from the Department of Health

In fulfilling its statutory duties, the government issues circulars providing guidance to NHS organisations on how they should function. These are available from the DH website.[22]

While in general the advice in these circulars is not the law as such, there is a clear responsibility on organisations to follow the recommendations. The failure by a health authority to follow DH guidelines

on the prescribing of beta interferon led to a successful action being brought by a patient suffering from multiple sclerosis[23] (see above). In a contrasting case,[24] a court held that government circular 1998/158, which limited the powers of GPs to prescribe Viagra, was unlawful in that by preventing the issue of a prescription, where the GP considered it to be justified, the clinical judgment of the GP was usurped. As a consequence, regulations were then issued by the Secretary of State which placed restrictions on the prescription of Viagra on the grounds of cost to the NHS. Pfizer's challenge to the legality of these regulations on the basis of an EU Directive (89/105) failed. (The restrictions were removed on 1 August 2014 when the price of Viagra fell by 93 per cent as generic versions of the drug became available.)

The National Health Service Commissioning Board (NHS England)

The Health and Social Care Act 2012 established the NHS Commissioning Board (now known as NHS England). Regulations[25] provide for a range of matters relating to the functions of NHS England. The Board is subject to the same duty under Section 1(1) as the Secretary of State except for public health functions (see chapter 26). In discharging that duty the Board has the functions set out in Statute Box 5.2.

Statute 5.2 Section 1H of the 2006 Act as amended by section 9(1) of the 2012 Act

NHS Commissioning Board

1H There is to be a body corporate known as the National Health Service Commissioning Board ('the Board').

(2) The Board is subject to the duty under section 1(1) concurrently with the Secretary of State except in relation to the part of the health service that is provided in pursuance of the public health functions of the Secretary of State or local authorities.

(3) For the purpose of discharging that duty, the Board –

(a) has the function of arranging for the provision of services for the purposes of the health service in England in accordance with this Act, and

(b) must exercise the functions conferred on it by this Act in relation to clinical commissioning groups so as to secure that services are provided for those purposes in accordance with this Act.

Schedule A1 of the 2012 Act makes further provision about the NHS Commissioning Board (hitherto referred to as NHS England).

NHS England was established as an arm's length independent body. Its initial function was to authorise clinical commissioning groups (CCGs) and it took up its full functions on 1 April 2013. From this date NHS England has taken on many of the current functions of primary care trusts with regard to the commissioning of primary care health services, as well as some nationally based functions previously undertaken by the Department of Health.

NHS England aims

1 to end unjustifiable variations in services and a reduction of health inequalities;
2 to secure better outcomes for patients as primary care clinicians are empowered to focus on delivering high quality, clinically effective, evidence-based services;
3 to achieve greater efficiencies in the delivery of primary care health services through the introduction of standardised frameworks and operating procedures.

The Board is required to meet the objectives set out in the Mandate (see below) which is to be published each year by the Secretary of State (section 13A and 13B of the 2006 Act as amended by section 23 of the Health and Social Care Act 2012). The functions of NHS England include those specified in the 2012 Act which are shown in Statute Box 5.3.

Statute 5.3 Specified functions of the NHS Commissioning Board

13C Duty to promote NHS Constitution
- **(a)** act with a view to securing that health services are provided in a way which promotes the NHS Constitution, and
- **(b)** promote awareness of the NHS Constitution among patients, staff and members of the public.

13D The Board must exercise its functions effectively, efficiently and economically.

13E The Board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with –
- **(a)** the prevention, diagnosis or treatment of illness, or
- **(b)** the protection or improvement of public health.

In particular, the Board must act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services, in particular
- **(a)** the effectiveness of the services,
- **(b)** the safety of the services, and
- **(c)** the quality of the experience undergone by patients.

It must have regard to (a) any document published by the Secretary of State relating to this duty and (b) the quality standards prepared by NICE under section 234 of the Health and Social Care Act 2012.

13F Duty as to promoting autonomy
13G Duty as to reducing inequalities
13H Duty to promote involvement of each patient
13I Duty as to patient choice
13J Duty to obtain appropriate advice
13K Duty to promote innovation
13L Duty in respect of research
13M Duty as to promoting education and training
13N Duty as to promoting integration of those services
13O Duty to have regard to impact on services in certain areas
13P Duty as respects variation in provision of health services
13Q Public involvement and consultation by the Board
13R Information on safety of services provided by the health service
13S Guidance in relation to processing of information
13T Business plan
13U Annual report
13V Establishment of pooled funds
13W Board's power to generate income etc.
13X Power to make grants etc.
13Y Incidental powers
13Z Exercise of functions and interpretation.

Further rules relating to the functions of NHS England and the clinical commissioning groups are set out in Regulations.[26] Further regulations require NHS England and clinical commissioning groups to ensure good practice when procuring healthcare services for the purposes of the NHS, to protect patients' rights to make choices and to prevent anti-competitive behaviour. The regulations also provide scope for complaints to, and enforcement by Monitor as an alternative to challenging decisions in the courts.[27]

Clinical commissioning groups

The Health and Social Care Act 2012 abolished strategic health authorities and placed the responsibility for the commissioning of health services upon corporate bodies known as clinical commissioning groups (CCGs). Each clinical commissioning group has the function of arranging for the provision of services for the purposes of the health service in England in accordance with the Health and Social Care Act 2012 (which amended section 3 of the NHS Act 2006).

The statutory duties placed upon CCGs are set out in Statute Box 5.4.

Statute 5.4 Statutory duties of clinical commissioning groups

Duties of clinical commissioning groups as to commissioning certain health services (S. 13 of 2012 Act amending S. 3 of 2006 Act)

3(1) A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.

- **(a)** Hospital accommodation;
- **(b)** Other accommodation for the purpose of any service provided under this Act;
- **(c)** Medical, dental, nursing and ambulance services;
- **(d)** Such other facilities for the care of pregnant women, women who are breast feeding and young children as the group considers are appropriate as part of the health service;
- **(e)** Such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service;
- **(f)** Such other services as are required for the diagnosis and treatment of illness.

(1A) For the purposes of this section, a clinical commissioning group has responsibility for –

- **(a)** persons who are provided with primary medical services by a member of the group, and
- **(b)** persons who usually reside in the group's area and are not provided with primary medical services by a member of any clinical commissioning group.

(1B) Regulations may provide that for the purposes of this section a clinical commissioning group also has responsibility (whether generally or in relation to a prescribed service or facility) for persons who –

- **(a)** were provided with primary medical services by a person who is or was a member of the group, or
- **(b)** have a prescribed connection with the group's area.

(1C) The power conferred by subsection (1B)(b) must be exercised so as to provide that, in relation to the provision of services or facilities for emergency care, a clinical commissioning group has responsibility for every person present in its area.

(1D) Regulations may provide that subsection (1A) does not apply –

- **(a)** in relation to persons of a prescribed description (which may include a description framed by reference to the primary medical services with which the persons are provided);
- **(b)** in prescribed circumstances.

(1E) The duty in subsection (1) does not apply in relation to a service or facility if the Board has a duty to arrange for its provision.

(1F) In exercising its functions under this section and section 3A, a clinical commissioning group must act consistently with –

- **(a)** the discharge by the Secretary of State and the Board of their duty under section 1(1) (duty to promote a comprehensive health service), and
- **(b)** the objectives and requirements for the time being specified in the mandate published under section 13A. [See Statute Box 5.5]

3(2) For the purposes of the duty in subsection (1) services provided under
- **(a)** section 83(2) (primary medical services), section 99(2) (primary dental services) or section 115(4) (primary ophthalmic services) or,
- **(b)** a general medical services contract, a general dental services contract or a general ophthalmic services contract must be regarded as provided by the Secretary of State.

3(3) This section does not affect Chapter 1 of Part 7 (pharmaceutical services).

3A Power of clinical commissioning groups to commission certain health services

(1) Each clinical commissioning group may arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement –
- **(a)** in the physical and mental health of the persons for whom it has responsibility, or
- **(b)** in the prevention, diagnosis and treatment of illness in those persons.

(2) A clinical commissioning group may not arrange for the provision of a service or facility under subsection (1) if the Board has a duty to arrange for its provision by virtue of section 3B or 4.

(3) Subsections (1A), (1B) and (1D) of section 3 apply for the purposes of this section as they apply for the purposes of that section.

The general duties of clinical commissioning groups are set out in section 26 of the Health and Social Care Act 2012 which adds sections 14P to 14Z24 to the 2006 Act. These duties include the following:

14P	Duty to promote the NHS Constitution
14Q	Duty to exercise its functions effectively, efficiently and economically
14R	Duty as to improvement in quality of services
14S	Duty in relation to quality of primary medical services
14T	Duties as to reducing inequalities
14U	Duty to promote involvement of each patient
14V	Duty as to patient choice
14W	Duty to obtain appropriate advice
14X	Duty to promote innovation
14Y	Duty in respect of research
14Z	Duty as to promoting education and training
14Z1	Duty as to promoting integration
14Z2	Public involvement and consultation by clinical commissioning groups
14Z3	Arrangements by clinical commissioning groups in respect of the exercise of functions
14Z4	Joint exercise of functions with Local Health Boards
14Z5	Raising additional income
14Z6	Power to make grants
14Z7	Responsibility for payments to providers
14Z8	Guidance on commissioning by the Board
14Z9	Exercise of functions by the Board
14Z10	Power of Board to provide assistance or support
14Z11	Commissioning plan
14Z12	Revision of commissioning plans
14Z13	Consultation about commissioning plans
14Z14	Opinion of Health and Wellbeing Boards on commissioning plans
14Z15	Reports by clinical commissioning groups
14Z16	Performance assessment of clinical commissioning groups
14Z17	Circumstances in which powers in sections 14Z18 and 14Z19 apply
14Z18	Power to require documents and information etc.
14Z19	Power to require explanation

14Z20 Use of information
14Z21 Power to give directions, dissolve clinical commissioning groups etc.
14Z22 Procedural requirements in connection with certain powers
14Z23 Permitted disclosures of information.

The financial arrangements for clinical commissioning groups are covered by section 27 of the 2012 Act which inserts sections 23G to 23K into the 2006 Act.

Further information on clinical commissioning groups and their location can be found on the NHS choices website.[28] The reorganisation of health services and in particular the establishment of CCGs was intended to give General Practitioners a greater voice in the commissioning of local health services. However, concerns about the availability of services and the pressure on A&E departments (see chapter 23) have led to concerns about GP services. There are also concerns about revised payment methods. In the contracts agreed in 2004, GP practices received a minimum practice income guarantee (MPIG) which protected the smaller practices from falls in funding. However, current plans to taper out the MPIG over the next seven years may lead to the closure of many smaller practices.[29]

Both NHS England and the clinical commissioning groups have a statutory responsibility (the former under 13N and the latter under 14Z1 of the amended 2006 Act) to promote integration with social services. This is comparable to the duty under section 3 of the Care Act 2014 which requires local authorities to ensure the integration of care and support provision with health provision and health-related provision in carrying out its functions.

The Mandate

Under Section 13A of the amended NHS Act 2006 before the start of each financial year, the Secretary of State must publish and lay before Parliament a document to be known as 'the mandate'. In this the Secretary of State must specify the points set out in Statute Box 5.5.

Statute 5.5 Section 13A of the NHS Act 2006

The Mandate Contents to be specified by Secretary of State

(a) the objectives that the Secretary of State considers the NHS Commissioning Board should seek to achieve in the exercise of its functions during that financial year and such subsequent financial years as the Secretary of State considers appropriate, and
(b) any requirements that the Secretary of State considers it necessary to impose on the Board for the purpose of ensuring that it achieves those objectives.

The Secretary of State must also specify in the mandate the amounts that the Secretary of State has decided to specify in relation to the limits on capital and revenue resource use. Also specified may be the ways in which the Secretary of State proposes to assess the Board's performance in relation to the first financial year to which the mandate relates.

The NHS Commissioning Board has the responsibility of seeking to achieve the objectives specified in the mandate, and complying with any specified requirements.

In preparing the mandate the Secretary of State must consult the NHS Commissioning Board, the Healthwatch Committee England of the Care Quality Commission and any other appropriate persons.

Regulations[30] impose requirements on the NHS England and CCGs in order to ensure good practice in relation to the procurement of healthcare services for purposes of the NHS, to ensure the protection of patients' rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners with regard to such services.

NHS foundation trusts

NHS trusts were established following the NHS and Community Care Act 1990 which saw the introduction of the internal market in the NHS. NHS trusts were established that provided services under a non-legally enforceable contract or agreement with the health authorities. In addition, group fundholding practices of GPs were established which were allocated the funds to purchase services for the patients on their lists from the providers. Foundation trusts were set up in 2004 following the Health and Social Care (Community Health and Standards) Act. The statutory provisions were consolidated in the National Health Service Act 2006 sections 30–65 and Schedules 7, 8, 9 and 10. The transition from the status of NHS trusts to foundation trusts was overseen by an independent regulator (Monitor) which had the power to licence the trusts as foundation trusts. Section 179 of the Health and Social Care Act 2012 abolishes NHS trusts, with transition provisions, and from 2014 all NHS trusts are expected to be foundation trusts.

Monitor

A body corporate known as the Independent Regulator of NHS Foundation Trusts (called Monitor)[31] was set up under Section 31 of the 2006 Act with additional provisions relating to membership, tenure of office, general and specific powers, finance and reports set out in Schedule 8. Monitor has a duty to exercise its functions in a manner consistent with the performance by the Secretary of State of the duties under Sections 1, 3 and 258 of the NHS Act 2006 (duty as to health service and services generally and as to university clinical teaching and research).

Monitor has set criteria for the licensing of a healthcare service for the purposes of Part 3 of the Health and Social Care Act 2012[32]. A Schedule to the Order sets out criterion 1 in relation to registration with the Care Quality Commission and criterion 2 in relation to provider fitness.

The Health and Social Care Act 2012 and Monitor

Sections 61 to 71 and Schedule 8 of the 2012 Act set out provisions relating to Monitor. Under section 61 Monitor, the body corporate known as the Independent Regulator of NHS Foundation Trusts, is to continue to exist, and is to be known as Monitor. Schedule 8 (which makes further provision about Monitor) has effect.

Section 62 sets out the general duties and is shown in Statute Box 5.6.

Statute 5.6 Section 62 of the Health and Social Care Act 2012

General Duties of Monitor

(1) The main duty of Monitor in exercising its functions is to protect and promote the interests of people who use health care services by promoting provision of healthcare services which –
  (a) is economic, efficient and effective, and
  (b) maintains or improves the quality of the services.

(2) In carrying out its main duty, Monitor must have regard to the likely future demand for healthcare services.

(3) Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of healthcare services for the purposes of the NHS which is against the interests of people who use such services.

(4) Monitor must exercise its functions with a view to enabling healthcare services provided for the purposes of the NHS to be provided in an integrated way where it considers that this would –
  (a) improve the quality of those services (including the outcomes that are achieved from their provision) or the efficiency of their provision,
  (b) reduce inequalities between persons with respect to their ability to access those services, or
  (c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

(5) Monitor must exercise its functions with a view to enabling the provision of healthcare services provided for the purposes of the NHS to be integrated with the provision of health-related services or social care services where it considers that this would –
  (a) improve the quality of those healthcare services (including the outcomes that are achieved from their provision) or the efficiency of their provision,
  (b) reduce inequalities between persons with respect to their ability to access those healthcare services, or
  (c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those healthcare services.

(6) Monitor must, in carrying out its duties under subsections (4) and (5), have regard to the way in which –
  (a) the National Health Service Commissioning Board carries out its duties under section 13N of the National Health Service Act 2006, and
  (b) clinical commissioning groups carry out their duties under section 14Z1 of that Act.

(7) Monitor must secure that people who use healthcare services, and other members of the public, are involved to an appropriate degree in decisions that Monitor makes about the exercise of its functions (other than decisions it makes about the exercise of its functions in a particular case).

(8) Monitor must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in –
  (a) the prevention, diagnosis or treatment of illness (within the meaning of the National Health Service Act 2006), and
  (b) the protection or improvement of public health.

(9) Monitor must exercise its functions in a manner consistent with the performance by the Secretary of State of the duty under section 1(1) of the National Health Service Act 2006 (promotion of comprehensive health service).

(10) Monitor must not exercise its functions for the purpose of causing a variation in the proportion of healthcare services provided for the purposes of the NHS that is provided by persons of a particular description if that description is by reference to –
  (a) whether the persons in question are in the public or (as the case may be) private sector, or
  (b) some other aspect of their status.

Under section 63 the Secretary of State is empowered to give guidance to Monitor for the purpose of assisting Monitor to comply with its duty under section 62(9).

Section 64 gives supplementary guidance on the meaning of anti-competitive behaviour, healthcare and the NHS.

Regulations can be made under section 65 to extend Monitor's scope to cover adult social care services which are defined to include all forms of personal care and other practical assistance provided for individuals who, by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance, but (b) does not include anything provided by an establishment or agency for which Her Majesty's Chief Inspector of Education, Children's Services and Skills is the registration authority under section 5 of the Care Standards Act 2000.

Section 66 sets out the matters to which Monitor must have regard to in exercise of functions and these are shown in Statute Box 5.7.

Statute 5.7 Section 66 of the Health and Social Care Act 2012

Matters to which Monitor must have regard

(1) In exercising its functions, Monitor must have regard, in particular, to the need to maintain the safety of people who use healthcare services.

(2) Monitor must, in exercising its functions, also have regard to the following matters in so far as they are consistent with the matter referred to in subsection (1) –

- **(a)** the desirability of securing continuous improvement in the quality of healthcare services provided for the purposes of the NHS and in the efficiency of their provision,
- **(b)** the need for commissioners of healthcare services for the purposes of the NHS to ensure that the provision of access to the services for those purposes operates fairly,
- **(c)** the need for commissioners of healthcare services for the purposes of the NHS to ensure that people who require healthcare services for those purposes are provided with access to them,
- **(d)** the need for commissioners of healthcare services for the purposes of the NHS to make the best use of resources when doing so,
- **(e)** the desirability of persons who provide healthcare services for the purposes of the NHS co-operating with each other in order to improve the quality of healthcare services provided for those purposes,
- **(f)** the need to promote research into matters relevant to the NHS by persons who provide healthcare services for the purposes of the NHS,
- **(g)** the need for high standards in the education and training of healthcare professionals who provide health care services for the purposes of the NHS, and
- **(h)** where the Secretary of State publishes a document for the purposes of section 13E of the National Health Service Act 2006 (improvement of quality of services), any guidance published by the Secretary of State on the parts of that document which the Secretary of State considers to be particularly relevant to Monitor's exercise of its functions.

Section 67 is concerned with the conflicts between functions, and the role of Monitor to ensure that the conflict is resolved in the manner it considers best. The section prioritises the different duties Monitor has.

Under Section 68 Monitor has a duty to review regulatory burdens and in reviewing the exercise of its functions must secure that it does not impose burdens which it considers to be unnecessary nor maintain burdens which it considers to have become unnecessary. It must publish a statement relating to what it proposes to do.

Where Monitor is intending to do something which could have a significant impact on service providers, then, under section 69, it must carry out an impact assessment.

Section 70 relates to information which can be used by Monitor and the duty of Monitor to provide the Secretary of State with such information as he may specify.

Section 71 makes provision for a situation where the Secretary of State considers that Monitor is failing to perform its functions.

Further information on Monitor and its role in regulating NHS trusts can be found on its website.[33] Its corporate report published in April 2014 sets out its strategy for 2014–2017. In December 2013 it issued an NHS foundation trust code of governance which sets out best practice principles and processes to help NHS foundation trust boards of directors.

Licensing

Sections 81 to 110 of the Health and Social Care Act 2012 makes provisions relating to the licensing of health service providers, their conditions and their enforcement. Under section 81 it is a requirement

that all health service providers are licensed. Any person who provides a healthcare service for the purposes of the NHS must hold a licence under the 2012 Act and regulations may make provision for determining, in relation to a service provided by two or more persons acting in different capacities, which of those persons is to be regarded as the person who provides the service.

Under section 86 Monitor has the responsibility of setting the criteria for obtaining a license. In February 2013 Monitor published the NHS Provider licence setting out conditions for providers of NHS services valid from April 2013. Further information for independent providers of NHS trusts was circulated in 2014. The licensing documents are available on the Monitor website.

National Health Service Trust Development Authority

The NHSTDA was established under section 28 of the NHS Act 2006 regulations for membership and procedure set out in National Health Service Trust Development Authority Regulations.[34] Further regulations set out the establishment and constitution.[35] Functions specified under section 28 of the 2006 Act are to exercise such of the Secretary of State's functions in connection with the performance management and development of NHS trusts in England and the making of certain public appointments to NHS bodies in England and such other functions as the Secretary of State may direct. The NHSTDA is responsible for overseeing the performance management and governance of NHS trusts, including clinical quality.

NHS Trust Development Authority (Establishment and Constitution) Order 2012 is amended by a later order[36] to provide for the transfer of property and liabilities from the Secretary of State to the Authority plus the transfer of staff from the Secretary of State for Health, strategic health authorities, primary care trust and the National Institute for Improvement and Innovation to the Authority. Further information, including its 2014/5 accountability framework for trust boards, can be found on its website.[37]

Community and primary care services

The NHS and Community Care Act 1990 changed the basis of community care, implementing the recommendations of the Griffiths Report.[38] Instead of places in nursing homes and residential care homes being funded on a means-tested basis by social security, funds were given to the local authority social services departments to become the purchasers of places, on a means-tested basis, for those residents in its catchment area who required nursing or residential care (see chapter 23 for community provisions).

Care trusts

The NHS Plan[39] envisaged that care trusts would be established to commission and provide social services as well as community healthcare (see chapter 23). Further provisions to regulate care trusts are contained in the Health and Social Care Act 2001 Part 3 re-enacted in section 77 of the NHS Act 2006 as amended by section 200 of the Health and Social Care Act 2012. Care trusts enable social services as well as health services to be provided by the same trust. Section 77 enables an organisation to be designated as a care trust. Regulations relating to care trusts were enacted in 2012 replacing those of 2001.[40] A list of all NHS care trusts can be found on the nhs.uk website.[41]

Clinical governance

One of the most significant changes envisaged by the government in its 1997 White Paper was the concept of clinical governance. It was defined as:

A framework through which NHS organisations are accountable for continuously improving the quality of their services.[42]

The idea of clinical governance is basically simple. In the past, the trust board and its chief executive have been responsible for the financial probity of the organisation; there has been no statutory responsibility of the trust for the overall quality of the organisation. Under the concept of clinical governance, the board and its chief executive are responsible for the quality of clinical services provided by the organisation. In theory, this could mean that a board is removed or a chief executive dismissed if a baby suffers brain damage at birth or a mother dies in childbirth as a result of negligence.

Duty of quality

The concept of clinical governance was based on the statutory duty of quality under section 18 of the Health Act 1999 which has now been replaced by section 45 of the Health and Social Care (Community Health and Standards) Act 2003, which places on each NHS body the duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare provided by and for that body.

Section 45 of the Health and Social Care Act 2008 (replacing section 46 of the Health and Social Care (Community Health and Standards) Act 2003 is shown in Statute Box 5.8.

Statute 5.8 Section 45 of the Health and Social Care Act 2008

Standards set by Secretary of State

(1) The Secretary of State may prepare and publish statements of standards in relation to the provision of NHS care.

(2) The Secretary of State must keep the standards under review and may publish amended statements whenever the Secretary of State considers it appropriate.

(3) The Secretary of State may direct a person –

- (a) to prepare a draft statement of standards for the purposes of subsection (1), submit it to the Secretary of State for approval and publish it in the form approved or modified by the Secretary of State;
- (b) to keep standards under review for the purposes of subsection (2) and, whenever the person considers it appropriate, submit a draft amended statement to the Secretary of State for approval and publish it in the form approved or modified by the Secretary of State.

(4) The Secretary of State must consult such persons as the Secretary of State considers appropriate –

- (a) before publishing a statement under subsection (1) or approving a statement under subsection (3)(a);
- (b) before publishing under subsection (2), or approving under subsection (3)(b), any amended statement which in the opinion of the Secretary of State effects a substantial change in the standards.

The role of Healthwatch and local Healthwatch in standard setting is discussed in chapter 27. Standard setting and monitoring have become an even more significant part of the practitioner's professional responsibilities. (Standards in relation to the law are discussed in chapter 3 on the law of negligence.)

The Care Quality Commission (CQC) will have regard to the adherence to these standards in its inspections, inquiries and investigations. Under section 46(4) of the Health and Social Care Act 2008 the Secretary of State can devise or approve the indicators of quality which are to be used by the CQC,

and under subsection 46(5) the Secretary of State can direct the CQC to devise these indicators for his approval.

Under section 234 of the Health and Social Care Act 2012 NHS England can direct NICE to prepare statements of standards (known as quality standard) in relation to the provision of:

(a) NHS services,
(b) public health services, or
(c) social care in England.

NICE quality standards can be accessed on its website.

The Care Quality Commission

In 2009 the Care Quality Commission took over the responsibilities of three commissions: the Healthcare Commission (i.e. the Commission for Health Audit and Inspection – formerly the Commission for Health Improvement (CHI)); the Commission for Social Care Inspection; and the Mental Health Act Commission.[43] CQC was intended to be a stronger force in the raising and implementation of standards across the NHS than its predecessor. Its main functions, objectives and matters to which it had to have regard under the Health and Social Care Act 2008 are listed in Statute Box 5.9. Regulations were enacted setting out its duties of registration.[44] Additional duties as the replacement body of the Mental Health Act Commission were later added.[45] By April 2010 all NHS trusts have been registered with the CQC, some conditional on action being taken to meet concerns about safety and quality of care. The CQC issued the essential standards of quality and safety in March 2009, which are available on its website. It also issued guidance on compliance which applies to all health and adult social care providers. The CQC stated that the guidance focuses on people rather than policies, on outcomes rather than systems. It related to important aspects of care such as: involvement and information; personalised care and treatment; and safety and safeguarding. The 16 essential standards which relate to the 28 regulations governing the work of the CQC can be found on its website, together with a 300-page booklet on essential standards of quality and safety published in March 2010 (What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008). Details on how the CQC enforces these standards are also available on its website, while their significance for nursing staff is explored by Alan Glasper.[46]

Statute 5.9 Sections 2, 3, 4 and 5 of the Health and Social Care Act 2008

Care Quality Commission

S.2 Main functions

1 Registration functions under chapter 2.
2 Review and investigation functions under chapter 3.
3 Functions under the Mental Health Act 1983.

S.3 The Commission's objectives

1 The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services.
2 The Commission is to perform its functions for the general purpose of encouraging –
   (a) the improvement of health and social care services,
   (b) the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and
   (c) the efficient and effective use of resources in the provision of health and social care services.

3 In this chapter, 'health and social care services' means the services to which the Commission's functions relate.

S.4 Matters to which the Commission must have regard

1 In performing its functions the Commission must have regard to –
   (a) views expressed by or on behalf of members of the public about health and social care services,
   (b) experiences of people who use health and social care services and their families and friends,
   (c) views expressed by local involvement networks about the provision of health and social care services in their areas,
   (d) the need to protect and promote the rights of people who use health and social care services (including, in particular, the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005 (c. 9), and of other vulnerable adults),
   (e) the need to ensure that action by the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed,
   (f) any developments in approaches to regulatory action, and
   (g) best practice among persons performing functions comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable and consistent).
2 In performing its functions the Commission must also have regard to such aspects of government policy as the Secretary of State may direct.
3 In subsection (1)(c), 'local involvement network' has the meaning given by section 222(2) of the Local Government and Public Involvement in Health Act 2007 (c. 28).

S.5 Statement on user involvement

1 The Commission must publish a statement describing how it proposes to –
   (a) promote awareness among service users and carers of its functions,
   (b) promote and engage in discussion with service users and carers about the provision of health and social care services and about the way in which the Commission exercises its functions,
   (c) ensure that proper regard is had to the views expressed by service users and carers, and
   (d) arrange for any of its functions to be exercised by, or with the assistance of, service users and carers.
2 The Commission may from time to time revise the statement and must publish any revised statement.
3 Before publishing the statement (or revised statement) the Commission must consult such persons as it considers appropriate.
4 In this section –
   (a) 'service users' means people who use health or social care services, and
   (b) 'carers' means people who care for service users as relatives.

Care Quality Commission (Membership) Regulations 2008 amended by the CQC membership Amendment Regulations in 2013 (SI 2157) to increase the maximum number of members from 12 to 14. Other amendments made by SI 2011/2547 and 2012/1186 (the latter substituted references to the Natonal Patient Safety Agency by the NHS Commissioning Board Authority, increased numbers of members to no more than 12 (subsequently 14) and removed the bar on the Secretary of State appointing CQC employees as members.

The enforcement powers of the CQC include the power to impose, vary or remove conditions, of cancelling registration and prosecuting for specified offences which were available to its predecessors under the Care Standards Act 2000, and also issuing a warning notice, issuing a penalty notice in lieu of prosecution and suspending registration (which are new powers from April 2010 under the Health and Social Care Act 2008).

Enforcement powers of the CQC as shown on its website include:

Issuing a warning notice requiring improvements within a short period of time
Restricting the services that the provider can offer
Stopping admissions into the care service
Issuing fixed penalty notices
Suspending or cancelling the service's registration
Prosecution.

The CQC also works with various bodies to enforce the standards. It has a reciprocal statutory duty with Monitor to co-operate together.

The Care Act 2014 section 89 inserts new provisions into the Health and Social Care Act 2008 to require the non-executives to appoint a Chief Inspector of Hospitals, a Chief Inspector of Adult Social Care, and a Chief Inspector of General Practice. Section 90 of the Care Act 2014 makes amendments to the Health and Social Care Act 2008 to ensure the independence of the Care Quality Commission by removing the Secretary of State's power in various functions such as making regulations as to procedure for representations before report publication or the need for the approval of the Secretary of state in conducting studies as to economy, efficiency, the frequency of inspections, etc.

Regulations drawn up under section 20 of the Health and Social Care Act 2008 which enable the CQC to set standards for regulated organisations across a range of areas are amended by section 95 of the Care Act 2014 to enable provision to be made for a specified person to set the standards for management and training in regulated activities. Section 46 of the Health and Social Care Act 2008 imposed a duty on the CQC to conduct reviews and performance assessments of the carrying on by prescribed registered service providers of specified regulated activities and publish reports of these assessments. Regulations in 2014 prescribe the registered service providers and regulated activities for those purposes.[47]

The CQC has carried out a survey of 69,000 NHS inpatients which revealed some major concerns, including the fact that 45 per cent of patients responding were not told about the side effects of their medication.[48] In October 2010 the CQC stated that almost 1,000 care homes in England were not being properly run by a qualified manager and faced closure.[49] A rehab clinic, the Causeway Retreat, was fined £8,000 and had to pay costs of £30,000 for failure to register with the CQC.[50]

The CQC has also carried out an inquiry into the health organisation's involvement in the case of Baby P, showing that communication between the different health bodies was systematically poor (see chapter 13).[51] It also reviewed a mental health unit in Devon where six elderly patients died and found nursing failures and poor staff supervision.[52]

The CQC has reported Colchester Hospital University NHS Trust to the police following disclosure that staff were 'pressured, bullied and harassed' to change the data on cancer waiting times to make it look as though targets had not been missed.[53] The Chief Inspector of Hospitals recommended that the trust be put into special measures. The medical director of NHS England had alerted the CQC to a whistleblower's allegations about the hospital. Monitor is also launching an investigation and has asked the trust to establish whether other patients did not receive treatment in accordance with national standards.

The CQC reported in 2013 the National Summary of the results of its 2012 inpatients survey. Patients were interviewed about their experiences on admission, cleanliness, food, help with meals, communication, nurses' and patients' questions, confidence and trust, availability of staff, worries and fears over privacy and pain management. Eighty per cent of respondents said they were always treated with respect and dignity, which was up from 78 per cent in 2011. The report gives a good picture of the actual situation of patients. In April 2014 the Chair of the CQC, David Prior, stated that the NHS buried the truth about the huge variation in standards of care out of misguided loyalty to the ideal of a universal health service. About 30 hospitals in England, he concluded, were likely to be offering poor care while about 10–20 were outstanding.[54]

In April 2014 the CQC reported that one in five hospitals had failed to meet its care standard in the year to March 2014 – a failure rate of 21 per cent. The rising incidence of failure reflected a more

rigorous approach of the CQC following the Francis Inquiry. Recent guidance suggests that registered nurses do not have to answer questions from the police because of their right not to incriminate themselves.[55] The NMC has been advised that there would be real risks if they tried to act against staff for refusing to help police.

In 2013 the NMC issued guidance on raising concerns which sets out the broad principles to be followed in taking action in the public interest. It includes information on recent legislation protecting whistleblowers and organisations to which the nurse could go for further advice.[56] (See chapter 4.)

The Care Act 2014 section 92 creates an offence for a care provider to supply or provide false or misleading information unless it can prove that it took all reasonable steps and exercised all due diligence.

National Institute for Health and Care Excellence (NICE)

The National Institute for Clinical Excellence (NICE) (subsequently renamed National Institute for Health and Care Excellence) was established on 1 April 1999 to promote clinical excellence and cost-effectiveness.[57] Subsequently it was abolished (section 248 of the Health and Social Care Act 2012) and reestablished on a new statutory basis under Sections 232–249 and Schedule 16 of the Health and Social Care Act 2012. Regulations relating to its constitution and functions were subsequently enacted[58].

The statutory provisions are shown in Statute Box 5.10.

Statute 5.10 Sections 232–234 of the Health and Social Care Act 2012

Statutory provisions on the National Institute for Health and Care Excellence (NICE)

Section 232

(1) There is to be a body corporate known as the National Institute for Health and Care Excellence (referred to in this Part as 'NICE').

(2) Schedule 16 (which makes further provision about NICE) has effect.

233 General duties

(1) In exercising its functions NICE must have regard to –

(a) the broad balance between the benefits and costs of the provision of health services or of social care in England,

(b) the degree of need of persons for health services or social care in England, and

(c) the desirability of promoting innovation in the provision of health services or of social care in England.

(2) NICE must exercise its functions effectively, efficiently and economically.

(3) In this Part –

'health services' means services which must or may be provided as part of the health service in England;

'social care' includes all forms of personal care and other practical assistance provided for individuals who, by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance.

234 Quality standards

(1) The relevant commissioner may direct NICE to prepare statements of standards in relation to the provision of –

(a) NHS services,

(b) public health services, or

(c) social care in England.

(2) In this Part such a statement is referred to as a 'quality standard'.
(3) In preparing a quality standard NICE must consult the public and, for that purpose, may publish drafts of the standard.
(4) NICE must keep a quality standard under review and may revise it as it considers appropriate.
(5) A quality standard (and any revised standard) –
  (a) has no effect unless it is endorsed by the relevant commissioner, and
  (b) must not be published by NICE unless the relevant commissioner so requires.
(6) The relevant commissioner may require NICE –
  (a) to publish the standard (or revised standard) or to disseminate it to persons specified by the relevant commissioner, and
  (b) to do so in the manner specified by the relevant commissioner.
(7) NICE must –
  (a) establish a procedure for the preparation of quality standards, and
  (b) consult such persons as it considers appropriate in establishing that procedure.
(8) Subsection (9) applies in a case where the Secretary of State and the Board each has power under this section to give NICE a direction to prepare a quality standard in relation to the same matter or connected matters.
(9) In such a case –
  (a) the Secretary of State and the Board may issue a joint direction under subsection (1), and
  (b) if they do so, NICE must prepare a joint quality standard in respect of the matter or matters concerned.
(10) In this section 'the relevant commissioner' –
  (a) in relation to a quality standard in relation to the provision of NHS services, means the Board, and
  (b) in relation to a quality standard in relation to the provision of public health services or of social care in England, means the Secretary of State, and a reference to the relevant commissioner in relation to a joint quality standard is a reference to both the Secretary of State and the Board.
(11) In this Part –
  'NHS services' means services the provision of which is arranged by the Board or a clinical commissioning group under the National Health Service Act 2006 (including pursuant to arrangements made under section 7A of the National Health Service Act 2006) or section 117 of the Mental Health Act 1983 (after-care);
  'public health services' means services provided pursuant to the functions of –
  (a) the Secretary of State under section 2A or 2B of, or paragraph 7C, 8 or 12 of Schedule 1 to, that Act, or
  (b) a local authority under section 2B or 111 of, or paragraphs 1 to 7B or 13 of Schedule 1 to, that Act.

Section 235 covers the supply of quality standards to other persons such as devolved authorities. Section 236 requires NICE to give advice or guidance to the Secretary of State or the Board on any quality matter referred to it by the Secretary of State or (as the case may be) the Board. Under section 237, regulations may confer functions on NICE in relation to the giving of advice or guidance, provision of information or making of recommendations about any matter concerning or connected with the provision of:

(a) NHS services,
(b) public health services, or
(c) social care in England.

However, the regulations cannot permit a direction to be given about the substance of advice, guidance or recommendations of NICE. Section 238 enables the regulations to stipulate provisions on appeals

against NICE recommendations. Section 239 enables the regulations to confer functions on NICE in relation to providing or facilitating the provision for training in connection with the provision of NHS services, public health services or social care in England. Section 240 enables the regulations to cover advisory services by NICE.

Under section 241 the NHS Commissioning Board may direct NICE to exercise any of the Board's functions in relation to the preparation of the guidance required to be published by the Board under section 14Z8 of the National Health Service Act 2006 (the 'commissioning guidance'). A direction under subsection (1) may direct NICE to exercise the functions in such manner and within such period as may be specified in the direction.

Under section 241(3) NICE must, if requested to do so:

(a) provide the Board with information or advice on such matters connected to the Board's functions in respect of the commissioning guidance as may be specified in the request, and

(b) disseminate the commissioning guidance to such persons and in such manner as may be specified in the request.

Regulations (under section 242) may make provision requiring NICE to publish a document (known as 'the charter') explaining the functions of NICE and how NICE intends to exercise them.

Section 245 makes provision for the situation if NICE is failing to discharge its functions.

In April 2014 NICE announced that it was not recommending that Kadclya (a drug for breast cancer estimated to extend life by an average of six months) for NHS use because it was too expensive at £90,000 per patient. NICE was attempting to negotiate with Roche over the price.[59] Individual patients could apply to the government's cancer fund which runs until 2016. The fact that NICE has recommended certain treatments does not automatically mean that patients can insist on them. For example, NICE recommended that three courses of IVF treatment should be available to infertile couples. However, as a result of financial pressures the Mid Essex Clinical Commissioning Group decided to restrict IVF treatments to HIV-positive men and to cancer patients. The CCG said that after consultation local GPs agreed that other types of care should take priority over fertility services in any spending decisions.[60] In another example NICE has approved the prostrate drug enzalutamide for men after chemotherapy has been exhausted but NHS England is refusing to fund it for those men who had already tried abiraterone.[61] NICE has come under criticism for its recommendations that statins should be taken by more than 4 million additional persons who would benefit from cholesterol lowering drugs. Critics fear that GPs will be unable to cope with the additional demands.[62]

National Service Frameworks (NSFs)

The White Paper on the NHS[63] set out a package of measures to raise standards within the NHS and these were further elaborated in the NHS Plan.[64] Included in this programme of action was the introduction of National Service Frameworks (NSFs). The circular[65] explaining their function stated:

> **NSFs will set national standards and define service models for a defined service or care group; put in place strategies to support implementation; and establish performance measures against which progress within an agreed timescale will be measured. The Commission for Health Improvement (CHI) (the Healthcare Commission) (now incorporated into the CQC) will assure progress through a programme of systematic service reviews.**

NSFs cover the following areas: cancer; children; coronary heart disease; diabetes; long-term health conditions; mental health; older people; paediatric intensive care; renal services; and chronic obstructive pulmonary disease. Each NSF is developed with the assistance of an external reference group (ERG) which brings together health professionals, service users and carers, health service managers, partner agencies and other advocates. ERGs adopt an inclusive process to engage the full range of

views. The Department of Health supports the ERGs and manages the overall process. In addition, the Department of Health makes a general invitation to professionals and the public to send in their views and their examples of good practice to the Department of Health website.[66] Guidance is issued by the Department of Health in the form of health service circulars (HSCs) on the implementation of NSFs. For example, HSC 2001/026 sets out the standards defined in the NSF for diabetes.[67] Twelve standards are laid down, from prevention of type 2 diabetes to the detection and management of long-term complications. Standard 9 relates to diabetes and pregnancy. Failure by an NHS organisation to comply with the NSF could lead to a complaint by a patient, but the patient could not sue for breach of a statutory duty since the NSF does not in itself create statutory duties. However, it would be possible for the Secretary of State, in setting standards under section 45 of the Health and Social Care Act 2008, to create a statutory duty binding on NHS bodies to comply with NSFs. One of the statutory duties of the CQC is to monitor and review the implementation of standards set by the Secretary of State which include the NSFs and NICE. The CQC reports can be found on its website.[68] The first NSF which it reviewed was on coronary heart disease.

The work of NICE contributes to the development of NSFs. For example, NICE has undertaken investigations into type 1 diabetes to develop clinical guidelines and these will contribute to the implementation of the Diabetes National Service Framework.

NHS 111 and walk-in clinics

NHS Direct, which enabled patients to seek advice on health problems, both by telephone and online, was replaced in England in 2014 by a new NHS 111 service. NHS 111 provides a free-to-call service but it is not an emergency number. The website[69] states that it can be used: if medical help is needed but it is not a 999 emergency; if you think you may need to get to A&E; you don't know who to call or you do not have a GP; if you need health information or reassurance about what to do next. The NHS 111 service is staffed by trained advisers supported by experienced nurses and paramedics.

Walk-in centres (WICs) are managed by clinical commissioning groups. A registered nurse is usually in charge of each WIC and patients do not usually need an appointment. Most centres are open 365 days a year and outside office hours. They are seen as providing a complementary service to GPs and A&E departments. They deal with many minor illnesses and injuries. (See also chapter 24).

Review of arm's-length bodies

In 2004 a review commenced of the arm's-length bodies (ALBs) in the NHS. Those ALBs in the Department of Health were to be reduced from 38 to 20 and there were to be significant changes elsewhere. The NHS Modernisation Agency and Board were abolished. Subsequently, as part of the Darzi review, a National Quality Board (NQB) was established. Those whose functions were to be transferred to other bodies included NHS Estates, NHS Professionals, NHS Direct (to become an NHS trust), NHS Logistics Authority and those bodies incorporated into the CQC. A revised scheme was published in 2010.[70]

The National Quality Board

The NQB (in the words of the Department of Health) is:

> **a multi-stakeholder board established to champion quality and ensure alignment in quality throughout the NHS. The Board is a key aspect of the work to deliver high quality care for patients.**

The aim of the Board is to bring together all those with an interest in improving quality, to align and agree the NHS quality goals, while respecting the independent status of participating organisations. Its role is to provide strategic oversight and leadership in quality across the NHS.

The key functions of the Board are to:

- Ensure the overall alignment of the quality system
- Deliver on specific technical responsibilities, including those set out in the Next Stage Review, namely to oversee the work to improve quality indicators, advise the Secretary of State on the priorities for clinical standards set by NICE and make an annual report to the Secretary of State on the state of quality in England using internationally agreed comparable measures
- Assume a wider leadership responsibility for driving the quality agenda and acting as a powerhouse for change
- Contribute to NICE quality standards, quality accounts, patient experience, accreditation and clinical audit policy areas.

The membership includes representatives from some of the national organisations, including: the chairs of the CQC, NICE, NPSA and Monitor. Also on the Board are the NHS medical director, the Chief Nursing Office, the Chief Medical Officer, the Director General for Social Care, Local Government and Care Partnerships. Expert and lay members from a variety of disciplines have also been appointed. Its annual report for 2012 is available from the government website.[71] In 2013 it published a final report on Quality in the new health system – maintaining and improving quality from April 2013. It has also published guidance for local and regional quality surveillance groups on 'how to run an effective QSG'.

The topic of patient representation and involvement is considered in chapter 27.

NHS inquiries

Airedale Inquiry Report

In 2010 the report of an inquiry into events at Airedale Foundation NHS Trust Hospital was published.[72] Anne Grigg-Booth, a night nurse, was accused of killing three patients by illegally administering opiates.

Winterbourne View Hospital Report

An undercover operation by BBC *Panorama* revealed cruel, callous and degrading abuse of residents at this private hospital and led to the imprisonment of six care workers and five others were found guilty. The government published a full response in December 2012 and set out a programme of action including tighter inspections and regulation by the Care Quality Commission.

Beverly Allitt

Beverly Allitt, a state-enrolled nurse, was convicted of murdering four children, of attempting to murder three others and of causing grievous bodily harm to six more. She was sentenced to life imprisonment on every count. An independent inquiry,[73] chaired by Sir Cecil Clothier, made significant and substantial recommendations on the selection procedures for nurses, including the prohibition of employment of those with a personality disorder, and that there should be formal health screening; that post-mortem reports should be sent by the coroner to doctors involved in the patient's care; that there should be a review of paediatric pathology services; that there should be a review of sickness information being referred to occupational health and of the criteria for management referrals to occupational health; that there should be untoward incident reports if there is a failure of an alarm on monitoring equipment; and that reports of serious untoward incidents should be made in writing to district and regional health authorities. The Department of Health drew the attention of NHS managers to the

report's recommendations.[74] The report accepted that no measures can afford complete protection against a determined miscreant and emphasised that:

> **Our principal recommendation is that the Grantham disaster should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events.**

A High Court judge ruled on 6 December 2007 that Beverly Allitt must serve a minimum of 30 years in custody and will therefore be over 60 years old before she is eligible for release.

Shipman Inquiry

It was apparent from the prosecution of a GP, Dr Shipman, for the murder of 15 patients, that the principal recommendation of the Allitt Inquiry applies as much to the care of adults as to children. An inquiry was set up after his conviction and several reports have been published: the first[75] identified the patients for whose deaths he was probably responsible (possibly over 200); the second[76] reviewed a police investigation into early police enquiries; and the third[77] made fundamental recommendations on the reform of the present system of death certification and the office and function of the coroner (see chapter 29). The fourth Shipman report, which was published in July 2004,[78] considered the regulation of controlled drugs in the community (see chapter 28). The fifth report of this inquiry was published in December 2004[79] and was concerned with the complaints against and the regulation of doctors. The sixth, and final, Shipman report considered how many patients Shipman killed during his career as a junior doctor at Pontefract General Infirmary and in his time at Hyde.[80] Shipman committed suicide in Wakefield prison on 13 January 2004.

Dr Rodney Ledward

Rodney Ledward was struck off the medical register after being found guilty of bungling 13 gynaecological operations. He died in 2000. An inquiry found that there had been a climate of fear and intimidation preventing nurses and junior doctors from telling tales in case they lost their jobs. It condemned NHS consultants for allowing him to carry on working for years and made recommendations that each trust should develop a list of untoward clinical events which should trigger an incident report. It also made recommendations relating to the function of each Royal College and clinical governance principles should apply to private practice as well as the NHS.[81] It was subsequently reported[82] that 59 women were suing the Kent and Medway Health Authority and East Kent Hospitals NHS Trust for damages. They alleged that they were raped or sexually assaulted by Rodney Ledward when they were in his care in the early 1980s.

Reports of other inquiries which can be downloaded from the Department of Health website include the inquiry into Clifford Ayling (a GP from Kent who was convicted of indecently assaulting women patients); Richard Neale (a gynaecologist who was struck off the GMC register for poor standards in a number of cases); and the Kerr/Haslam Inquiry (two psychiatrists in Yorkshire about whom several patients raised concerns).

Mid Staffordshire NHS Foundation Trust Inquiry

The report of Robert Francis QC of the independent inquiry into the failures of the trust to provide basic patient care between 2005 and 2009, published in February 2010, stated that the deaths of 400 people were attributable to major failings in the quality of care. It recommended that Monitor should be asked to deauthorise Mid Staffs as a foundation trust. The response of the government to the report, published the same day, emphasised the need to learn lessons from the failure and a further inquiry under Robert Francis was set up to look at why the commissioning, regulatory and supervisory bodies did not detect the failures earlier. The GMC and NMC were asked to review the evidence and report on whether any action was necessary. Action by the NMC against individual registered nurses involved in the Mid Staffs scandal was taken.[83] The Staffordshire Inquiry chaired by Robert Francis QC was followed by the setting

up of a public inquiry. The NHS Medical Director led a working group to look at hospital standardised mortality rates and develop a single clearer measure for the NHS and for patients. The government also called for greater openness and transparency among foundation trusts, with a strong presumption that, where appropriate, trust boards should meet in public and governors should have access to papers.

The report of the Francis Inquiry[84] was published on 6 February 2013. It made 290 recommendations to change the culture of the NHS to avoid a repeat of the tragedy. The report can be downloaded.[85] Robert Francis, in a letter to the Secretary of State for Health published with the executive summary of the report, described the essential aims of the report and these are shown in Box 5.1.

Box 5.1 Essential aims of the Francis Report on Mid Staffordshire NHS Foundation Trust

(a) Foster a common culture shared by all in the service of putting the patient first.
(b) Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
(c) Provide professionally endorsed and evidence-based means of compliance with these fundamental standards, which can be understood and adopted by the staff who have to provide the service.
(d) Ensure openness, transparency and candour throughout the system about matters of concern.
(e) Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
(f) Make all those who provide care for patients – individuals and organisations – properly accountable for what they do to ensure that the public is protected from those not fit to provide such a service.
(g) Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.
(h) Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.
(i) Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public and all other stakeholders in the system.

Some of the key recommendations to secure the achievement of the aims shown in Box 5.1 included:

- Changing the culture of the NHS for which three characteristics are required: openness, transparency and candour.
- A statutory obligation should be imposed on healthcare providers, registered medical and nursing practitioners to observe the duty of candour.
- There should be a statutory obligation on directors of healthcare organisations to be truthful in any information given to a regulator or commissioner.
- There should be a criminal offence for any registered doctor, nurse or allied health professional or director of a registered or authorised organisation to obstruct the performance of these duties or dishonestly or recklessly make an untruthful statement to a regulator.
- Enforcement of the statutory duties should be by the Care Quality Commission.
- Increased focus on a culture of compassion and caring in nurse recruitment, training and education.
- Registration system to be introduced for healthcare support workers.
- NHS Constitution should be the first reference point for all NHS patients and staff and the common values of the service should be enshrined and effectively communicated by the NHS Constitution which should set out the system's values and the rights, obligations and expectations of patients.
- A simpler system of regulation.
- Non-compliance with a fundamental standard leading to death or serious harm of a patient should be capable of being prosecuted as a criminal offence, unless the provider or individual concerned can show that it was not reasonably practical to avoid this.

- Complaints relating to possible breaches of fundamental standards and serious complaints, should be accessible to the CQC, relevant commissioners, health scrutiny committees, communities and Local Healthwatch. Recommendations of the Patient's Association on complaints handling should be implemented. Any expression of concern by a patient should be treated as a complaint unless the patient's permission is refused.

Many of the recommendations from the Francis Public Inquiry were enacted in Part 2 of the Care Act 2014 on Care Standards. Sections 81–95 create a duty of candour; impose licence conditions on NHS foundation trusts; provide for the appointment of a trust special administrator; increase the independence of the CQC; and create an offence of a care provider providing false or misleading information.

Offence of ill-treatment or wilful neglect

Section 44 of the Mental Capacity Act 2005 introduced a new offence of ill-treatment or wilful neglect of a person who lacks mental capacity (see chapter 17). Following the Francis Report on Mid Staffordshire a new statutory offence of ill-treatment or wilful neglect was recommended. In February 2014 the Department of Health issued a consultation on the topic.[86] The consultation ended on 31 March 2014 but at the time of writing the new statutory offence has still to be enacted.

The government established a number of specific reviews focusing on issues raised in the Report. Professor Don Berwick was asked to chair an independent review on improving the safety of patients in England. Berwick's report *A Promise to Learn – a Commitment to Act* was published in August 2013.[87] Its recommendations cover the framework, leadership, patient and public involvement, staffing, training and capacity building, measurement and transparency, structures and regulation. The National Advisory Group on the Safety of Patients in England was established to support his work with the review. The report identified a gap in existing legislation and suggested that there needed to be in place a system where an act or omission is not accidental, but amounts to ill-treatment or wilful neglect of adults with capacity and recommended that there should be a new statutory offence.

The Government Response to the House of Commons Health Committee Third Report of Session 2013–4 *After Francis: Making a difference* CM 8755 was published in November 2013. A statutory duty of candour is included in the Care Act, not on individuals but on the providers and will be included as a new registration requirement for health and social care providers registered with the Care Quality Commission. Section 81 of the Care Act 2014 provides for a duty of candour. It inserts into section 20 of the Health and Social Care Act 2008 (regulation of regulated activities), a new (5A) which states that regulations under this section must make provision as to the provision of information in a case where an incident of a specified description affecting a person's safety occurs in the course of the person being provided with a service. The GMC and NMC are working on a consistent approach to candour and reporting of errors. The NMC has included a duty of candour in its new draft code of practice and is issuing further guidance to underpin the Code.

The recommendation in the Francis Report that healthcare support workers should receive training and supervision is considered in chapter 24.

The NHS Constitution

Professor Lord Darzi was appointed by the government to undertake a review of the NHS, with four main objectives: to put clinical decisions at the centre of the NHS; to improve patient care, particularly for those with long-term and life-threatening conditions; to make care more accessible and convenient; and to establish a vision for the next decade based less on central direction and more on patient control. An interim report was published, followed on 9 May 2008 by a review, *Leading Local Change*, and the final report, *High Quality of Care for All*, on the future of the NHS was published in 2008.[88] This made many radical recommendations, including enhancing the enforcement powers of the CQC. The Darzi

Report also included in a draft format, an NHS Constitution[89] which can be seen on the website of this book in its finalised format. The Constitution sets out the seven key principles which guide the NHS; the rights and responsibilities of patients, the rights and responsibilities of staff and the values underpinning the NHS. It thus attempts to consolidate all the existing legal rights of patients, staff and public in one document and to set down some pledges such as:

> **The NHS will strive to provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed. (pledge)**

The NHS Constitution is accompanied by a statement of accountability. All organisations providing NHS services will be obliged by law to take account of the Constitution and its principles and values in their decisions and actions.

The Darzi review has been subject to many criticisms, including the absence of a timeframe and clear additional resources for its implementation. However, the Darzi review did set out a strategy which can be used by health professionals to develop their own services according to established values and clear standards. For example, it was planned that about 15 million clients with long-term conditions will have individual care plans.

Statutory provisions for the recommendations in the Darzi review were contained in the Health Act 2009. Under section 2 of the Act it is a requirement of specified NHS organisations to have regard to the NHS Constitution in performing their functions. Section 3 of the Health and Social Care Act 2012 inserts into the NHS Act 2006 the requirement that 'in exercising functions in relation to the health service, the Secretary of State must have regard to the NHS Constitution' (see Statute Box 5.1). Similarly in section 23 of the Health and Social Care Act 2012 the NHS Commissioning Board (NHS England) must, in the exercise of its functions:

(a) act with a view to securing that health services are provided in a way which promotes the NHS Constitution, and

(b) promote awareness of the NHS Constitution among patients, staff and members of the public (see Statute Box 5.3).

Section 26 places a similar duty upon the clinical commissioning groups.

An NHS Handbook providing guidance on the NHS Constitution was also drawn up and under the 2009 Act the Secretary of State must ensure that the Handbook continues to be available to patients, staff and members of the public and at least once in any period of three years the Secretary of State must carry out a review of the Handbook. The first review had to be completed no later than 5 July 2012.

A summary of the Seven Principles of the NHS as revised in 2013 is shown in Box 5.2.[90]

Box 5.2 Principles of the NHS Constitution

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism – in the provision of high-quality care; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations.
4. The NHS aspires to put patients at the heart of everything it does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

The Healthy NHS Board

In February 2010 the NHS Leadership Council launched the Healthy NHS Board: Principles for Good Governance, highlighting the critical role boards play in ensuring that quality, centred on patient safety, effective care and patient experience is at the heart of the NHS. In 2013, described as 'the new refreshed Healthy NHS Board', it responded to the Francis Report and can be downloaded from the resources section of the Foresight Partnership (www.foresight-partnership.co.uk) which was established in 2004 to support governance, leadership and improvement.

Nursing initiatives

Nursing road map to quality

In March 2010 the Department of Health published a nursing road map for quality.[91] This identifies seven elements to improve quality: measure quality; publish quality performance; recognise and reward quality; leadership for quality; safeguard quality; and stay ahead. Each element is considered in turn and the appropriate resources identified.

Prime Minister's Commission on the future of nursing and midwifery

In 2009 the Prime Minister appointed a commission to report on the future of nursing and midwifery. Its report, *Front Line Care*, was published in 2010. The report made 20 high-level recommendations on the following seven key themes:

- High quality, compassionate care
- Health and well-being
- Caring for people with long-term conditions
- Promoting innovation in nursing and midwifery
- Nurses and midwives leading services
- Careers in nursing and midwifery
- The socioeconomic value of nursing and midwifery.

Among its recommendations were the protection of the title 'nurse' through registration with the NMC; strengthening the role of ward sister; regulating nursing and midwifery support workers and regulating advanced nursing and midwifery practice; a named midwife for every woman and flexible roles and career structures.

NHS and the private sector

In a development which can be seen as a sign of future changes it was announced that Hinchingbrooke Hospital in Cambridgeshire was to be run by a private company.[92] The hospital had an annual turnover of £92 million and debts of £40 million. All prospective NHS bidders had pulled out of the tender process, leaving only private companies bidding. The contract requires the maternity and emergency services to be kept open, the NHS staff to retain their employment and the hospital assets to continue to be owned by the NHS. In another development, some NHS foundation trusts have linked up with FTSE 100 companies. For example, Oxleas NHS Foundation Trust has partnered up with DHL, a logistics company. DHL is sharing its experience in marketing and using patient surveys. British Telecom is working with the University Hospitals Birmingham.[93] The first private company to take over an NHS hospital was Circle Health, to which Hinchingbrooke Hospital was franchised out in November 2010, and this is an indicator of the direction in which the White Paper may take the NHS.[94]

NHS charges

A basic principle of the NHS when established was that it should be free at the point of use. However, charges for prescriptions (with exemptions) were soon levied and subsequently other charges have been raised but each must be based on specific legislation. Charges following treatment after a road accident were initiated in 1999 and have been amended in subsequent years. From injuries occurring on or after 1 April 2014[95] the charges are £192 where the injured person had used ambulance services, NHS treatment without admission is £637 and the daily charge for inpatient treatment is £783. The maximum charge is £46,831. The Compensation Recovery Unit, part of the Department of Works and Pensions is able to recover costs of hospital treatment and ambulance services from the insurers where personal injury compensation is paid. Further information can be found on the government website.[96] From spring 2015, patients from outside the EU seeking treatment in Britain are to be charged 150 per cent more of the cost of their care in an attempt to deter 'health tourism', saving the NHS an estimated £500 million per year.

An independent commission set up by the King's Fund and chaired by Kate Barker stated that NHS charges such as for GP appointments, A&E and other services and taxes on pensioners need to be considered to fix the fracture between the health service and councils, which condemns the elderly to confusing and chaotic care. The report recommended that means-tested social care run by councils should be unified in a single, ring-fenced budget. It noted that it is unfair that people with some conditions such as cancer have their treatment fully paid by the NHS but those with others such as dementia or Parkinson's often have to pay many costs themselves.[97]

Conclusions

This chapter has considered the statutory duties placed on the Secretary of State and the organisations that have been introduced in recent years to ensure that accountability and high standards of care are provided in the NHS. It is perhaps too soon to evaluate the implications of the Health and Social Care Act 2012 and the new institutions established under that Act. However, the impact of the Mid Staffordshire scandal and the subsequent Francis Reports are still reverberating around the NHS in England and there are calls in Wales for a similar inquiry to be held. The NHS is facing the most significant funding problems in its entire history and there are calls for major changes in how the organisation should be financed and how the long-term problems of an aging population and increasing numbers suffering from chronic diseases together with the challenges of meeting the opportunities arising from new technologies such as genetic screening are to be managed. In 2014 Unite estimated that 70 per cent of NHS contracts had been awarded to private companies over the previous two years and the number of contracts for tender was up by 30 per cent. Unite questioned the impact of these developments on patient care and service quality.

Reflection questions

1 Assess the likely contribution of NICE, CQC and the statutory duty of quality to the standards of care within your own sphere of professional practice.

2 Discuss the national scheme for the reporting of adverse healthcare incidents. How does it operate within your particular field of work? (See also chapter 12).

3 Consider the effects of the Health and Social Care Act 2012. What impact have they had upon your work and how has its implementation improved standards of care within the NHS?

Further exercises

1 Consider the present organisation of primary health and social care services as a result of the Health and Social Care Act 2012 and Care Act 2014. To what extent do you think that patient care has improved?

2 Analyse the NHS Constitution (see the website of this book) and consider specifically the effects that it could have in the area in which you work. To what extent do you consider that it affects your own working practices?

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Chapter 6

Progress of a civil claim: defences and compensation

This chapter discusses

- Civil proceedings
- Compensation in civil proceedings for negligence
- Defences to a civil action
- Clinical Negligence Scheme for Trusts (CNST) and the NHS Litigation Authority (NHSLA)
- NHS Redress Act 2006
- Reforms to civil litigation

Introduction

This chapter considers the likely course that any civil case against a nurse and/or NHS trust might follow, the ways in which compensation in the civil courts is assessed and the defences that may be available. It takes into account the major reforms in civil procedure which came into effect in April 1999, following the Report on Access to Justice by Lord Woolf[1] and the more recent changes.

Civil proceedings

Two issues

In any civil case there are two separate issues:

1 Is the defendant liable?
2 How much compensation is payable?

It is sometimes possible that one of these issues has been agreed, e.g. the defendant accepts liability, but disagrees with the amount of compensation (known as quantum) claimed by the victim, or that the amount of compensation that would be payable is agreed, but the defendant refuses to accept liability for that sum. Sometimes both issues are disputed. Evidence will therefore be required on both issues. The elements to establish liability and the kinds of harm for which compensation is payable are discussed in chapter 3. In some cases a defendant may be prepared to pay compensation without admitting liability. This is known as an ex gratia payment and is considered below.

A nurse is first likely to be asked by management to provide a statement on the events. Care should be taken in the completion of this and guidelines are given in chapter 9. If the victim has sought advice and has decided to commence an action, the next stages are set out below. The High Court hears claims exceeding £50,000. Claims below that amount are heard in the County Court and follow different tracks. Claims up to £10,000 are dealt with in the small claims branch. Claims between £10,000 and £25,000 are heard in the fast track branch and those between £25,000 and £50,000 are heard in the Multi Track branch of the County Court (see chapter 1 for civil courts).

Mediation

One of the results of the Woolf reforms in civil justice is that the parties are encouraged to resolve the dispute before going to court using mediation or other forms of resolution, such as **alternative dispute resolution**. Often such processes can be linked with the complaints procedure (see chapter 27) to avoid litigation. In mediation, an independent mediator attempts to assist the parties to reach an agreement to resolve the dispute. Unlike arbitration, the parties are under no compulsion to accept any ruling by the independent person. Changes to legal aid recommended by the Justice Secretary announced in November 2010 include the removal of legal aid for most clinical negligence claims (see below on pages 150) and also the encouragement for mediation to resolve issues.

Case management

The overriding principle enshrined in the Civil Procedure Rules[2] (see Box 6.1) is that all cases should be dealt with justly. The court must seek to give effect to this overriding principle when it exercises any powers under the rules and when it interprets any rule. The parties also have a duty to help the court to further this overriding objective. The court, in furthering this principle of dealing with cases justly, must actively manage the cases. Active management includes:

1 Encouraging the parties to cooperate with each other in the conduct of the proceedings.
2 Identifying the issues at an early stage.
3 Deciding promptly which issues need full investigation and trial and accordingly disposing summarily of the others.
4 Deciding the order in which the issues are to be resolved.
5 Encouraging the parties to use an alternative dispute resolution procedure if the court considers that appropriate, and facilitating the use of such procedure.
6 Helping the parties to settle the whole or part of the case.
7 Fixing timetables or otherwise controlling the progress of the case.

8 Considering whether the likely benefits of taking a particular step justify the cost of taking it.
9 Dealing with as many aspects of the case as it can on the same occasion.
10 Dealing with the case without the parties needing to attend court.
11 Making use of technology.
12 Giving directions to ensure that the trial of a case proceeds quickly and efficiently.

Box 6.1

The Civil Procedure Rules are a procedural code with the overriding objective of enabling the court to deal with cases justly. They are available online.[3]

Dealing with a case justly includes, so far as is practicable:

1 Ensuring that the parties are on an equal footing.
2 Saving expense.
3 Dealing with the case in ways which are proportionate:
   (a) to the amount of money involved;
   (b) to the importance of the case;
   (c) to the complexity of the issues; and
   (d) to the financial position of each party.
4 Ensuring that it is dealt with expeditiously and fairly.
5 Allotting to it an appropriate share of the court's resources, while taking into account the need to allot resources to other cases.

A prime mechanism for judicially led case management is the introduction of three tracks:

1 Small claims track
2 Fast track
3 Multi-track.

The court allocates each case to one of these three tracks on the basis of information provided by the claimant on the statement of the case. If it does not have enough information to allocate the claim then it will make an order requiring one or more parties to provide further information within 14 days.

Small claims track (CPR Part 27)

This provides a procedure for straightforward claims that do not exceed £10,000, without the need for substantial pre-hearing preparation and the formalities of a traditional trial and where costs are kept low.

Fast track (CPR Part 28)

Factors deciding whether a case is allocated to the fast track include: the limits likely to be placed on disclosure; the extent to which expert evidence may be necessary; and whether the trial will last longer than a day. Case management directions will be given at the allocation stage or at the listing stage.

Multi-track (CPR Part 29)

Other cases may be allocated to be dealt with on a multi-track basis and dealt with at a civil trial centre.

Pre-action protocol

Lord Woolf found that one of the major sources of increased costs and delay in clinical negligence litigation is at the pre-litigation stage and he therefore recommended the development and introduction

of a **pre-action protocol**. A draft protocol was drawn up in 1997 by the Clinical Disputes Forum and was formally launched on 23 July 1998.[4] The protocol sets a standard of good practice with emphasis on better handling of potential disputes and more effective and efficient management of information and investigation. It also sets out the steps to be followed where litigation is in prospect.

Summary judgment or other early termination

Part of the court's duty of active case management is the summary disposal of issues that do not need full investigation and trial. The court can strike out a statement of case or give a **summary judgment** where either claimant or defendant has no reasonable prospect of success.

Disclosure and inspection of documents

A party discloses a document by stating that the document exists or has existed. Rules relating to the disclosure and inspection of documents are to be found in Part 31 of the Civil Procedure Rules. There are rules relating to standard disclosure that list the documents that are to be disclosed. These include:

1 the documents on which the party relies;
2 the documents that adversely affect his own case or another party's case or support another party's case;
3 the documents that he is required to disclose by a relevant practice direction.

A party is required to make a reasonable search for any relevant documents. Some documents are obtainable before a case begins under the Supreme Court Act 1981 section 33. The nurse may well not be aware of this activity unless she is being personally sued or unless good communication ensures that she is kept in the picture. In *Harris* v. *Newcastle HA* [1989] 2 All ER 273, the court allowed pre-trial disclosure of records relating to events 26 years before, even though the health authority intended to plead that the case was out of time. The emphasis now is on full disclosure by each party to ensure that the case can be dealt with as promptly as possible.

Claim form is issued

This marks the beginning of the case. There are important time limits (discussed below) within which the claim form (originally known as a writ) is issued. The claim form indicates that action is now being commenced. It is preceded by what is known as a letter before action, i.e. a warning by the claimant (usually the claimant's solicitor) that if there is no acceptance of the claim, then the legal action will commence. The claim form usually names the NHS trust as the defendant, but it is possible for an individual employee to be named as a party and more than one defendant can be named.

Service of claim form (CPR Part 7)

This must be sent to the defendant within four months of its issue. (In the past there was a requirement for personal service, i.e. the claim form had to be handed to the defendant personally. Now, however, the claim form is sent to a known address or sent by fax or electronic methods under Rule 7.5.) The defendant must then respond by filing a defence or an admission or filing an acknowledgement of service. If the defendant fails to respond, the claimant may be able to obtain judgment in default.

The drafting of the documents or statements of case (these were once known as pleadings) is arranged by the respective parties' solicitors, who often instruct counsel (i.e. barristers). A litigant may, however, represent himself personally. Strict time limits are laid down for the service and response to the documents. Under the Woolf reforms, the documents exchanged between the parties should be simpler and be verified by the parties. If there are uncertainties, the court can require the parties to clarify any matter in dispute.

Pre-trial review

Eventually, there will be an assessment of the situation by the parties, together with a registrar or judge, account taken of the number of witnesses to attend, exchange of any experts' medical reports and, finally, the case will be set down for hearing.

Payment into court

Rules about offers to settle and **payments into court** are set out in Parts 36 and 37 of the Civil Procedure Rules. In some cases where there is dispute over the amount of compensation, but liability is accepted, the defendant will probably be advised to pay a sum in settlement of the case into court. If the claimant accepts this payment in, then the defendant will be liable for the claimant's costs up to that point. The court will be notified that there has been a settlement of the case. A payment in may also be made where the defendant does not accept liability, but he is not confident of winning the case and rather than risk losing and having to pay the costs of both sides he offers a sum in full and final settlement.

If the claimant decides that the payment in is not acceptable, the case will continue. In these circumstances, the judge is not told that there has been a payment in. He will not therefore be influenced by that in determining the case and deciding what compensation to award. If he awards less than the payment in or if he decides there is no liability by the defendant, then the claimant will have to pay both the defendant's costs from the time of the payment in as well as his own, since, of course, had the claimant accepted that sum deemed reasonable in comparison with the judge's award, there would have been no time-consuming and costly court hearing. These costs may well exceed the amount of the award. The judge has a discretion over whether to award the defendant the costs in these circumstances. An example of a refusal to accept a reasonable offer and becoming liable for the costs of a defendant is a case brought by a tourism student who sued his college for not warning him of leeches on a barefoot walk through a jungle. He was awarded £4,795 but could have to pay the college's court costs because he refused an offer of £10,000.[5]

The hearing

Claimant's case

Examination in chief

This is when questions are put to the witness by the party that has called him to give evidence.

The claimant has the burden of establishing to the satisfaction of the judge, on a **balance of probabilities**, that there has been negligence or some other alleged civil wrong. The claimant will therefore be asked to give evidence first.

His witnesses will be sworn in, in turn, and will then give evidence under examination of the claimant's legal representative. This has, in the past, usually been a barrister (counsel), instructed by the solicitor; however, increasingly solicitors are taking on an advocacy role. Sometimes the claimant appears personally. This initial questioning is known as **examination in chief**. The witness cannot be asked leading questions when being examined in chief. Counsel will have before him the proof of the witness statements to the solicitor and will take him through this to bring his evidence to the court.

Expert evidence

Expert evidence from witnesses may be required on the nature of the standard of care that should have been provided or on the amount of compensation payable. The new Civil Procedure Rules have led to major changes in the giving of expert evidence and these are discussed in chapter 9.

Cross-examination

Counsel for the defence is then able to question the witness, i.e. cross-examine. Here the task is to discredit the evidence by showing that it is irrelevant, unreliable or for some other reason is of no weight against the defendant. Alternatively, the witness can be used to support the case of the other

side. Leading questions are allowed when the witness is under cross-examination. The judge will, however, intervene to protect the witness from harassment. (See chapter 9 on giving evidence in court.) At this stage, the judge may wish to question the witness to clarify points on which he is not certain.

Re-examination

Finally, the side calling that witness has the chance of repairing any damage that the cross-examination has inflicted, but the re-examination is confined to points that have arisen during cross-examination or under questioning by the judge. All the claimant's witnesses give evidence in this way.

When the case for the claimant has ended, the judge has the opportunity of ending the case at this point and of finding against the claimant on the grounds that he has not established a *prima facie* case and therefore the defence is not required to give evidence. He cannot, of course, decide at this point against the defendant because the defence has not as yet given evidence.

Defendant's case

If the case proceeds, the defence must put forward its witnesses who are examined in chief, cross-examined and then re-examined as previously described. If it is alleged that the nurse has been negligent, she will be called as a witness for the defence. Several years may have elapsed since the events and her recall may be limited or even nil. She is able to refresh her memory by referring to contemporaneous records and therefore she should refer to the case notes. In this situation, she will appreciate the value of detailed, accurate, clear information on those events. Counsel who examines her in chief will have a copy of statements she has previously given. She should ensure that she had help in making this statement and prior to the court hearing she should be instructed on the procedure to be followed and some of the pitfalls she may encounter. Most of those who have appeared in court describe the event as particularly harrowing, and preparation is essential. (Giving evidence in court is discussed further in chapter 9.)

Judge's summing up

After summaries by counsel, the judge then has the task of making his or her judgment. This may be reserved, i.e. the parties are notified that they will be informed of the outcome, or it might be given immediately. The judge will determine both liability and damages (whichever are in dispute). The party having to pay costs will usually depend on the outcome, i.e. the loser pays the costs of both sides. There is no jury in a civil case (except in defamation cases, if the judge directs).

Res ipsa loquitur

In certain cases, inferences can be made from the facts about the existence of negligence.[6] If the claimant can establish that it is a *res ipsa loquitur* situation ('the matter speaks for itself'), then the defendant can be asked to show how the incident occurred without negligence on his part. The claimant would have to show the following factors to raise a presumption of *res ipsa loquitur*:

1 What has occurred would not normally occur if reasonable care were taken.
2 The events were under the control or management of the defendant.
3 The defendant has not offered any reasonable explanation for what occurred.

The most obvious example is leaving a swab inside a patient or amputating the wrong limb. The doctrine was applied when a patient went into hospital with two stiff fingers and was discharged with four stiff fingers: he was entitled to receive an explanation from the hospital as to how this could have happened without negligence on its part.[7] This procedure gives the claimant a technical advantage that is very necessary when he is ignorant of the actual events that caused harm. If the defendant fails to give a reasonable explanation of the events, the court can draw the inference that there was negligence. In a case brought against Tesco by a woman who slipped on some yoghurt that had been spilt on the floor, the doctrine was applied and Tesco found liable.[8] In medical negligence cases the effect of *res ipsa loquitur* is to enable the claimant to force the defendant to respond at peril of having a finding of negligence made against him.[9]

A surgeon who had been found negligent in carrying out a gall bladder operation appealed on the grounds that the judge should not have disapplied the *res ipsa loquitur* principle failed in his appeal. The Court of Appeal held that the judge had correctly addressed the issue as to whether negligence had been proved in the circumstances. The award of £92,391 damages was not unreasonable.[10]

Compensation in civil proceedings for negligence

Nurses sometimes meet patients who are hesitant to undertake all the necessary physiotherapy and other rehabilitative work lest the compensation (known as quantum) will be reduced because they are seen to have made a full recovery. However, the powers of the court to make provisional awards or award interim amounts of compensation should make it easier for a claimant to focus on rehabilitation. There is also a duty on a claimant to mitigate or reduce their loss. In medical cases the test will be whether in all the circumstances and the medical advice given the claimant acted reasonably (for example, in refusing surgery).[11] The chance of a recommended remedial operation failing to rectify the claimant's condition has to be taken into account in determining compensation payable. In 2009 the NHS Litigation Authority applied to set aside an award in the case of *Michael Spence* v. *Angela Naveda and Barking, Havering and Redbridge University Hospitals NHS Trust* of over £3 million paid to the claimant on the grounds that video evidence showed that he had not suffered such serious injuries as he claimed. A new figure of £300,500, of which the NHS trust was liable for £141,250, was agreed.[12]

An attempt to recover money already paid out was made by Bedford Hospital NHS Trust which had failed to detect fetal spina bifida. It had paid an interim sum of £705,000 with the final moneys due when the boy was 10, but he died aged 6 in 2011. The Trust claimed back £330,000 paid for his care. The mother had bought a four-bedroomed house adapted to his needs which might have to be sold to repay the moneys.[13] Solicitors have advised the mother to sell the home in order to repay the Trust.

A patient whose cancer was not diagnosed received £300,000 in an out-of-court settlement after losing his tongue and vocal cords. He went to his GP with a lump in his throat and suggested it may be cancerous since he worked with chemicals, but cancer was not diagnosed until the following year.[14]

A £2.8 million lump sum plus £383,000 a year until the victim was 19 when it would rise to £424,000 a year was paid by Great Ormond Street Hospital for Children to Maisha Najeeb whose brain was injected by glue. She was being treated for a brain condition where arteries and veins had been disentangled. There was no system in place to distinguish between two syringes: one with glue to block off bleeding blood vessels, and one with a harmless dye to monitor the flow of blood around the brain and head. As a result of the error, glue was wrongly injected into the artery causing catastrophic and permanent brain damage. She needed 24-hour care.[15]

How do you quantify compensation for a person who is wrongly told that they have a terminal illness? Denise Clark, aged 34, was told that she had terminal cancer, arranged her funeral and was then told the diagnosis was wrong. NHS Grampian is reported to have settled her case for a large five-figure sum.[16]

Ian Knauer was awarded £642,972, the bulk of it for lost services, following the death of his wife as a result of exposure to asbestos while employed at HM Prison Guys Marsh Dorset. The Ministry had admitted liability but disputed the amount of compensation[17].

Practical Dilemma 6.1 Leslie's leg

Leslie was travelling on his motorbike when a car started to overtake him. Unfortunately, a lorry was coming in the opposite direction and the vehicle pulled in to the side, knocking Leslie off. Leslie was admitted to the orthopaedic ward from A&E. He suffered a serious compound fracture. The prognosis was that he was unlikely to make a complete recovery and could anticipate further problems with the leg, a slight limp and a vulnerability to arthritis later on. He had been advised not to expect to return to his existing job (a PE instructor) for at least nine months. How will his likely compensation be calculated?

Special damages

Leslie will first be entitled to receive special damages. These are amounts to cover specific losses that have already been suffered and where the amount can therefore be accurately stated. For example, the loss and damage to his motorbike, damage to his clothing, loss of wages up to the present day. Interest is allowed on the items.

General damages

The headings under which such damages are calculated are shown in Box 6.2.

Box 6.2

1 Special damages: expenses and losses to the date of judgment.
2 General damages:
   (a) *non-pecuniary loss*:
      pain and suffering
      loss of amenity
   (b) *pecuniary loss*:
      loss of earnings
      loss of earning capacity
      cost of future care and expenses
      interest.

Non-pecuniary loss (i.e. non-financial loss)

1 *Pain and suffering*: this is to cover the pain from the injury itself, as well as from any consequential medical treatment and worry about the effects of the injury on the patient's lifestyle. It could also include damages for the mental suffering resulting from the fact that the person's life has been shortened. (Administration of Justice Act 1982 section 1(1)(a) introduced this form of compensation since there is no longer any compensation for the actual shortening of life itself. This used to be known as 'loss of expectation of life' and was abolished by this Act.)
2 *Loss of amenity*: Leslie will be able to recover additional compensation if it is established that his activities will be restricted because of the injuries to his leg. Clearly, if his leg had to be amputated, then he would recover an additional sum for that loss.

These non-pecuniary losses are notoriously difficult to calculate. How can money ever be an adequate compensation for blindness or loss of the ability to have children or to enjoy normal activities? The answer is that it cannot. However, since there is no other form of compensation, the non-pecuniary loss has to be converted into pecuniary form. Judges follow precedents in calculating the awards. They examine decisions in preceding cases, taking into account any relevant differences between the present case and the earlier cases and allowing for inflation. A judge's award is subject to appeal.

Pecuniary loss

1 *Loss of earnings*: Leslie's loss of future earnings would be calculated by determining his net annual loss multiplied by a figure to cover the number of years the disability will last. The figure takes into account the fact that the compensation will be paid out all at once rather than each week or month over the next few years. (Structured payments are now being introduced.)

2 *Loss of earning capacity*: because of his injury Leslie may never be able to work as a PE instructor again. Alternatively, he may retain his job initially, but with the risk that if he loses it he might never get similar paid work again because of his disability. He is entitled to be compensated for this risk.
3 *Expenses*: Leslie would also be entitled to recover reasonable expenses in getting to and from hospital, medical and similar expenses (e.g. physiotherapy) and, in some circumstances, domestic help. This may also include the costs of hospice care.[18]
4 *Interest*: interest is payable on the pecuniary loss already suffered and on the non-pecuniary loss.
5 *Deductions*: deductions are made in respect of the value of certain social security benefits, which are paid to the compensation recovery unit.

Interim payments can be made by the court under the Rules of the Supreme Court. The claimant can apply for an interim payment at any time after the claim form has been served on the defendant. Thus, where the defendant has admitted liability, but disputes the amount of damages payable, the court could make an order for an interim payment to be made. Because of the uncertainty of prognosis, there is the power for an order of provisional damages for personal injuries to be made if there is a chance that at some time in the future the injured person will, as a result of the act or omission, develop some serious disease or suffer some serious deterioration in his physical or mental condition (Supreme Court Act 1981 section 32A). Provisional damages in relation to exposure to asbestos were awarded in one case.[19] (The Mesothelioma Act 2014 is considered below see page 150). Where large settlements are to be paid, parties often agree a structured settlement whereby an annuity is purchased with part of the lump sum, thus providing an income to the claimant for life.

Case 6.1 *S (a child) v. Royal Bournemouth and Christchurch Hospital NHS Trust* (2012)

Brain damage at birth[20]

The boy was aged 14 at the date of the child settlement approval hearing. He had sustained severe brain injury during delivery resulting in his being diagnosed with severe four-limb athetoid cerebral palsy. His multiple difficulties led to his being highly dependent on others for his care needs. In particular he was unable to walk or stand independently, unable to care for his own hygiene and could not feed himself. He would never be able to achieve independence or undertake gainful employment. He was predicted to live for a further 40 years.

Past losses:	including sums for gratuitous care, accommodation, and aids and appliances	£273,227
Future losses:	Loss of earnings	£437,797
	Physiotherapy	£67,000
	Occupational Therapy	£40,440
	Speech therapy	£150,000
	Assistive technology	£200,000
	Holiday expenses	£133,045
General Damages for pain suffering and loss of amenity:		£230,000
Total damages on capitalised basis:		£7,102,012
Periodical payments:		£60,318 for two years
		£77,618 for 3 years
		£180,000 pa for life

Periodical payments based on a whole life multiplier of 25.42.

In December 2003 £5.75 million in agreed damages was awarded to Matthew King, then aged 8, who had been starved of oxygen at birth and suffered from cerebral palsy. South Kent Hospitals NHS Trust admitted liability for his injuries, but the valuation of his claim had been deferred so that his needs could be assessed.[21] In January 2004 Oliver Davies, then 8 years old, received £3.4 million damages for oxygen starvation at birth which led to acute cerebral palsy. Oxford Radcliffe Hospitals NHS Trust admitted liability. There had been an inexcusable delay in arranging an emergency delivery.[22]

Where there has been a failure to diagnose a terminal condition such as cancer, damages can be awarded for the loss of a chance of successful treatment being given, but it may be difficult for the claimant to establish, on a balance of probabilities, that it was more probable than not that the outcome would have been materially different had the diagnosis been made earlier[23] (see chapter 3 and causation).

Calculating amount of compensation

The House of Lords ruled that in awarding compensation, victims should not be expected to speculate on the stock market and therefore lower levels of return based on index-linked government securities can be used as the basis of calculation. The effect of this ruling was to increase the capital amount awarded to victims. In the case itself, James Thomas, a cerebral palsy victim as a result of negligence at birth, was awarded £1,285,000 by the High Court judge, but this was reduced by the Court of Appeal by £300,000 on the basis that the capital could be invested in higher return (but more risky) equities. The House of Lords restored the original amount.[24] Subsequently the Lord Chancellor issued a statement[25] which recognised that the use of index-linked government stock as the basis for calculation was appropriate, even though the Court of Protection invested client funds partly in equities. Courts were able to adopt a different rate if there were exceptional circumstances under section 1(2) of the Damages Act 1996.

The Law Commission recommended changes to the present system relating to the quantifying of damages for personal injury[26] in 1996 and suggested, among other recommendations, that the NHS should be able to recover the costs arising from the treatment of road traffic and other accident victims. It is estimated that this might bring in £120 million to the NHS. A later report by the Law Commission[27] in 1999 recommended that compensation for non-pecuniary loss (e.g. pain, suffering and loss of amenity) should be increased and this could be implemented through the courts' decisions on damages. The Court of Appeal gave judgment in March 2000[28] and decided that a modest increase was required to bring some awards up to a figure that was fair, reasonable and just. It recommended that damages for claims above £10,000 should be raised by a maximum of about 35 per cent with increases tapering downwards. The Court of Appeal acknowledged that the life expectancy for many seriously injured claimants has increased and they can now survive for many years. In 2012 the Court of Appeal announced an increase in general damages by 10 per cent in accordance with the recommendations of the Jackson final report on civil litigation costs.[29] (See below page 152.) The Court of Appeal has the responsibility of monitoring and where appropriate altering the guideline rates for general damages in personal injury cases. The continuity of future periodic payments as a result of the possible failure of the NHS foundation was questioned in one case. The judge held that the continuity was reasonably secured because arrangements had been agreed whereby the NHS Litigation Authority was the source of the payments and was therefore legally responsible for the payments.[30]

The principles of determining the compensation payable when a child is born following a failed sterilisation or a failure to advise a woman that the fetus is suffering from disabilities (and therefore the possibility of a termination not being discussed) are considered in chapter 15.

Defences to a civil action

A considerable number of claims that are brought against NHS trusts and health authorities are dropped before they reach a final outcome, and many of those that survive to the end are unsuccessful.

They may fail because on investigation there are no grounds for negligence or some of the other defences succeed. This section looks at the defences open to a nurse or her employer in civil actions for negligence.

Denial of facts

It often happens that, when things go wrong, it is one person's word against another. The patient might complain that the nurse has been negligent, but the nurse might be able to show that the events were not as the patient describes. Many court cases are simply disputes over facts. Where only two people are involved, with no other witnesses and no other circumstantial evidence, if such a case comes before the courts, the judge will have to decide, on the basis of the evidence in court and the way the parties stand up to cross-examination, which account of the events is acceptable. Records of what took place can be of considerable significance in determining the outcome of the hearing.

In civil cases, the burden is on the claimant to establish, on a balance of probabilities, that the defendant has been negligent.

A missing element

Even where the facts are not disputed, it might still be possible for an action for negligence to be defended on the grounds that one of the essential elements is missing. From chapter 3 it will be recalled that to succeed in a negligence case it is necessary for the claimant to establish that a duty of care was owed by the defendant, that the defendant was in breach of this duty and that this breach caused reasonably foreseeable harm to the claimant. If one of these elements has not been established on a balance of probabilities, then the defendant will win the case.

Contributory negligence

Practical Dilemma 6.2 Walking aids

Fred, who has recently had an operation for a fractured leg, has been receiving help from the physiotherapist in walking with crutches. Fred asks a nursing auxiliary, who has only just come on to the ward, for help in going to the toilet. She is not aware that Fred has been told not to try to walk yet unless he is accompanied by a qualified person. She assists him out of bed and on to the crutches. As she does so, the crutches slip from under Fred and he falls to the ground, sustaining another fracture.

In this situation, the nursing auxiliary or the ward management are clearly at fault in allowing Fred out of bed in these circumstances. However, Fred is also at fault. He should have followed instructions. Fred's responsibility for the harm that has occurred depends to a large extent on his level of understanding, how clear the instructions were to him and how reasonable it was to expect him to have waited for experienced help in using the crutches. If he were to sue the NHS trust and its staff, they may well defend themselves on the grounds that he was partly at fault in not taking care of himself. This defence is known as a defence of contributory negligence. The defendant is saying to the claimant: 'You failed to take care of yourself and that has led to or increased the harm that you have suffered.' If the judge is satisfied that the defendant has succeeded in this defence, he is able to reduce the compensation by the extent to which he considers the claimant's fault has contributed to the harm. The wording of section 1 of the Law Reform (Contributory Negligence) Act 1945 is shown in the following Statute Box 6.1.

Statute 6.1 Law Reform (Contributory Negligence) Act 1945 Section 1

Section 1(1) Where any person suffers damage as the result partly of his own fault and partly of any other person or persons a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such an extent as the court thinks just and equitable having regard to the claimant's share in responsibility for the damage.

Case 6.2 *Froom* v. *Butcher* (1975)

No seatbelt[31]

Mr Froom was driving his car carefully at a speed of 30–35 mph with his wife sitting beside him and his daughter in the back seat. The front seats were fitted with seatbelts, but neither Mr nor Mrs Froom was wearing one. Unfortunately, Mr Froom's car was struck head-on by a car travelling at speed in the opposite direction and on the wrong side of the road as it had pulled out to overtake a line of traffic.

The trial judge decided that failure to wear a seatbelt was not contributory negligence. The defendant appealed to the Court of Appeal and won his appeal. Lord Denning emphasised that where the damage to the claimant would not have been reduced by failure to wear the seatbelt, then there should be no reduction of compensation, but where, as here, the injuries would have been reduced by wearing a seatbelt, there should be a reduction of compensation. In Mr Froom's case, the injuries to the head and chest would have been prevented by wearing a seatbelt. His finger would have been broken anyway and therefore there was no reduction on that account. The overall deduction of compensation for Mr Froom's contributory negligence was held to be 20 per cent. (This case was heard before the wearing of front seatbelts was compulsory.)

Reductions of compensation on grounds of contributory negligence can vary from 95 per cent to 5 per cent. When it is larger, then there is held to be no liability on the part of the defendant; when it is smaller it is considered to be too insignificant to count. To succeed, the defendant has to establish that the claimant failed to take reasonable care of himself and that this failure contributed to the harm he suffered, or increased it. In the case of *Badger* v. *The Home Office*,[32] the deceased was employed by the defendants as a boiler maker and it was established that he had been exposed to asbestos. However, he was also a smoker and that had contributed to his death by lung cancer. The compensation awarded to his widow was reduced by 20 per cent because a reasonably prudent man would have stopped smoking.

Contributory negligence and children

Lord Denning has said:

> **A very young child cannot be guilty of contributory negligence. An older child may be; but it depends on the circumstances. A judge should only find a child guilty of contributory negligence if he or she is of such an age as reasonably to be expected to take precautions for his or her own safety: and then he or she is only to be found guilty if blame should be attached to him or her.**

In the same case, Lord Justice Salmon said:

> **The question as to whether the plaintiff can be said to have been guilty of contributory negligence depends on whether any ordinary child of 13½ years could be expected to have done any more than this child did. I say 'any ordinary child'. I do not mean a paragon of prudence; nor do I mean a scatter-brain child; but the ordinary girl of 13½ [the age of the child in that case].**[33]

Willing assumption of risk (*volenti non fit injuria*)

Sometimes, where there is a known risk, the possibility of this taking place is accepted and the defendant is not liable. The most obvious example is dangerous sports where both players and spectators are at some risk. If that risk occurs, it is assumed that there will be no court action, but that the risk has been willingly accepted (known as ***volenti non fit injuria***). For example, in a rugby match it is possible that a player may be seriously injured, even though no rules have been broken and there is no criminal act. This is a risk of the game and is accepted by the players. If, of course, the rules have been broken and thus resulted in injuries, then the injured player may well have an action for assault.

In the health service context, the agreement by the patient that treatment can proceed counts not only as consent to what would otherwise constitute a trespass to the person, but it is also an acceptance of the possibility that those hazards that are an inextricable risk of that particular treatment could occur. Consent, however, does not imply consent to the risk that the professional will be negligent (see chapter 7 on consent).

Practical Dilemma 6.3 | Blood donor

Rachel had been giving blood for many years. She was summoned on one occasion to the session. As the needle was inserted and the cannula put in place, she felt an appalling pain. She shrieked and the needle was quickly withdrawn and a new painless site was found. After the session, Rachel found that it was very difficult to move her hand, arm and fingers. She was examined by a doctor who sent her for tests and eventually she was told that a very rare damage to the nerve had occurred. However, she was assured that with physiotherapy she would soon recover full function. Unfortunately, this did not prove to be true. She was eventually forced to take early retirement on the grounds of ill health and did not recover full arm or hand movement. She sought advice about suing the doctor and was given an expert's report that such a rare event could occur without any negligence on the part of the doctor, so that there was no point in suing either the doctor or the blood transfusion authority. However, Rachel argued that if she had known of the risk she would not have agreed to give blood unless she had been given an assurance that in the event of the risk taking place she would have received compensation.

As the law stands at present, unless Rachel can show negligence (either in carrying out the treatment or in failure to warn her of the risk of harm) by the professional staff or the employer, she would be unable to recover compensation in court. We do not have a system of no-fault liability. As a volunteer, she can be assumed to have accepted the possibility of those risks occurring, although she may well be able to show that there was a breach of the duty owed to her as a volunteer if certain risks were not pointed out to her. The Pearson Report on compensation for personal injuries recommended that there should be an acceptance of no-fault liability for volunteers in medical research. These recommendations have not been implemented in law (although pharmaceutical companies offer compensation on a no-fault liability basis to those who take part in drug trials (see chapter 28)) and it could be argued that if the recommendations are ever implemented they should be extended to cover such situations as donation of blood. In such situations, many NHS trusts would make an ex gratia payment, i.e. a payment without any acceptance or implication of liability on its part.

To establish a defence of willing assumption of risk, the defendant has to show that the claimant knew of the risk, willingly consented to run it and waived any right to sue for compensation. If it is successfully pleaded, it operates as a total defence.

Sometimes employers have tried to rely on this defence when sued by an employee for injuries at work. For example, it has been said that back injuries are an occupational hazard for nurses; all psychiatric

nurses accept the risk of physical violence; central sterile supply department (CSSD) assistants are likely to suffer from 'sharp' injuries as an occupational hazard. However, it is quite clear that where there is a failure of the employer in his duty to care for the employee's safety, then the defence of willing assumption of risk will not prevail. (See chapter 12 on health and safety law.)

Exemption from liability

NHS trust premises are a blaze of exemption notices: 'no responsibility is taken for cars parked in this area'; 'the "X" NHS trust accepts no liability for patients' property'. How effective are these notices if the NHS trust or its employees are negligent? Can a patient be persuaded to sign a form saying that he will not hold the 'X' NHS trust liable in any respect? Sometimes an NHS trust responds to a complaint by asking for a declaration that if the complaint is to be pursued and an investigation conducted, then the NHS trust requires an assurance that there will be no civil action. Can such a declaration be held against the person who signed? The answer to these questions is to a considerable extent given by reference to the Unfair Contract Terms Act 1977. This Act prevents anyone in the course of any business activity (and this covers professional, local and public authority activity) from exempting himself from negligence if that negligence gives rise to personal injury or death. Any agreement, notice or clause to that effect is void (see Statute Box 6.2 on page 147).

Practical Dilemma 6.4 No liability

A surgeon said: 'I am prepared to carry out upon you a very risky operation and I want you to sign that you will exempt me from all blame if anything goes wrong.' The patient, in his desire to have the operation, signed the form, but, unfortunately, the surgeon made a very careless error that no competent surgeon would have made, leaving the patient severely disabled.

Is the patient bound by that form? The answer is no. The Unfair Contract Terms Act prevents the surgeon relying on that form as a defence against the patient. He cannot exclude or restrict his liability for death or personal injury resulting from his negligence. The same principles do not apply to loss of or damage to property. Under the Unfair Contract Terms Act 1977, an exemption for damage to or loss of property is valid if it is reasonable (see Statute Box 6.2). (For further discussion on this, see chapter 25.)

Limitation of time

Most civil court actions must be brought within a certain length of time. The time limit for actions concerning personal injury and death is three years from the cause of action arising or the date of the knowledge of the cause of action arising. The issue of the claim form marks the beginning of the court action and it is the time that elapses from the cause arising to the day the claim form is issued that is critical.

Knowledge of the harm

If a patient did not realise that he was suffering from the effects of someone's negligence in that time, then the time limit does not apply until he has that knowledge. It used to be law that if the claimant was out of time for whatever reason then he was barred from proceeding with the case. The injustice of this rule is very easy to see from cases involving such long-term diseases as pneumoconiosis, asbestosis and similar conditions. The law was therefore amended so that the period did not start to run until the claimant had knowledge of the facts shown in Statute Box 6.3.

The potential claimant cannot, however, simply turn a blind eye to knowledge that any reasonable person would acquire from the facts around him. If, however, he had no knowledge of the facts, then he is not barred from proceeding.

In a significant decision the House of Lords[34] ruled in January 2008 that claims could be brought by the victims of rape and sexual assault outside the time limit, if the judge ruled that the personal characteristics of the claimant might have prevented him or her acting as a reasonable person. Three of the cases were remitted to High Court for reconsideration in the light of the House of Lords ruling. It overruled its previous decision in the case of *Stubbings* v. *Webb*[35] and allowed time-barred appeals in cases which involved a rape victim, whose rapist had subsequently won the lottery, and several victims of sexual assault by council employees in council run schools or residential homes. The consequence of the decision is that many thousands of victims of indecent assault may pursue claims against councils and churches. The High Court also held that claims by former servicemen for radiation injury resulting from nuclear tests in the 1950s could go ahead and were not to be struck out on grounds that they were time-barred or had no reasonable prospect of success.[36] The Court of Appeal held that all the cases but one were statute-barred ([2010] EWCA Civ 1317). The Supreme Court in 2012[37] dismissed the appeals by a 4 to 3 majority. The Supreme Court was divided on how knowledge should be determined. The majority took the view that a reasonable belief of the possibility that injuries were the result of fault was what was required; the minority held that a claimant's knowledge, not belief, was the relevant issue and that by definition knowledge must be based on fact. The majority also held that the use of the judge's discretion under section 33 to permit the case to continue would not be appropriate.

Statute 6.2 Sections from the Unfair Contract Terms Act 1977

1 Scope of Part I

1 For the purposes of this part of this Act, 'negligence' means the breach:
   (a) of any obligation, arising from the express or implied terms of a contract, to take reasonable care or exercise skill in the performance of the contract
   (b) of any common law duty to take reasonable care or exercise reasonable skill (but not stricter duty)
   (c) of the common duty of care imposed by the Occupiers' Liability Act 1957 or the Occupiers' Liability Act (Northern Ireland) 1957.

2 This part of this Act is subject to Part III; and in relation to contracts, the operation of Sections 2 to 4 and 7 is subject to the exceptions made by Schedule 1.

3 In the case of both contract and tort, Sections 2 to 7 apply (except where the contrary is stated in Section 6(4)) only to business liability, that is liability for breach of obligations or duties arising:
   (a) from things done or to be done by a person in the course of a business (whether his own business or another's), or
   (b) from the occupation of premises used for business purposes of the occupier; and references to liability are to be read accordingly. (Addendum added by Occupiers' Liability Act 1984 on liability of an occupier of premises for recreational or educational purposes not a business liability unless granting the person access falls within the business purposes of the occupier.)

4 In relation to any breach of duty or obligation, it is immaterial for any purpose of this part of this Act whether the breach was inadvertent or intentional, or whether liability for it arises directly or vicariously.

2 Negligence liability

1 A person cannot by reference to any contract term or to a notice given to persons generally or to particular persons exclude or restrict his liability for death or personal injury resulting from negligence.

2 In the case of other loss or damage, a person cannot so exclude or restrict his liability for negligence except insofar as the term or notice satisfies the requirement of reasonableness.

3 Where a contract term or notice purports to exclude or restrict liability for negligence a person's agreement to or awareness of it is not of itself to be taken as indicating his voluntary acceptance of any risk.

11 The 'reasonableness' test

3 In relation to a notice (not being a notice having contractual effect), the requirement of reasonableness under this Act is that it should be fair and reasonable to allow reliance on it, having regard to all the circumstances obtaining when the liability arose or (but for the notice) would have arisen.

4 Where by reference to a contract term or notice a person seeks to restrict liability to a specified sum of money, and the question arises (under this or any other Act) whether the term or notice satisfies the requirement of reasonableness, regard shall be had in particular (but **without prejudice** to subsection (2) above in the case of contract terms) to:

(a) the resources which he could expect to be available to him for the purpose of meeting the liability should it arise, and

(b) how far it was open to him to cover himself by insurance.

5 It is for those claiming that a contract term or notice satisfies the requirements of reasonableness to show that it does.

14 Interpretation of Part I

In this part of this Act: 'business' includes a profession and the activities of any government department or local or public authority.

Statute 6.3 Limitation Act 1980 Section 14

Definition of knowledge

(a) that the injury in question was significant

(b) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence

(c) the identity of the defendant, and

(d) the identity of any other defendant.

The term 'significant' is further defined as where 'the person whose date of knowledge is in question would reasonably have considered it sufficiently serious to justify instituting proceeding against a defendant who did not dispute liability'. (A subsection 1A to section 14 is added by the Consumer Protection Act 1987 to cover the date of knowledge for the purposes of that Act.)

Practical Dilemma 6.5 Delay

Claire French was admitted for an appendicectomy. The operation was performed successfully and she was discharged. From time to time, however, she complained of violent stomach pain for which she took very strong painkillers. Some six years after the first operation, she was admitted to hospital in intense agony and no painkiller could relieve it. The consultant was reluctant to operate since he could not identify any possible cause for which surgery was the solution. However, a laparoscopy was performed and it was then discovered that a swab had been left behind in the previous operation. The consultant was completely open with Claire about his findings and assured her that from now on she should not get any pain. She felt that she should be compensated for the fact that she had already suffered much pain and had had to endure the risks, pain and suffering of a second operation. Is she entitled to compensation?

As a result of the changes by the Limitation Act 1980, she would not be barred on the grounds of exceeding the time limit, which would run from the time she was informed of the cause of her suffering. The House of Lords has eased the time limit of those suing for rape or sexual assault.[38]

Judge's discretion to extend time limit

In addition, under section 33 of the Limitation Act 1980 the judge has the discretion to allow a case to proceed that would otherwise be outside the time limit where it would be equitable to allow the claimant to continue. A judge refused to extend the time limit in the following case.

Case 6.3 *Fenech v. E. London and City Health Authority* (2000)

No extension of time[39]

On 5 July 1960 the claimant gave birth to her first child. Afterwards, the doctor suturing her episiotomy informed her that the needle that he had been using had broken. In fact, a two-inch piece of the needle had been left inside the wound. The claimant experienced pain in the area of the episiotomy, but was too embarrassed to discuss her symptoms with her general practitioner. She gave birth to five more children. In 1983, she came under the care of a female gynaecologist and underwent a number of negative investigations and operations over a period of 11 years. The fragment of the needle was identified on a hip X-ray when she was being reviewed by orthopaedic surgeons in 1991, but it was not until a repeat X-ray in 1994 that she was informed of the needle's presence. She issued proceedings in January 1997 and the issue of limitation was tried as a preliminary point. At the County Court, her claim was held to be statute-barred: although she had not attained actual knowledge until 1994, she had had constructive knowledge 'long before 1994'. She appealed to the Court of Appeal on the grounds that the judge had erred in refusing to take into account her embarrassment when considering when she ought reasonably to have sought medical advice and the defendant could not prove that such earlier advice would have led to an earlier detection of the needle fragment.

The Court of Appeal dismissed the appeal on the grounds that she should have sought medical advice earlier; she failed to give the gynaecologist sufficient information about her symptoms and, while the 1991 X-ray had revealed the fragment of the needle, its significance and relationship to her gynaecological problems were not realised by the orthopaedic specialists who were reviewing her for a hip replacement.

In contrast, in the case of *Amanda Godfrey* v. *Gloucester Royal Infirmary NHS Trust*,[40] in which the claimant argued that while she had been told following an ultrasound scan that her baby (who was born in 1995) had severe abnormalities, she did not have sufficient information to make a decision about a termination until she read the medical report in 2001, the judge did not accept this argument but was still prepared to exercise his discretion under section 33 of the Limitation Act 1980 and held that it was equitable to allow the case to proceed. In the case[41] of a boy born with cerebral palsy, the Court of Appeal held that he was expected to bring a claim of negligence within three years of his actual knowledge or such knowledge as he might reasonably be expected to acquire to mount a claim against the defendant responsible for causing the injury. Applying this test, the claimant had constructive knowledge of the facts by 1998 and the claim (which was brought in 2006) was statute-barred but the Court exercised its discretion under section 33 and allowed the claim to proceed on equitable grounds.

Extension of the time limit on other grounds

Where minors under 18 years of age have suffered personal injury, there is no time barrier to bringing an action until they reach the age of 18 years, at which time the time limit comes into operation. (See chapter 13 on children.) The same principle applies to those of unsound mind whose disorder prevents them from bringing an action within the appropriate time limits. The time limits do not commence until the disorder ceases, which in most cases will be at death.

Legal aid and conditional fees

One of the recent changes in civil justice is the withdrawal of legal aid in personal injury claims. The introduction of **conditional fee systems** into civil litigation, sometimes referred to as 'no win, no fee', enables an agreement to be drawn up between solicitor and client, whereby the former would act on behalf of the latter in civil proceedings and only claim a fee if the outcome is satisfactory to the client. Regulations[42] that came into force in June 2003 enabled clients to enter into simpler, more transparent conditional fee agreements (CFAs) with the solicitors and enable solicitors to guarantee to clients that they would get all the damages awarded. In some cases, especially those involving clinical negligence, it may be necessary for the client to purchase insurance cover for possible witnesses and other costs. The Conditional Fee Regulations 2000 and 2003 were revoked in November 2005[43] with the aim of simplifying CFAs and making them more transparent and easier to use for both solicitors and their clients. Further information on CFAs is available from the Bar Council website.[44]

From April 2013 the attractions of no win, no fee have been reduced by changes which mean that claimants can no longer recover the extra fees that they must pay their lawyers or their legal insurance premiums from the losing side.[45] Commercial third party funding schemes have begun whereby they agree to fund a case if the claimant's solicitor provides a convincing argument that it will ultimately succeed. The fee comes out of recovered damages.[46] The fees which lawyers can charge for personal injury cases have also been reduced from May 2013. Fees for minor injuries in road accidents have been cut from £1,200 to £500. Referral fees paid between lawyers, insurers, claims firms, garages and others when cases are passed on are banned.[47]

Insurers are also seeking MRI scans on claimants who are seeking compensation for alleged whiplash injuries.[48]

Section 44 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 amended the Act 1990 so that a success fee payable under a CFA may no longer be recovered by a lawyer from a losing party but is subject to additional conditions[49]. The Conditional Fee Agreements Order 2013/689 makes provision as to how the success fee should be calculated: in a claim for personal injuries the success fee is limited to a maximum of 25 per cent of damages awarded for pain, suffering and loss of amenity and pecuniary loss. The Damages-Based Agreements (DBA) Regulations[50] set conditions for them to be enforceable under the Courts and Legal Services Act 1990. A cap of 25 per cent for a DBA is set in a claim for personal injuries.

The Financial Services (Banking Reform) Act 2013 places claims management complaints in the jurisdiction of the Legal Ombudsman who has the power to force companies to pay compensation or provide another form of redress. The result is that those bombarded by ambulance chasers could receive compensation through the Legal Ombudsman. The Claims Management Regulation Unit (at the Ministry of Justice) will be able to fine companies which use information provided by unsolicited calls and texts or who provide poor quality services. Referral fees paid to middlemen are banned. The Legal Ombudsman[51] reported in January 2014 that nearly £1 million in compensation was ordered to be paid to clients because of disputes over no win, no fee agreements.[52]

A special out-of-court scheme to settle compensation for those with asbestos related disease has been set up. The Mesothelioma Act 2014 creates a package of support – funded by insurance firms – to pay in excess of 800 eligible people in 2014, and 300 every year after that until 2024. Further information is available on the government website[53] and from the Asbestos Victims Support Group Forum.[54] (See chapter 26.)

Clinical Negligence Scheme for Trusts (CNST) and the NHS Litigation Authority (NHSLA)

The CNST was established in 1996[55] to administer trusts and other NHS bodies that take part in a voluntary scheme whereby compensation is met from a pooling system. The payment into the pool depends on an assessment of the risk presented by that particular trust and amounts over a specified minimum will be met from the pool. The CNST visits organisations that belong to or wish to belong to the scheme to assess their risk: they examine, in particular, the standard of risk assessment and management in the organisation, and the standards of record keeping. In the light of their assessment, premiums payable into the scheme are assessed. Over 95 per cent of NHS trusts are members of CNST. Liabilities prior to April 1995 are covered by the Existing Liabilities Scheme (ELS), which is centrally funded. The NHS Litigation Authority (NHSLA) is a special health authority, i.e. a statutory body, set up in 1995 to oversee the CNST in the handling of claims. The NHSLA uses an approved list of solicitors to handle litigation. In one case,[56] when the parties disputed the details for the setting up of a structured settlement, the claimant gave notice that they would ask the judge to summon the NHSLA's chief executive to explain why the defendants were attempting to charge the claimant for setting up the structured settlement. The defendants then reached agreement with the claimant. The NHSLA is subject to an annual performance review. A key function for the NHSLA is to contribute to the incentives for reducing the number of negligent or preventable incidents. It aims to achieve this through an extensive risk management programme. It has designed a set of risk management standards for each type of healthcare organisation, incorporating organisational, clinical, and health and safety risks. They cover: NHSLA Acute, PCT and Independent Sector Standards; NHSLA Mental Health and Learning Disability Standards; and NHSLA Ambulance Standards. In addition, the CNST has devised a set of standards for maternity services. These standards can be accessed on the NHSLA website.[57] The NHSLA has a key role to play in encouraging the implementation of NICE guidance, and has prepared a joint paper with NICE on litigation which is available on the NHSLA website.

Amendments to the Clinical Negligence Scheme for Trusts were enacted through regulations in 2014.[58] These update the definition of relevant function relating it to how services are now commissioned and covers the activities of bodies exercising other functions in relation to the health service and other powers to generate income.

NHS Redress Act 2006

The National Audit Office reported in May 2001 that almost £4 billion would be required to meet the costs of known and anticipated claims in the NHS.[59] In the light of this report, the DH announced in July 2001 that it was setting up a committee under the chairmanship of the Chief Medical Officer of Health to consider a new scheme for compensation for clinical negligence and published a consultation paper.[60] This was followed, on 30 June 2003, by a further consultation document, 'Making Amends',[61] which provided a comprehensive account of the background to the present situation. It looked at the present system of medical negligence litigation and its costs. It analysed public attitudes and concerns and the earlier reviews of the negligence system by the Pearson Commission,[62] the Woolf Report on Access to Justice[63] and the National Audit Office Report in 2001.[64] It considered recent action taken to reform civil court procedures, claims handling by the NHS Litigation Authority and the use of alternative dispute resolution. It analysed systems of no-fault liability in Denmark, Finland, France, New Zealand, Norway and Sweden and discussed no-fault liability as an option along with continued reform of the present tort process, a tariff-based national tribunal or a composite option drawing on all three. The scheme eventually recommended in 'Making Amends' was a composite package of reform drawing on the best elements of these three options. It included suggestions for the care and compensation for severely neurologically impaired babies; for the NHS redress scheme to be part of the system for handling

complaints; for the retention of right to pursue litigation through the courts and changes to the existing scheme for civil proceedings; and for a duty of candour to be placed on healthcare professionals and managers to inform patients where they become aware of a possible negligent action or omission.

The NHS Redress Act which was eventually agreed was a very much less radical scheme than that proposed in the consultation paper. It gave power to the Secretary of State to establish a scheme for the purpose of enabling redress to be provided without recourse to civil proceedings. The NHS (Clinical Negligence Scheme) Regulations 1996 SI were the principal regulations and have been amended most recently by an SI in 2013[65] which added a number of additional bodies to be eligible to take part in the scheme including NICE, the Health and Social Care Information Centre, local authorities which provide or arrange for the provision of NHS services plus other changes.

On 1 April 2011 in Wales regulations were implemented to deal with complaints against the NHS providers. There is a redress scheme for the resolution of low-value clinical negligence claims (those under £25,000). Further details can be found on the Welsh Assembly website.[66]

On 18 March 2009, in response to a written question, a statement was made by Lord Darzi to the effect that the government's priority was to put in place across the health and social care in the country general foundations of redress, in its wider sense, by placing the patient at the heart of any complaints system and move to a more robust sensitive complaints procedure. In other words, the government's priority was the NHS Constitution and the rights and pledges outlined in that, rather than the implementation of the NHS Redress Scheme, which has not yet been enacted in England.

Reforms to civil litigation

In 2010 the Final Report of Lord Jackson's review on civil litigation costs was published and has resulted in many of the changes to the conditional fee system outlined above being implemented.[67] The Review considered that the consequences of its recommendations were that:

Most personal injury claimants will recover more damages than they do at present, although some will recover less
Claimants will have a financial interest in the level of costs which are being incurred on their behalf
Claimant solicitors will still be able to make a reasonable profit
Costs payable to claimant solicitors by liability insurers will be significantly reduced
Costs will also become more proportionate, because defendants will no longer have to pay success fees and after-the-event insurance premiums.

Conclusions

Unfortunately, little progress seems to have been made in the reform of the current system for obtaining compensation for clinical negligence. Earlier criticisms of the handling of clinical negligence cases from the Public Accounts Committee[68] and the Health Service Committee of the House of Commons with the possible introduction of no-fault compensation being introduced[69] have not been acted upon. The NHS redress scheme, which does not contain the radical proposals set out in 'Making Amends', has not at the time of writing been implemented in England though it has been in Wales and there is ongoing concern that in the vast bills for clinical negligence more money is going to lawyers than to claimants.[70] The Jackson report has not met with unqualified support from lawyers,[71,72] but the Young Report recommended its speedy implementation (see chapter 12). Obtaining legal aid in civil cases has become more difficult and there is more regulation of no win, no fee schemes. For those who have suffered harm as a result of negligence by health and social care providers obtaining compensation is becoming more and more difficult. It may be that the statutory duty of candour by organisations may assist potential litigants (see chapter 5).

Reflection questions

1. Look at the aspects of case management as set out on pages and consider the extent to which this should ensure that cases are dealt with faster and more justly to the parties.
2. What is meant by *res ipsa loquitur*? In what situations in healthcare do you think it could apply?
3. What is the difference between pecuniary loss and non-pecuniary loss as a result of a civil wrong? How is compensation for the latter calculated?
4. What is meant by contributory negligence? What are the principles on which the judge works in deciding the level of deduction of compensation? (See Statute Box 6.1)
5. Are there any tasks that you perform that are likely to cause harm to you? Do you consider the principle of *volenti non fit injuria* applies to any of them and, if so, why?

Further exercises

1. Examine the notices in your hospital that disclaim any responsibility for loss or damage. Consider any ways in which they might not be completely effective in the light of the Unfair Contract Terms Act 1977.
2. What action do you consider could be taken to reduce the level and therefore the cost of litigation within the NHS?
3. Obtain a copy of your local complaints scheme and consider the extent to which its implementation could reduce civil action being brought within the NHS.

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Chapter 7

Consent to treatment and informing the patient

This chapter discusses

- Basic principles
- Requirements of a valid consent
- How should consent be given?
- Right to refuse treatment
- Taking one's own discharge
- Definition of mental capacity under the Mental Capacity Act 2005
- Hunger strikes
- Amputation of healthy limbs
- Defences to an action for trespass to the person
- Mental Capacity Act 2005
- Mental Health Act 1983
- Giving information to a patient prior to consent being obtained
- Non-therapeutic procedures
- Giving information to the terminally ill patient
- Notifying the patient of negligence by a colleague
- No decision about me, without me

Introduction

This chapter covers the principles relating to consent to treatment and giving information to the patient.

Basic principles

Any adult, mentally competent person has the right in law to consent to any touching of his person. If he is touched without consent or other lawful justification, then the person has the right of action in the civil courts of suing for **trespass to the person – battery** where the person is actually touched, **assault** where he fears that he will be touched. The fact that consent has been given will normally prevent a successful action for trespass. However, it may not prevent an action for negligence arising on the ground that there was a breach of the duty of care to inform the patient. This chapter explores both these aspects of consent and looks at the information that must be legally given to the patient and other questions that arise on informing the patient. Reference should be made to chapter 13 on consent in relation to children and young persons – those under 18 years; to chapter 20 on consent in relation to the mentally disordered; to chapter 19 on consent in relation to the elderly; and to chapter 17 in relation to those with learning disabilities. The situation relating to AIDS and HIV is considered in chapter 26 and to operations in chapter 16.

Requirements of a valid consent

To be valid, consent must be given voluntarily by a mentally competent person without any duress or fraud. In the case of *Freeman* v. *Home Office*,[1] a prisoner challenged the legality of his being injected with drugs for his personality disorder on the basis that he had not given his consent and that being given medicine by a doctor in a custodial situation precluded consent being voluntarily given. The Court of Appeal refused to accept this proposition and agreed with the High Court judge that: 'Where, in a prison setting, a doctor has the power to influence a prisoner's situation and prospects, a court must be alive to the risk that what may appear, on the face of it, to be real consent is not in fact so.' There is a presumption that the patient is mentally competent, now enshrined in statutory form in section 1(2) of the Mental Capacity Act 2005. However, this can be rebutted on a balance of probabilities (s. 2(4) of the Mental Capacity Act 2005) if there is evidence to the contrary. The criteria to be used in assessing competence are set by sections 2 and 3 of the Mental Capacity Act 2005 and are shown in Statute Box 7.1. Where a person falsely claims to be a doctor and gave a woman a breast examination, she had not consented to the treatment.[2]

How should consent be given?

Figure 7.1 illustrates the different forms of giving consent. As far as the law is concerned, there is no specific requirement that consent for treatment should be given in any particular way. They are all equally valid. However, they vary considerably in their value as evidence in proving that consent was given. Consent in writing is by far the best form of evidence and is therefore the preferred method of obtaining the consent of the patient when any procedure involving some risk is contemplated. The Department of Health updated its guidance on consent to examination and treatment in 2001 and produced two publications: a reference guide to the principles on consent to examination and treatment[3] and a good practice in consent implementation guide.[4] Subsequently the Department of Health amended the reference guide[5] and indicated the changes necessary to the forms of consent in the light of the Mental Capacity Act and recent court decisions.[6] The forms recommended for use by the Department of Health in the implementation guide are considered below.

In certain circumstances the fact that consent has been given does not prevent a criminal offence occurring. In the case of *R* v. *Brown* sado-masochists were prosecuted for an offence of causing actual bodily harm under the Offences Against the Person Act 1861 and the defence that they were consenting to the activities was not accepted.[7] In another case the House of Lords held that an irrational fear preventing the free exercise of choice by B was sufficient to make criminal A's sexual touching of B, who

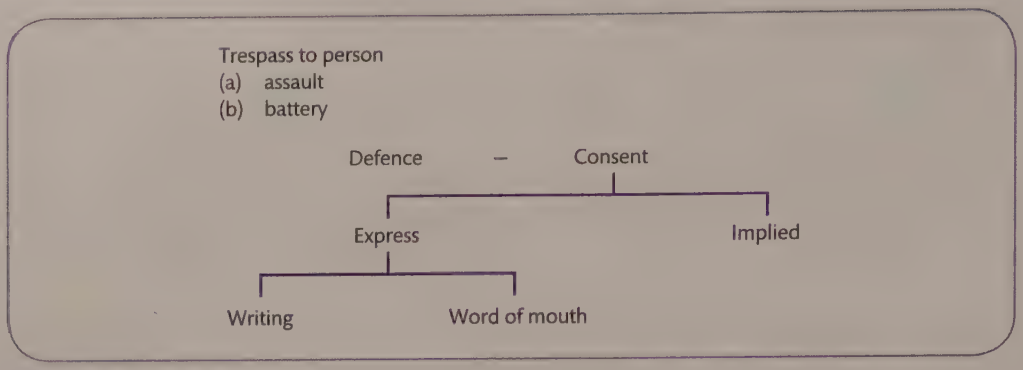


Figure 7.1 Various forms of consent to a trespass to the person

was unable to refuse through a mental disorder. Inability to communicate any choice made was not limited to physical inability.[8] In an unreported case[9] a deputy manager at a care home was sentenced to 3 months for assault when he attempted to carry out manual evacuation of faeces on a resident, when he was not qualified to carry out the procedure. Consent by the resident was not an effective defence.

Consent in writing

The forms of consent to examination and treatment that are contained in the Department of Health guidance[10] require the health professional providing the treatment (and this can include a nurse practitioner or midwife) to discuss with the patient the benefits of the treatment and also any serious or frequently occurring risks associated with it and also identify any additional procedures which may be necessary, including the possibility of a blood transfusion or other specified procedure. Form 1 can be used for adults and young persons over 16 years and Form 3 for procedures where consciousness is not impaired. Form 2 can be used for parental consent on behalf of children (see chapter 13) and Form 4, which is for use where the patient is mentally incapacitated, is to be revised in the light of the Human Tissue Act 2004 and the Mental Capacity Act 2005. The Department of Health has published information to assist in amending consent forms.

Consent is not simply a signature on a form: it is the result of a process of communication between patient and professional that may result in the patient signing a form, which is evidence that the patient agrees to the proposed treatment. Significant recommendations were made in the Kennedy Report[11] following the inquiry into paediatric heart surgery at Bristol Royal Infirmary on greater openness and honesty between health professionals and the patient. The recommendations on consent included those shown in Box 7.1 (numbers refer to recommendations in the Report).

Box 7.1 Recommendations on consent in Kennedy Report

1 In a patient-centred healthcare service patients must be involved, wherever possible, in decisions about their treatment and care.

5 Information should be tailored to the needs, circumstances and wishes of the individual.

23 We note and endorse the recent statement on consent produced by the DH reference guide to consent for examination and treatment (DH 2001). It should inform the practice of all healthcare professionals in the NHS and be introduced into practice in all trusts.

24 The process of informing the patient, and obtaining consent to a course of treatment, should be regarded as a process and not a one-off event consisting of obtaining a patient's signature on a form.

25 The process of consent should apply not only to surgical procedures but also to all clinical procedures and examinations that involve any form of touching. This must not mean more forms: it means more communication.

26 As part of the process of obtaining consent, except when they have indicated otherwise, patients should be given sufficient information about what is to take place, the risks, uncertainties, and possible negative consequences of the proposed treatment, about any alternatives and about the likely outcome, to enable them to make a choice about how to proceed.

If a nurse were to become aware that the patient who has put his signature to a consent form has very little idea of what he has given consent to, then she should ensure that the health professional concerned gives more information to the patient about what is proposed. Where does the nurse stand if she is aware that the patient has signed a form without realising what is involved?

Practical Dilemma 7.1 Ignorance is bliss

Susan Smith had signed the form to consent to an operation for the investigation of a lump in her breast. She was very distressed to be undergoing surgery and ever since she had come into hospital had been able to understand and take in very little of what was said to her. The doctor had explained that a biopsy would be carried out and if that were positive further surgery would be undertaken. It was apparent to Staff Nurse Rachel Bryant that Susan had very little awareness that a radical mastectomy could be performed.

Where does Staff Nurse Bryant stand in relation to the proposed operation? The staff nurse has a legal duty to the patient and if she knows that the patient did not understand what she signed or failed to take in the information given by the doctor, she should arrange for the doctor to return and give the patient more information. From the court's point of view, the fact that the patient has signed the form and expressly agreed to a named procedure or course of treatment and that she understands that 'any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health' would be very strong evidence to defend any action for trespass to the person.

There is a possibility, however, of a successful action in negligence if the patient has not been given relevant information (see below). There is a clear duty on any health practitioner to take reasonable care that a patient receives the appropriate information before any consent form is signed and treatment proceeds. The nurse should, as far as possible, take appropriate steps to inform the relevant health practitioner if she discovers that this duty has not been carried out.

Consent by word of mouth

Many of the less risky treatments are carried out without any formal signature of the patient. Consent by word of mouth is valid, but it may be far more difficult to establish in court, since it might be one person's word against another. Many of the day-to-day treatments and tests are, however, carried out on this basis.

Case 7.1 *Davis v. Barking, Havering and Brentwood HA* (1993)

Consent to anaesthesia[12]

The claimant signed a consent form giving consent to a general anaesthetic. She was subsequently given a caudal block and, unfortunately, suffered some harm as a result. She claimed that she had not given consent to this block, which therefore amounted to a trespass to her person, i.e. battery. The High Court judge held that separate consent was not required for each part of the treatment.

The Department of Health recommends that consent in writing be obtained for any significant procedure such as a surgical operation or when the patient participates in a research project or a video recording (even if only minor procedures are involved).[13]

Implied consent

It is sometimes said that the fact that a patient comes into hospital means that he or she is giving his consent to anything that the consultant deems appropriate. That, however, is not supported in law. There are many choices of available treatment and when care is provided there must be evidence that the patient has agreed to that particular course. Similarly, it is said that when an unconscious patient is treated in the A&E department, he implies consent to being treated. This, however, is likewise not so. An unconscious patient implies nothing. The professionals care for him in the absence of consent as part of their duty to care for the patient out of necessity in an emergency[14] and could defend any subsequent action for trespass to the person on that basis. They would now be acting under the statutory duty provided by the Mental Capacity Act 2005 to act in the best interests of a mentally incapacitated person.

Implied consent is better reserved for situations where non-verbal communication by the patient makes it clear that he is giving consent. Nurses are familiar with the signs: the patient rolls up his sleeve for an injection; the patient opens his mouth as the nurse waves the thermometer in the air. Such actions indicate to the nurse that the patient agrees to the treatment/care proceeding. No words are spoken, there is no signature, but it is clear that the patient is in agreement. In an Australian case of 1891, a passenger on a ship who held out his hand to be vaccinated lost his action for battery.[15]

The weakness of implied consent is, however, that it is not always clear that the patient is agreeing to what the nurse intends to do. Thus the patient who rolls up his sleeve for blood pressure to be taken would get a nasty shock when the nurse gives him an injection, yet that is how the nurse has interpreted his non-verbal actions. To avoid such misunderstandings, it is preferable if the nurse tells the patient what she wishes to do and obtains a spoken consent from the patient. (The problems in giving day-to-day care to the confused elderly are considered in chapter 19.)

Once a mentally competent patient has given a valid consent to treatment, then he/she cannot succeed in an action for trespass to the person,[16] but if it is claimed insufficient information on the risks of the treatment was given to them they would have to bring an action in negligence alleging a breach of the duty of care in failing to provide sufficient information (see pages 173–8).

Right to refuse treatment

It is a basic principle of law in this country that an adult, mentally competent person has the right to refuse treatment and take his own discharge contrary to medical advice. The Court of Appeal has emphasised that provided the patient has the necessary mental capacity, which is assessed in relation to

the decision to be made, then he or she can refuse to give consent for a good reason, a bad reason or no reason at all. This was the principle set out in the case of *Re MB* shown in Case 7.2.

Case 7.2 *Re MB* (1997)

Consent to a Caesarean section[17]

A pregnant woman suffered from needle phobia as a result of which she was unable to agree to have an injection that would precede a Caesarean section. The High Court judge held that her needle phobia rendered her mentally incapacitated to take the decision not to have a Caesarean operation. The Court of Appeal confirmed that decision, but emphasised that had she been competent, she could have refused the operation. The Court of Appeal in *Re MB* laid down the steps and rules that should be followed when a health professional is faced with a patient who appears to be mentally incompetent. (This advice is set out in Box 14.4 on page 388.)

The ruling in *Re MB* was followed by the Court of Appeal in a case brought against St George's Hospital,[18] which is considered in chapter 14 together with a more recent case where a judge declared that a Caesarean and all necessary procedures could be performed on a woman detained under Section 5(2) of the Mental Health Act 1983.[19]

Mental capacity of the patient

The fact that mentally capacitated adult patients can refuse life-saving treatment can be upsetting for staff, as the following case shows.

Case 7.3 *Re C (An Adult: Refusal of Medical Treatment)* (1994)

The patient's autonomy[20]

The patient was a 68-year-old man who suffered from paranoid schizophrenia and was detained at Broadmoor Hospital. He developed gangrene in one foot and doctors believed an amputation to be a life-saving necessity. He refused to give consent and sought an injunction restraining the hospital from carrying out an amputation without his express written consent. He succeeded on the grounds that the evidence failed to establish that he lacked sufficient understanding of the nature, purpose and effects of the proposed treatment. Instead, the evidence showed that:

1 he had understood and retained the relevant treatment information
2 believed it, and
3 had arrived at a clear choice.

The sole issue in this case was whether the patient had the mental capacity to give a valid refusal. It should be noted that the presence of a mental disorder does not automatically mean that a person is incapable of making a valid decision in relation to treatment. *Re C* should be contrasted with a case[21] where a patient refused a blood transfusion which was required because she self-harmed. She described her blood as being evil and it was held that this was evidence of mental disorder which made her incapable of using and weighing the relevant information.

In a more recent case with similar facts to those in Case 7.3 the Court of Protection ruled that doctors must respect the wishes of a patient with schizophrenia who refused to undergo a potentially

life-saving amputation of her leg. JB had a gangrenous foot after an ulcer became infected. Judge Jackson ruled that her mental illness had not robbed her of the power to make rational decisions. 'The freedom to choose for oneself is part of what it means to be human'[22] (see also the case of *Nottinghamshire Healthcare NHS trust* v. *RC* where the patient was detained under the Mental Health Act 1983) (see chapter 20).

In contrast, a compulsory Caesarean was authorised on a woman with autistic spectrum disorder and borderline learning disabilities who lacked the requisite mental capacity.[23] (The case is discussed in chapter 17.)

In *Re MB*[24] the Court of Appeal laid down a test for the competence of the patient which was applied in the case of Miss B, where a woman who had been paralysed refused to be placed on a ventilator and when that refusal was ignored applied to the court for the ventilator to be switched off. The facts are shown in the following case.

Case 7.4 *Ms B* (2002)

Refusal to be ventilated[25]

Miss B suffered a ruptured blood vessel in her neck which damaged her spinal cord. As a consequence she was paralysed from the neck down and was on a ventilator. She was of sound mind and knew that there was no cure for her condition. She asked for the ventilator to be switched off. Her doctors wished her to try out some special rehabilitation to improve the standard of her care and felt that an intensive care ward was not a suitable location for such a decision to be made. They were reluctant to perform such an action as switching off the ventilator without the court's approval. Miss B applied to court for a declaration to be made that the ventilator could be switched off.

The main issue in the case was the mental competence of Miss B. If she were held to be mentally competent, she could refuse to have life-saving treatment for a good reason, a bad reason or no reason at all. She was interviewed by two psychiatrists who gave evidence to the court that she was mentally competent. The judge therefore held that she was entitled to refuse to be ventilated. The judge, Dame Elizabeth Butler-Sloss, President of the Family Division, held that Miss B possessed the requisite mental capacity to make decisions regarding her treatment and thus the administration of artificial respiration by the trust against her wishes amounted to an unlawful trespass. Dame Elizabeth Butler-Sloss restated the principles which had been laid down by the Court of Appeal in the case of St George's Healthcare Trust:

- There was a presumption that a patient had the mental capacity to make decisions whether to consent to or refuse medical or surgical treatment offered.
- If mental capacity was not an issue and the patient, having been given the relevant information and offered the available option, chose to refuse that treatment, that decision had to be respected by the doctors, considerations of what the best interests of the patient would involve were irrelevant.
- Concern or doubts about the patient's mental capacity should be resolved as soon as possible by the doctors within the hospital or other normal medical procedures.
- Meanwhile, the patient must be cared for in accordance with the judgement of the doctors as to the patient's best interests.
- It was most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. Since the view of the patient might reflect a difference in values rather than an absence of competence, the assessment of capacity should be approached with that in mind and doctors should not allow an emotional reaction to or strong disagreement with the patient's decision to cloud their judgement in answering the primary question of capacity.

- Where disagreement still existed about competence, it was of the utmost importance that the patient be fully informed, involved and engaged in the process, which could involve obtaining independent outside help, of resolving the disagreement since the patient's involvement could be crucial to a good outcome.
- If the hospital were faced with a dilemma that doctors did not know how to resolve, this must be recognised and further steps taken as a matter of priority. Those in charge must not allow a situation of deadlock or drift to occur.
- If there was no disagreement about competence, but the doctors were for any reason unable to carry out the patient's wishes, it was their duty to find other doctors who would do so.
- If all appropriate steps to seek independent assistance from medical experts outside the hospital had failed, the hospital should not hesitate to make an application to the High Court or seek the advice of the Official Solicitor.
- The treating clinicians and the hospital should always have in mind that a seriously physically disabled patient who was mentally competent had the same right to personal autonomy and to make decisions as any other person with mental capacity.

It was reported on 29 April 2002 that Miss B had died peacefully in her sleep after the ventilator had been switched off.

The patient therefore has a right to refuse treatment, but it must be clear that he has the requisite mental capacity. The case of *Re C* (Case 7.3) clearly brings out the clash between the patient's autonomy and the professional duty of care. Clearly, it would be essential for those in charge of the patient to take all reasonable precautions to ensure that the patient has appropriate counselling and all the necessary information and help in facing the future, but if this fails, it is the competent patient's right to refuse. Similarly, an adult Jehovah's Witness is able to refuse a blood transfusion. It was reported that a young mother who was a Jehovah's Witness died on 25 October 2007 after giving birth to twins because she refused a life-saving blood transfusion.[26] Different principles apply in relation to children and these are discussed in chapter 13.

The Court of Appeal in the case of *Re T* (see Case 7.5) emphasised the importance of ensuring that, when a patient refuses treatment, the patient has the mental capacity to make a valid decision and has not been subjected to the undue influences of another.

Case 7.5 *Re T* (1992)

Refusal of blood transfusion[27]

A young pregnant woman was injured in a car accident and told the staff nurse that she did not want a blood transfusion. Her mother was a Jehovah's Witness. At the time, it was unlikely to be necessary. However, subsequently she went into labour and a Caesarean was necessary. She told medical staff that she would not want a transfusion and had signed a form to that effect. She was not told that it might be necessary to save her life. After the operation, she required blood as a life-saving measure and her father and co-habitee applied to court. The judge authorised the administration of blood on the ground that the evidence showed that she was not in a fit condition to make a valid decision: pain or exhaustion can lead to lack of capacity.

See also the case of *In Re S*,[28] (see chapter 14). For a case on refusal of treatment by a 16-year-old, see *In Re W* (see chapter 13 Case 13.1).

The common law principles relating to the presumption of capacity in the person over 16 years and the definition of capacity and best interests have now been placed on a statutory basis by the Mental Capacity Act 2005 (see pages 168–73).

Taking one's own discharge

It follows from what has been said so far that the adult, mentally competent patient is able to take his own discharge. However, this principle may, in practice, cause concern for staff, as Practical Dilemma 7.2 illustrates.

Practical Dilemma 7.2 Self-discharge

Don Pritchard was admitted from the A&E department with a suspected head injury. Before X-rays had been taken, he insisted on leaving the hospital, contrary to medical advice. The nursing staff knew that he was still very confused and it seemed likely that his aggression was a result of a brain injury.

This is a difficult situation because it could be argued here that, as a result of the brain injury, the patient was not mentally competent and therefore his decision to discharge himself was an irrational one. If the patient is mentally incapacitated and there is clear danger to the patient's life if he is allowed to leave, it could be argued that these are circumstances in which the staff would be justified in acting in an emergency to save the patient's life. If this does not apply, then the patient has the right to go. An assessment should be carried out of his mental competence. If he is deemed mentally competent, he cannot be compelled to stay, unless he presents a danger to other people. If possible, he should be persuaded to sign a form that he took his own discharge contrary to medical advice. However, it is not always possible to get this signature and therefore it is necessary to ensure that another member of staff can act as a witness to what occurred. In either case, it is essential that full records be made of the circumstances leading to the patient's discharge and the efforts made to persuade him to stay. If harm eventually befalls the patient as a result of his taking his own discharge contrary to medical advice, if there is evidence that the staff did all they could to persuade him to stay and if there was clear evidence that the patient was mentally competent, there is unlikely to be a successful action for negligence against the staff.

Definition of mental capacity under the Mental Capacity Act 2005

The definition of mental capacity under Sections 2 and 3 of the Mental Capacity Act (MCA) is shown in Statute Box 7.1.

Statute 7.1 Sections 2 and 3 of the Mental Capacity Act 2005

Section 2 People who lack capacity

1 For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
2 It does not matter whether the impairment or disturbance is permanent or temporary.
3 A lack of capacity cannot be established merely by reference to:
   (a) a person's age or appearance, or
   (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

4 In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.
5 No power which a person ('D') may exercise under this Act:
  (a) in relation to a person who lacks capacity, or
  (b) where D reasonably thinks that a person lacks capacity, is exercisable in relation to a person under 16.
6 Subsection (5) is subject to section 18(3).

Section 3 Inability to make decisions

1 For the purposes of section 2, a person is unable to make a decision for himself if he is unable:
  (a) to understand the information relevant to the decision,
  (b) to retain that information,
  (c) to use or weigh that information as part of the process of making the decision, or
  (d) to communicate his decision (whether by talking, using sign language or any other means).
2 A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
3 The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.
4 The information relevant to a decision includes information about the reasonably foreseeable consequences of:
  (a) deciding one way or another, or
  (b) failing to make the decision.

From Statute Box 7.1 it will be noted that there are two stages for the definition of mental capacity. The first is: is the person suffering from an impairment of, or a disturbance in, the functioning of the mind or brain? The second is: is the effect of the impairment or disturbance an inability to make a decision?

In the case of *RT* v. *LT & Anor*[29] the Court of Protection had to decide if a young woman aged 23 lacked the capacity to make decisions: (1) about where she should live; and (2) what contact she should have with members of her family. The judge held that she lacked the requisite mental capacity because of her inability to use or weigh that information as part of the process of making the decision (s. 3(1)(c)).

On 26 May 2010 the Court of Protection gave permission to an NHS trust to sedate a cancer patient (PS) with a phobia of hospitals and needles, and to perform a hysterectomy considered necessary to save her life, treatment which was necessary in her best interests. PS, who was represented by the Official Solicitor, had a significant impairment in intellectual functioning as a consequence of a learning disability which meant that she lacked the requisite mental capacity to give or refuse consent under the Mental Capacity Act 2005.[30] It was recognised that some force may be necessary to sedate her, convey her to hospital and care for her in the period of postoperative recovery. The judge did not consider it necessary to invoke the Deprivation of Liberty provisions (DoLS) under Schedule 1 of the MCA (see chapter 17).

The Supreme Court ruled on the definition of mental capacity in March 2014 in a case following a road accident. The defendant motor cyclist had knocked down the claimant who was crossing the road. An initial agreement had been reached whereby the claimant received £12,500 with costs. That was a gross undervaluation of the claim which was assessed as £2 million by the claimant's advisers and about £800,000 by the defendant. The Supreme Court held that the claimant lacked the capacity to commence and conduct proceedings. She should have had a litigation friend from the outset and the settlement should have been approved by the court under rule 21(10)(1) of the civil procedure rules. The consent order was set aside and the case was to go to trial.[31]

In the case of *A Local Authority* v. *SY*, (where S had mild learning disabilities and entered into a sham marriage with T and unsuccessfully used the marriage to prevent deportation) the Court of Protection stated that while it was usual for an assessment of capacity to be undertaken by a medical practitioner or a psychiatrist an appropriately qualified social worker was eminently suited to undertake such assessments. It granted the declarations sought by the local authority (LA): that S lacked the capacity to litigate, to make decisions about her residence, contact and care or to enter into a contract of marriage; that it was both lawful and in S's best interests for her to reside at a placement identified by the LA, to receive a care package in accordance with her assessed needs and for her contact with others to be regulated by the local authority. The Court of Appeal also declared that the marriage ceremony was a non-marriage and stated that it would not tolerate the exploitation of young and vulnerable adults.[32]

The Court of Appeal emphasised that the statutory test for capacity was decision specific, rather than being 'person' or 'act' specific, when allowing an appeal in part against a decision by the Court of Protection. The judge held that W did not have sufficient mental capacity to decide whether to live with her husband on his release from prison. The judge had found that she had the capacity to marry but he failed to explain how and why her mental impairment did not rob her of capacity in other aspects of her life, yet caused an inability for her to decide to live with her husband. He had not given the explanations required by section 2(1) and his decision had to be set aside.[33]

Hunger strikes

In an old case,[34] a suffragette went on hunger strike and was force-fed in prison. She lost her claim for trespass to the person. The court held that the prison doctor was justified in feeding her on the grounds that it was the duty of the officials to preserve the health and lives of prisoners. However, in a case in 1995,[35] a prisoner went on hunger strike and the application was made to court to decide whether it was lawful for his doctors and nurses to abstain from force-feeding him. The judge held that there were four grounds for intervening against the prisoner's right of self-determination:

1 The interest that the state holds in preserving life.
2 The interest of the state in preventing suicide.
3 Maintaining the integrity of the medical profession.
4 The protection of the rights of innocent third parties.

He concluded that these did not overrule the right of self-determination of a mentally competent person and the prisoner could be permitted to starve himself to death, provided that he has the legal capacity. The European Court of Human Rights held in a case in 2007 brought against Moldavia that a prisoner's forced feeding with no medical justification was a breach of his Article 3 rights.[36]

In a more recent case in 2013 (*A NHS Trust* v. *Dr A*)[37] an Iranian doctor who was detained under section 3 of the Mental Health Act was on hunger strike and the NHS Trust sought a declaration that he lacked capacity and that he could be given artificial nutrition and hydration. The judge held that he would not make an order under the Mental Health legislation nor under the Mental Capacity Act but under the inherent jurisdiction of the court to act in the best interests of Dr A and declared that it would be lawful for Dr A to be provided with artificial nutrition and hydration and to use reasonable force and restraint for that purpose even though there would be deprivation of liberty. It was subsequently reported that as a result of the feeding, Dr A's mental state improved and he recovered his capacity and returned to Iran.

In a case in 2000,[38] the Moors murderer Ian Brady, who was in Ashworth Special Hospital, applied to court to be allowed to starve himself to death. The court held that he did not have the mental competence to make that decision. The decision to commence force-feeding was in all respects lawful, rational and fair. Brady was incapacitated by his mental illness. The failed attempts by the Ashworth Special Hospital Authority to discover who had leaked information about Brady to a journalist are considered in chapter 8. Brady applied in 2014 to a Mental Health Review Tribunal to be transferred to prison. (The case is considered in chapter 20.)

Amputation of healthy limbs

Media attention has been given to the condition of body dysmorphic disorder, where the patient wishes to have his healthy limbs removed. A surgeon in Falkirk and District Royal Infirmary, in a private operation, removed one lower limb from each of two patients who suffered from this disorder.[39] The hospital has subsequently banned such operations. In the absence of any doctor prepared to amputate, patients are known to have shot their limbs off or committed suicide. The General Medical Council has offered ethical guidance and the Medical Defence Union has emphasised that the utmost caution should be taken by doctors considering such an operation. They must be certain that the operation is right and that the patient has had full counselling as to the consequences. Everything must be carefully documented.[40] The House of Lords has held that consent is not a defence to an offence of grievous bodily harm.[41]

Defences to an action for trespass to the person

Consent is the main form of defence to an action for trespass to the person. However, it is not the only one and Box 7.2 shows the other defences.

Box 7.2 Defences to an action for trespass to the person

1. Consent
2. Acting under a statutory power, e.g. Mental Capacity Act (see below), Mental Health Act 1983 (see chapter 20)
3. Making a lawful arrest
4. Parental powers (see chapter 13).

Patients lacking mental capacity

This issue is considered below under the defence of statutory powers and also in chapter 20 in relation to mentally disordered persons. Where a patient lacks the capacity to give consent then treatment without consent may be given under statutory powers. Detention and compulsory treatment for mental disorder may be justified under the Mental Health Act 1983 (as amended by the 2007 Act) (see chapter 20). Alternatively, care and treatment can be given under the Mental Capacity Act 2005. Powers under this Act could be used not only if temporary restraint is justified in the interests of the patient but also if it is necessary to detain patients in hospitals or care homes when the use of the Mental Health Act powers is not required. This loss of liberty is possible under the Deprivation of Liberty (Bournewood) safeguards, which are explained below and considered in detail in chapter 17. In this chapter we look at the provisions of the Mental Capacity Act 2005 and the care and treatment of those adults who are incapable of giving the requisite consent.

Unconscious patients

It was mentioned earlier that the doctors and nurses in their duty of care for the patient may take life-saving action. This was originally on the basis of their common law powers (recognised in the *Re F* case)[42] to act out of necessity in the best interests of a mentally incapacitated adult, but is now on the basis of the statutory powers in the Mental Capacity Act 2005. The Act requires actions to be taken in the best interests of a person who lacks mental capacity and this requires ascertaining from relatives and friends information about the personal beliefs and views and feelings of the patient. Where serious medical treatment decisions are to be made on behalf of a person who lacks mental capacity, then in

the absence of a relative or informal carer or person who can be consulted on the person's best interests, an independent mental capacity advocate must be appointed to report on the patient's best interests (see below). This topic of lack of mental capacity is also considered in relation to the care of the elderly in chapter 19 and of those with learning disabilities in chapter 17. The legal situation relating to a patient in a persistent vegetative state is considered in chapter 29.

Case 7.6 *Malette* v. *Shulman* (1991)

Do not give me blood[43]

In a Canadian case, an unconscious patient was given a life-saving blood transfusion in spite of the fact that she was carrying a card refusing such treatment. She was awarded C$20,000. The doctor had ignored her written request not to give her blood and this constituted a trespass to her person.

In this case, the card setting out the wishes of the patient acted as a living will or advance directive. These are now placed on a statutory footing under the Mental Capacity Act 2005 (see chapter 29).

Mental Capacity Act 2005

Where a practitioner takes measures to save the life of an unconscious patient, that is not a situation of implied consent, but a situation of necessity which is now covered by the Mental Capacity Act 2005. In such circumstances, the Mental Capacity Act 2005 recognises the duty of a professional to take action in the best interests of the patient following the accepted standard of care of the reasonable professional. The House of Lords had established the principle of acting out of necessity in the case of *Re F*,[44] which concerned the sterilisation of a woman who suffered from severe learning disabilities and who was incapable of giving consent. However, the principle of acting out of necessity where an adult was incapable of giving consent also applied to day-to-day care. In the case of a girl of 18 with an intellectual age of between 5 and 8, the Court of Appeal held that the court had the power under its inherent jurisdiction and in the best interests of that person to hear the issues involving her future and to grant the necessary declarations.[45] The House of Lords (in the Bournewood[46] case) also held that the common law powers can be used to detain a mentally incapable adult if that is in the person's best interests but this was overruled by the European Court of Human Rights[47] (see page 464).

Recommendations were made by Law Commission No. 231[48] for a statutory duty to replace this common law power, with specific requirements depending on the seriousness of the treatment to be undertaken. Following further consultation by the Lord Chancellor,[49] the government published its proposals for decision making on behalf of mentally incapacitated adults[50] and this was followed by a draft Bill.[51] The Bill was subject to scrutiny by a Joint Committee of Parliament[52] and revised in the light of its recommendations. The Mental Capacity Act 2005 came into force partly on 1 April 2007 and on 1 October 2007. The Act will be considered under the following headings:

Principles
Definition of mental capacity
Best interests
Code of Practice
Independent mental capacity advocate
Lasting powers of attorney
Court of Protection, deputies and the Office of Public Guardian
The Deprivation of Liberty (Bournewood) safeguards

(In chapter 29 will be found a discussion of the statutory provisions for advance decisions. The Mental Capacity Act 2005 protections provided in relation to research on those lacking capacity can be found in chapter 18.)

Principles of the Mental Capacity Act 2005

The basic principles set out in section 1 of the Act are shown in Statute Box 7.2.

Statute 7.2 Principles set down in Section 1 of the Mental Capacity Act 2005

1 The following principles apply for the purposes of this Act.
2 A person must be assumed to have capacity unless it is established that he lacks capacity.
3 A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
4 A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
5 An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
6 Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Definition of mental capacity

Sections 2 and 3 provide a statutory definition of mental capacity (see Statute Box 7.1). The definition is decision-specific, i.e. a person may have the capacity to make a decision on one matter but not on another. For example, a person with learning disabilities may be able to decide on the food to eat and clothes to wear, but not whether to have an operation for an appendectomy. In the case of *PH* v. *Local Authority*[53] the Court of Protection held that PH, a 49-year-old man suffering from Huntingdon's disease, did not have the capacity to make decisions about his care and treatment and also about his future care and residence. The second declaration was to remain in force for six months. A final declaration was not to be made until all practical steps to assist him in acquiring the necessary capacity had been taken.

In contrast in the case of SB[54] the Court of Protection judge decided that a 37-year-old woman with bi-polar disorder did have the mental capacity to make her own decisions and this included her wish to have a termination. The judge stated that:

> **It seems to be, therefore, that even if aspects of the decision making are influenced by paranoid thoughts in relation to her husband and her mother, she is nevertheless able to describe, and genuinely holds, a range of rational reasons for her decision. When I say rational, I do not necessarily say they are good reasons, nor do I indicate whether I agree with her decision, for section 1(4) of the Act expressly provides that someone is not to be treated as unable to make a decision simply because it is an unwise decision.**
>
> ***(Holman J)***

Best interests

The Mental Capacity Act sets out the steps which must be taken in determining what are the best interests of the patient. They are shown in Statute Box 7.3.

Statute 7.3 Best interests

Section 4 of the Mental Capacity Act

1 In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of:
   (a) the person's age or appearance, or
   (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.
2 The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.
3 He must consider:
   (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
   (b) if it appears likely that he will, when that is likely to be.
4 He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.
5 Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
6 He must consider, so far as is reasonably ascertainable:
   (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
   (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
   (c) the other factors that he would be likely to consider if he were able to do so.
7 He must take into account, if it is practicable and appropriate to consult them, the views of:
   (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
   (b) anyone engaged in caring for the person or interested in his welfare,
   (c) any donee of a lasting power of attorney granted by the person, and
   (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
8 The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which:
   (a) are exercisable under a lasting power of attorney, or
   (b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.
9 In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.
10 'Life-sustaining treatment' means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.
11 'Relevant circumstances' are those:
   (a) of which the person making the determination is aware, and
   (b) which it would be reasonable to regard as relevant.

The implication of the statutory steps which must be taken in determining what are a person's best interests is a modified best interest test. For example, if a person, who was once a firm believer in the sin of any surgical intervention, lost the mental capacity to make his decisions, then his earlier views on non-surgical intervention would be taken into account in determining what was in his best interests.

In 2013 the Supreme Court held that in deciding whether medical treatment should be withheld from a person lacking the requisite mental capacity the focus had to be on whether it would be in the

patient's best interests to give the treatment, rather than on whether it would be in his best interests to withhold it. The Supreme Court held that the Court of Appeal had been in error in using an objective approach to decide what the patient would think rather than the subjective test used by the trial judge.[55] The patient was a guitarist who had been treated for cancer of the colon but then suffered a serious infection. He lost the capacity to make his own decisions and the Trust sought a declaration that it would be in his best interests to have certain painful and deeply physical treatments withheld from him in the event of clinical deterioration. His family accepted that he would never return to full health but believed that he gained pleasure from his present life and would want it to continue. The judge held that it would not be appropriate to make the declarations sought. The Court of Appeal reversed the decision on the ground that futility was to be judged by the level of improvement the treatment would bring to the general health of the patient and recovery meant that the patient would recover to the extent that imminent death was averted. The patient died but the family wished the Supreme Court to hear the appeal.

Code of Practice

The Department for Constitutional Affairs (now absorbed in the Ministry of Justice) prepared guidance on the Mental Capacity Act in the form of a Code of Practice. There is a statutory duty for those professionals involved in the care of those lacking mental capacity to have regard to the Code of Practice (s. 42(4)). It can be accessed via the internet.[56] While not statutorily bound by the Code of Practice, informal carers and others caring for those lacking the requisite mental capacity should find it of assistance both in determining whether a person lacks capacity and also in deciding what are the person's best interests.

Independent mental capacity advocate

Where serious medical treatment is proposed or accommodation arrangements are being made then, in the absence of an informal carer, relative or friend who can be consulted on behalf of a person lacking the capacity to make his or her own decisions, an independent mental capacity advocate (IMCA) must be appointed to report on the best interests of the patient. A report is given of one of the first situations where an IMCA was appointed where a patient had lost consciousness and had no meaningful brain activity and no next of kin had been traced.[57] The IMCA reported on the patient's best interests and the treating clinicians decided that antibiotics would not be administered for an infection and the patient passed away.

Lasting power of attorney

The Mental Capacity Act enables a person, when competent, to set up a lasting power of attorney (LPA) by which the donee of the power can make decisions on his behalf. Unlike the earlier enduring power of attorney, which could only relate to the delegation of decisions relating to property and affairs, the LPA can be set up for both property and affairs and also for decisions relating to personal welfare. There are different LPA forms for property and finance and for personal welfare. From 1 October 2007 enduring powers of attorney can no longer be set up, but those which are already in existence can continue to be used. There is one major difference between the two kinds of delegation. Although the donee under an LPA relating to property and affairs can exercise those powers while the donor still has the mental capacity to make his own decisions (for example, the donor might appoint an attorney to sell his house for him while he is abroad), the donee under an LPA relating to personal welfare decisions can only make decisions for the donor if the donor lacks the requisite mental capacity. Practical Dilemma 7.3 illustrates the effect of the appointment of an LPA for a patient in hospital. Further details and the forms to be completed can be obtained from the government website.[58]

Practical Dilemma 7.3 Lasting power of attorney

Meryl, the ward sister of a medical ward, was informed that a patient, Agnes, recently admitted with a severe chest infection and who appeared unable to make her own decisions, had set up an LPA giving the power to make personal welfare decisions to her daughter, Nicky. Meryl was concerned about whether Nicky could refuse antibiotics and resuscitation on Agnes's behalf if it were to be a life-saving necessity.

Nicky should be asked to show Meryl the LPA which Agnes has drawn up so that the specific instructions were made known to the ward team. Life-sustaining treatment, which was in her best interests, could only be refused on Agnes's behalf if she had specifically included that in the LPA, which had been appropriately drawn up, witnessed and registered. The LPA would only come into effect if Agnes lacked the capacity to make her own decisions.

Court of Protection, deputies and the Office of Public Guardian

Another significant innovation of the Mental Capacity Act 2005 was the establishment of a new Court of Protection with the jurisdiction to make decisions relating to personal welfare as well as property and finance. (The predecessor Court of Protection could only cover issues relating to property and affairs.) The court can either make one-off decisions (with or without a court hearing) or appoint deputies with powers to make specific decisions on behalf of those lacking the requisite mental capacity who were over 16 years. Property decisions could be made on behalf of those under 16 years, if the mental capacity was likely to extend after they became 16 years. For example, if a young boy was badly brain-damaged in a road accident at 12 years old and received compensation from the driver responsible, decisions relating to the property and finances could be made by the Court of Protection while he was still under 16 years, because he was unlikely to recover his mental capacity. It might decide to appoint a deputy to make decisions relating to his finances. The Mental Capacity Act also made provision for an Office of Public Guardian. This keeps registers of deputies and LPAs and keeps a watching brief of their functioning. Complaints about the donee under an LPA who appeared not to be acting in the best interests of the donor could be made to the Office of Public Guardian which might decide to appoint a Visitor (General or Specific) to investigate the situation. The Court of Protection has opened its hearings to the public with reporting restrictions, and reports of cases can be accessed on its website. Further discussion of the Court of Protection and its role in property matters can be found in chapter 25 and from the Court of Protection website.[59] See also the website of 39 Essex Street chambers.[60]

The Deprivation of Liberty Safeguards (DoLS) (Bournewood)

The European Court of Human Rights ruled that there was a breach of Article 5.4 of the European Convention on Human Rights where a person with learning disabilities, and incapable of consenting to the admission, was detained in a hospital without being placed under the Mental Health Act 1983.[61] The facts of the case are given in chapter 17 (Case 17.3). As a consequence of the case the UK government had to ensure that legislation was introduced to safeguard those who were incapable of giving consent to admission to hospitals and care homes but needed to be kept there for their safety, in a situation where the powers of detention under the Mental Health Act 1983 were inappropriate. Following extensive consultation the Department of Health decided in favour of amending the Mental Capacity Act 2005 to safeguard the rights of those kept in hospitals and care homes and ensure that there was no violation of Article 5. (See chapter 17 for further details of the Bournewood safeguards.) A Supreme

Court decision on the right of those with severe disabilities to enjoy the protection of the deprivation of liberty safeguards [62] is discussed in chapter 17 (Case 17.4).

Mental Health Act 1983

Justification for acting without the consent of a patient may also be provided by the Mental Health Act 1983 (as amended by the Mental Health Act 2007) and this is considered in chapter 20.

Giving information to a patient prior to consent being obtained

As has been mentioned, there are two main actions in relation to consent:

1 An action for trespass to the person.
2 An action in negligence for a breach of the duty of care to inform the patient.

We now turn to the action for negligence. The courts have made it clear that if a competent patient has given a willing consent for a procedure, then an action for trespass to the person cannot proceed. If the patient alleges that he was not given significant information about possible side effects, then the action will be one of negligence. This raises the question of how much information must be given to the patient. The leading case on this question is Case 7.7 presented here.

Case 7.7 *Sidaway v. Bethlem Royal Hospital Governors* (1985)

Failing to inform[63]

Amy Sidaway suffered from persistent pain in her neck and shoulder and was advised by a surgeon to have an operation on her spinal column to relieve the pain. The surgeon warned her of the possibility of disturbing a nerve root and the possible consequences of doing so, but did not mention the possibility of damage to the spinal cord, even though he would be operating within 3 millimetres of it. The risk of damage to the spinal cord was very small (less than 1 per cent), but if the risk materialised, the resulting injury could range from mild to very severe. Amy consented to the operation, which was performed with due care and skill. However, in the course of the operation, she suffered an injury to her spinal cord that resulted in her being severely disabled. She sued the surgeon and the hospital governors, alleging that the surgeon had been in breach of a duty owed to her to warn her of all possible risks inherent in the operation, with the result that she had not been in a position to give an informed consent to the operation. Amy lost the case before the trial judge and her appeal to the Court of Appeal. She then appealed to the House of Lords.

The House of Lords held that her appeal should fail. Three of the judges held that the test of liability in respect of a doctor's duty to warn his patient of risks inherent in treatment recommended by him was the same as the test applicable to diagnosis of treatment, i.e. the doctor was required to act in accordance with a practice accepted as proper by a responsible body of medical opinion. This is known as the 'Bolam Test' (see page 50). Since the surgeon's non-disclosure of risk of damage to the plaintiff's spinal cord accorded with a practice accepted as proper by a responsible body of neurosurgical opinion, the defendants were not liable to the plaintiff.

The other two judges (Lord Scarman and Lord Templeman) were also of the opinion that Amy's appeal must fail since she had not proved on the evidence that the surgeon (who had died since the operation) had been in breach of duty by failing to warn her of the risks. Lord Scarman, while finding

against her, alone of all the judges held that a patient had a right to give informed consent and he followed an American case,[64] where the 'prudent patient' test was applied to decide on the information a patient should be given prior to any consent, i.e. 'What would a reasonable prudent patient think significant if in the situation of this patient?' Lord Scarman concluded that:

> **English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing, and especially so if the treatment be surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if on a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health.**

Comment on the Sidaway case

While the case was concerned with treatment by a doctor, the same principles would apply to treatment by any other professional. Although the judges turned down Amy's appeal, their reasons for doing so were extremely varied. The majority applied the Bolam Test of the accepted approved professional practice.

Even Lord Scarman, who used the 'prudent patient' test, still agreed that there may well be exceptions where the doctor is entitled to use 'therapeutic privilege' in deciding what to tell or what not to tell the patient prior to any procedure. This exception means that in the end the professional must follow the accepted approved practice in so far as it is applicable to the particular needs of that specific patient.

The Sidaway case was cited and followed in the case of *Blyth* v. *Bloomsbury Health Authority*.

Case 7.8 *Blyth* v. *Bloomsbury HA* (1987)

Depo-Provera[65]

In this case, a patient had been given an injection of Depo-Provera and claimed that she had suffered harm as a result of it and that knowledge that was possessed by hospital researchers about some of the side effects of the drug was not made known to her at the time that she was prescribed it. The Court of Appeal applied the Bolam Test and the Sidaway case to the facts and decided that there was no negligence by the doctors who cared for her in the information they gave to her. They emphasised that the extent of the duty to give information is to be judged in the light of the state of medical knowledge at the time and one must avoid the danger of being wise after the event. In addition, they refused to interpret the Sidaway judgments as implying that where the patient asked specific rather than just general questions this meant that the doctor is under an obligation to tell the patient all he knows about the subject.

> The amount of information to be given must depend on all the circumstances, and as a general proposition it is governed by what is called the Bolam Test.
>
> *(Lord Justice Neill)*

Another important point is that in subsequent cases (see below), the courts have held that the professional's duty is not divisible. Diagnosis, treatment, carrying out that treatment and informing the patient are all part of the doctor's duty of care and cannot be separated into different boxes. Informing the patient of risks is as much a part of the clinical judgement of the doctor as all his other tasks.

The general proposition therefore is that a person giving information to the patient must follow the reasonable standard of approved practice, i.e. the Bolam Test. However, in one case, a judge held that what was purported to be the approved practice was not acceptable.

Case 7.9 *Smith v. Tunbridge Wells HA* (1994)

Failure to warn[66]

Evidence given by experts to the court suggested that a body of experienced competent surgeons would not have warned the patient of a risk of impotence from the operation. The judge disagreed with this and held that the failure to warn of the risk of impotence was neither reasonable nor responsible and the surgeon was therefore in breach of his duty to warn the patient.

In the following case, the court had to decide whether the doctors had followed the reasonable standard of care when they gave advice that the baby should not be induced.

Case 7.10 *Pearce v. United Bristol Healthcare NHS Trust* (1998)

Clinical opinion[67]

Mrs Pearce was expecting her sixth child. The expected date of delivery was 13 November 1991, but it had still not arrived on 27 November. She begged the consultant to give her an induced labour or a Caesarean section. He suggested that she should have a normal birth and let nature take its course. He pointed out that it would be very risky to induce the birth and she would take longer to recover from a Caesarean. He did not tell her that there was an increased risk of a stillbirth as a result of the delay in delivery between 13 and 27 November. She accepted his advice. The baby died *in utero* some time between 2 and 3 December.

The trial judge dismissed the claim. The Court of Appeal dismissed the appeal. It applied the reasoning in the Sidaway case and held that this was a case 'where it would not be proper for the courts to interfere with the clinical opinion of the expert medical man responsible for treating Mrs Pearce'.

Subsequently the House of Lords had to decide if the patient has to prove that he would not have had the treatment had he known of the serious risks of harm.

Case 7.11 *Chester v. Afshar* (2002)

Warning the patient of risks[68]

The patient suffered from severe back pain and gave consent to an operation for the removal of three intravertebral discs. The neurosurgeon failed to give a warning to her about the slight risk of post-operative paralysis, which the patient suffered following the operation. The trial judge held that the doctor was not negligent in his conduct of the operation, but was negligent in failing to warn her of the slight risk of paralysis which she suffered. He also held that, had she been aware of the risk, she would have sought advice on alternatives to surgery and the operation would not have taken place when it did, if at all. He therefore held that there was a sufficient causal link between the defendant's failure to warn and the damage sustained by the claimant and that link was not broken by the possibility that the claimant might have consented to surgery in the future. He gave judgment for damages to be assessed. The defendant appealed to the Court of Appeal which dismissed the appeal. The defendant then appealed to the House of Lords which by a majority verdict dismissed his appeal.[69]

The House of Lords held that the claimant had shown that had she been notified of the risk, which in fact occurred, she would have had to think further about undergoing the surgery and therefore she had established a causal link between the breach and the injury she had sustained and the defendant was liable in damages. Lord Hope's reasoning is shown in Box 7.3.

Box 7.3 *Chester* v. *Afshar* (Lord Hope)

I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here – the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is to be carried out. For some the choice may be easy – simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately.

To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.

The outcome of *Chester* v. *Afshar*, therefore, was that the appeal by the surgeon failed and the patient won the case.

Chester v. *Afshar* was applied by the Court of Appeal where the claimant appealed against the decision of the High Court. He alleged that there had been negligence in the diagnosis and treatment of a rare genetic disorder. He had been diagnosed with aplastic anaemia in 1993 at the age of 21 and in 2003 a specialist had prescribed Prednisolone to which he suffered a rare side effect of avascular necrosis of which he had not been warned and he had to have bilateral hip replacements. The Court of Appeal rejected his appeal and held that the duty to advise and warn about diagnosis, treatment and possible side effects was to be assessed in accordance with the practice of a responsible body of doctors (the Bolam Test). There was no authority for a duty to warn of possible alternative diagnoses not reasonably suspected.[70]

In the following case, the claimant succeeded in his allegation that he had been given inadequate information.

Case 7.12 *Chinchen* v. *University Hospital of Wales Healthcare NHS Trust* (2001)

Insufficient information[71]

In April 1996, C underwent surgery for a revision decompression of his spine. A consultant orthopaedic surgeon carried out the procedure. Four days later, C suffered loss of spinal fluid from the operation wound and was readmitted to hospital. In May a posterior exploration of C's lower lumbar spine was carried out. The dura was inspected and there was no obvious leak. A muscle patch was applied to

the dura and C was later discharged and sent home. C suffered constant and debilitating pain and an inability to return to work after the procedures and claimed that he was not given proper advice before the decompression procedure. Had he received proper advice, he would not have consented to that procedure. The judge found in favour of C. The reasons for the judge's decision were as follows.

The judge preferred C's recollections of the preoperative discussion. Both C and his wife's version were the same, they were convincing witnesses and they had the benefit of consulting solicitors no later than a year after the operation and so events were fresh in their minds. The surgeon's evidence had changed and he had been in a difficult position, as he had not had to try to recall the events until four years after the operation. On the evidence, C had not been advised of alternative procedures, neither had he been warned of the possible risks consequent on undergoing revision surgery. The surgeon had conveyed assurances that it would be fine and C had not been told that the surgery was urgent. The advice given did not satisfy the minimal standards of professional competence. There should have been a clear warning of the higher incidence of problems arising from revision surgery and other options should have been discussed. The surgeon admitted that he had not explained to C that any course of action was available other than surgery. In the instant circumstances, had C received the appropriate advice he would not have agreed to undergo the operation. The judge found that there was a causal and temporal connection between the surgery and the symptoms, which were different and worse very soon after the surgery. The two operations had occurred within a short period on a site previously operated on and had caused damage resulting in C's operation. The symptoms were much worse than they would have been without the surgery.

The case shows the importance of which side can prove what was actually said before the patient agreed to undergo the operation.

Non-therapeutic procedures

It was suggested in a case in 1987 (see Case 7.13) that the principles set out in the Sidaway case did not apply where non-therapeutic care was being provided but this was not accepted by the Court of Appeal.

Case 7.13 *Gold* v. *Haringey Health Authority* (1987)

Risk of sterilisation failing[72]

The claimant had two children and when she became pregnant agreed with her husband that they would have no further children after that pregnancy. She was seen by a consultant who suggested sterilisation following the birth of the child, but made no mention of the possibility of her husband having a vasectomy. Neither did he give her any warning of the risk of the sterilisation failing. The sterilisation operation was performed the day after the birth, but she subsequently became pregnant with her fourth child. She brought an action against the health authority alleging that there was negligence in failing to warn her of the risk of the operation failing and that the statement to her that the operation was irreversible amounted to a negligent misrepresentation.

The trial judge held that there was a distinction in the information that should be given in a non-therapeutic context compared with a decision on therapeutic treatment and that a sterilisation operation was non-therapeutic. He awarded her damages of £19,000. On appeal, the Court of Appeal held that the principles set out in the Sidaway case should apply in both contexts and it did not accept the validity of a distinction between therapeutic and non-therapeutic:

> **The [Bolam] principle does not depend on the context in which any act is performed or any advice given. It depends on a man professing skill or competence in a field beyond that possessed by the man on the Clapham omnibus. If the giving of contraceptive advice required no special skill, then I could see an argument that the Bolam Test should not apply. But that was not, and could not have been suggested. The fact (if it be a fact) that giving contraceptive advice involves a different sort of skill and competence from carrying out a surgical operation does not mean that the Bolam Test ceases to be applicable. It is clear from Lord Diplock's speech in Sidaway that a doctor's duty of care in relation to diagnosis, treatment and advice, whether the doctor be a specialist or general practitioner, is not to be dissected into its component parts. To dissect a doctor's advice into that given in a therapeutic context and that given in a contraceptive context would be to go against the whole thrust of [the decision in Sidaway].**

The judge should have accepted the body of responsible medical opinion on the standard that should have been followed in giving her information.

Giving information to the terminally ill patient

In research reported by the Marie Curie Palliative Care Institute in Liverpool and the Royal College of Physicians,[73] it was found that only 45 per cent of patients know that they are in 'the dying phase', compared with 80 per cent of their carers. The failure to inform patients was also evidenced in a report by the Royal College of Physicians in May 2014 which is considered in chapter 29.[74]

If a patient is terminally ill, should the nurse tell the patient contrary to medical advice? What is the position if the relatives do not wish the patient to be told?

Practical Dilemma 7.4 Silence or lies?

Paul George has been operated on for 'ulcers'. Unknown to him, the surgeons actually found an inoperable tumour with wide spreading of the malignancy throughout the body. It is estimated that death is likely to occur in a few months. The consultant, who is normally in favour of a very open approach to patients, believes that Paul, who is 54, would not be able to cope with this news yet and he discusses this with Paul's wife, who agrees. The nursing staff are advised accordingly.

This kind of situation is in substance not unfamiliar to nursing staff and is repeated in different guises on many occasions. Unfortunately, however, it is the nursing staff who are most frequently with the patients and who are most likely to be asked: 'I don't have cancer, do I nurse?' or 'When am I likely to get out of here?' or 'Is it worth my while booking for this holiday next year?' and other direct or indirect questions designed to obtain a little more information for the patient as to where he stands. The questions that then arise in the nurse's mind are: Where does the patient stand in law? Does the patient have a legal enforceable right to obtain this information? What is the nurse's position in regard to the patient, the doctor and the relative?

Patient's rights

As has been seen in the discussion thus far, there is a duty on professional staff when advising certain forms of treatment to ensure that the patient is notified of any significant risks of substantial side effects. However, this duty on the professional is qualified by the power to withhold information in the rare cases where it is deemed to be in the patient's interest not to know. This is known as therapeutic privilege. Informing the patient that he is terminally ill may well come under this heading. Thus, if, in the opinion of the doctor, it would be harmful to tell a patient such disturbing news, then the doctor

can withhold such information on the grounds that he is acting in the patient's best interest. A doctor may not withhold information about risks because he believes the patient would refuse consent if he were aware of them. There must be other reasons to justify withholding this information. There is no clear right in law for the patient to insist on being told, and even where the patient is exercising his right under the Data Protection Act 1998, there is the power to withhold such data from him if serious harm would be caused to the patient's mental or physical health or condition (see chapter 8).

The consultant or general practitioner has clinical responsibility for the patient. If in the doctor's opinion the patient would be harmed by any disclosure and he has exercised his judgement on this in accordance with the approved professional practice, then that decision must be accepted and implemented by the rest of the team of professionals. The nurses might disagree with the decision and, of course, they may well have the opportunity of persuading the doctor to change his mind, based on their own personal knowledge of the patient, his needs and his own understanding. Ultimately, however, they would be obliged to defer to the clinical decision of the doctor. Any nurse who flagrantly went against the doctor's view on this might well face disciplinary proceedings. What is clear at the present is that in the absence of any absolute statutory provision for accessing information, patients do not have a clear right to obtain this information. It may be that future cases based on the Articles of the European Convention on Human Rights may hold that keeping significant information from patients is a breach of Article 3 or Article 8 (see website of this book).

The court has yet to deal directly with the question as to whether the patient has a right to be told and whether the doctor has a duty to tell when the patient is in a terminal condition. It is quite likely that if this is put before the courts, the court will apply the Bolam Test and leave it to the approved professional practice in relation to that particular patient. (The issue of obeying instructions is considered in chapter 4.)

Relatives' rights

It is not uncommon for relatives, on hearing of a particularly upsetting diagnosis, to ask for the patient not to be informed of it 'because he could not cope with that yet'. Often, perhaps, it is not the patient's inability to deal with the information, but the relatives' inability to cope with the patient's knowledge of it. The conspiracy of silence thus begins. As far as the law is concerned, unless the patient is mentally incompetent, this should not arise. The patient is entitled to have information about him kept confidential (see chapter 8). It is a breach of this duty to the patient when the relative is told first. It is always open to the patient to say to the doctor, 'I would rather that my wife was not told about my diagnosis yet.' That is his right. Yet, when terminal illness or chronic sickness are concerned, the rules of confidentiality are broken and the relative is often informed first. Obviously, there are exceptions to this duty of confidentiality when the patient is too ill to be told and decisions have to be made that therefore involve the relative. However, that should be the exception.

Let us return to the situation of Paul George (Practical Dilemma 7.4). If the nurse has received clear instructions that Paul should not be told that he is terminally ill, the nurse should not act contrary to these instructions. Neither, however, should she lie to Paul. If Paul makes it clear that he is seeking more information, the nurse should arrange for Paul to speak with the doctor concerned and express to the doctor her own views of Paul's needs. Ultimately, the wife has no right to insist that information is withheld from Paul. Obviously, because of her knowledge of Paul, she should be involved in any discussions on the correct approach.

Notifying the patient of negligence by a colleague

If a colleague has been negligent or even acts criminally, should the nurse inform the patient? This is not a hypothetical question, as the cases of Beverly Allitt, Dr Shipman and the Francis Inquiry[75] into Mid Staffordshire NHS Trust (see chapters 2 and 5) show, and it sometimes happens that a nurse is

aware that a mistake has been made and that neither patient nor relatives have been made aware of this, although they may realise that all has not gone according to plan. What is the nurse to do in these circumstances? Does she have a duty to inform the patient?

The nurse should take every action that she reasonably can to ensure that the patient is fully informed. Reference must also be made to the Code of Professional Conduct and the practitioner's duty to ensure that any untoward occurrences are brought to the attention of the appropriate officer. Where the nurse is herself at fault the NMC has made it clear that, where a practitioner has honestly admitted an error, she should be treated differently from a practitioner who has attempted to cover up a mistake.[76] NHS trusts and health authorities are required to establish procedures to implement the Public Interest Disclosure Act 1998, known as the whistleblower's charter. Guidance is given in HSC 1999/198 by the Department of Health on the implementation of this Act. Its aim is to protect any employee who brings a protected disclosure (e.g. a criminal offence, health and safety danger, failure to fulfil legal duty) to the attention of the appropriate person in the organisation from any victimisation. (This legislation is further discussed in chapter 4.) The Kennedy Report on Bristol paediatric heart surgery[77] recommended that there should be openness and honesty with patients. The Francis Report recommended that there should be a duty of candour on the individual but the government has instead opted for a duty of candour to be placed on the organisation and section 81 of the Care Act 2014 enables the appropriate regulations to be made (see chapter 5). The National Patient Safety Agency's effectiveness depends on health professionals being prepared to admit when hazards exist or where accidents have occurred. The Action for Victims of Medical Accidents is campaigning for a duty of candour to be included as one of the standards required for registration with the Care Quality Commission (CQC). They call it 'Robbie's Law', after Robbie Powell whose family fought for justice against cover-up and alleged fraud (Robbie Powell died in 1990 of Addison's disease which was not diagnosed, but suspected. The medical records were found to have been falsified. Subsequently the parents accepted an out-of-court settlement with the health authority, and have called for a public inquiry into his death and the post-death cover-up.) Barrister Nicholas David Jones conducted an inquiry which reported in February 2012 and the report was presented to the Welsh Assembly in July 2012 heavily redacted. Jonathan Evans MP, who has supported the Powell family, has called for greater openness in disclosing the reasons why failures occur and for a duty of candour to be recognised.

The CQC stated in its website that 'the CQC is working closely with the DH and the National Patient Safety Agency to address concerns about outstanding safety alerts. On 1st April 2010 the CQC implemented a new regulatory scheme and now uses information about safety alerts to monitor standards in the NHS.'[78] The CQC's own problems with its own failures are considered in chapter 5. (See also chapter 12 and the reporting of safety alerts.)

No decision about me, without me

The White Paper *Equity and Excellence: Liberating the NHS* set out the government's vision of an NHS that puts patients and the public first, where 'no decision about me, without me' was the norm. It made proposals on giving everyone more say over their care and treatment with more opportunity to make informed choices, as a means of securing better care and better outcomes. The Department of Health issued two consultations: the first, *Greater choice and control* (2010) sought views on the choices people wanted to make and led to the introduction of choice in the providers of community services. The second (2012) was on how to make patient choice a reality in primary care, before diagnosis at referral and after diagnosis. The government published its response to the results of the latter consultation in December 2012.[79] It noted that the Health and Social Care Act 2012 made clear the duties on the NHS Commissioning Board and the clinical commissioning groups to promote the involvement of patients and carers in decisions about their care and treatment, and to enable patient choice. In addition the Care Act 2014 focused on the personalisation of care, with people, not institutions, in control. It also created a right to a care and support plan, which should be prepared in consultation with the person

and carer. It also created a new entitlement to a personal budget (see chapter 23). A pledge was to be introduced into the NHS Constitution to involve patients in care planning discussions and to offer them a written record of what is agreed, if they want one. The NHS Commissioning Board will be held to account for delivering this. As part of the implementation strategy, the Department of Health's Choice Framework for NHS-funded care and treatment in England will set out the choices that people can expect to be offered, which will raise awareness of these choices, including where people have legal rights to make choices, as well as screening. The NHS Choice framework can be found on the DH website and on gov.uk. The Department of Health also intended to establish regulations that would include requirements to safeguard patients' rights to exercise choice, and Monitor would oversee the regulations.

Conclusions

The government's strategy for the past two years has been to involve patients in the decisions relating to their care and to ensure that they have the necessary information. This has been bolstered by statutory duties placed on the NHS Commissioning Board, on the clinical commissioning groups, Monitor and in the NHS Choice Framework and in revisions to the NHS Constitution. However, it is not clear that this explicit recognition of patients' rights provides any greater protection than the existing laws in relation to trespass to the person and the duty of care to inform. The new statutory provisions are likely to be enforced through the NHS complaints procedures and these have been notorious failures in ensuring that complaints are dealt with effectively and efficiently. (See chapter 27.)

The implementation of the Mental Capacity Act 2005 and the establishment of the new Court of Protection with its extended remit to cover personal welfare has had a radical impact on decision making on behalf of the mentally incapacitated. There should now be clear policies in place in each health and social care organisation. The consent forms used by health service organisations should have been amended to take account of the new legislation. Increasingly, too, it is likely that more relatives will have lasting powers of attorney in relation to decisions on personal welfare and more advance decisions will be created. (Advance decisions are considered in chapter 29.)

Reflection questions

1 What is meant by implied consent to treatment? Consider examples of implied consent from your own practice.

2 Consider the implications of the Mental Capacity Act for your particular specialty.

3 What is the difference between the 'Bolam Test' and the 'prudent patient' test so far as consent to treatment is concerned?

Further exercises

1 Obtain a copy of Form 1 of the Department of Health's recommended consent forms. How appropriate do you think it is to cover the wide range of treatments for which it is used? Could it be adapted to cover specific treatments that you provide?

2 Refer to the specialist subject areas in Part II of this book and consider the principles that apply to consent by children under 16, consent by young persons of 16 and 17, consent by a person with learning disabilities and by a mentally disordered person and on behalf of an unconscious patient.

3 Consider the first Schedule to the Human Rights Act 1998 (see website of this book) and consider any other rights in relation to healthcare that you consider should be included.

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Chapter 8

Data protection: confidentiality and access

This chapter discusses

- Data Protection Act 1998
- Data protection principles
- First data protection principle
- Duty of confidentiality
- Caldicott Guardians
- Health and Social Care Information Centre (HSCIC)
- Freedom of Information Act 2000
- DNA databases
- Access to personal health records
- Access to Medical Reports Act 1988

Introduction

Two main Acts of Parliament regulate the privacy and access to information: the Data Protection Act 1998 which establishes principles for the control over and access to personal information, and the Freedom of Information Act 2000 which enables individuals to obtain, subject to major exceptions, information held by public bodies. This chapter explains these provisions in the light of the duty of confidentiality binding upon health professionals and the patient's right to access their health records.

Data Protection Act 1998

The European Directive on Data Protection[1] was implemented in this country by the Data Protection Act 1998 (DPA). Under the legislation, members have to establish a set of principles with which users of personal information must comply. The legislation also gives individuals the right to gain access to information held about them and provides for a supervisory authority to oversee and enforce the law. NHS guidance on the Act was provided by a circular in March 2000.[2] The NHS Information Authority was abolished in April 2005 and its work undertaken by NHS Connecting for Health and the Health and Social Care Information Centre. Information is available on the NHS Connecting for Health website.[3] Subsequently, NHS Connecting for Health's functions were transferred to the Health and Social Care Information Centre[4] on 1 April 2013. (The Information Security Management: Code of Practice prepared by the DH is considered in chapter 9.) An explanation of the Data Protection Act 1998 is also available from the Data Protection Commissioner, now known as the Information Commissioner.[5] Good practice notes on the Data Protection Act 1998 are available from the Information Commissioner's website.[6]

The Data Protection Act 1998, unlike its 1984 predecessor, applies to manual records if they form part of a relevant filing system as well as to computerised records and provides tighter provisions on the processing of sensitive personal data. New rules for the transfer of personal data outside the European Community are set out.

Manual files

Data under the 1998 Act includes manually held records if they form part of a relevant filing system. A possible exception to manual records not coming under Data Protection provisions are clinical supervision records in which specific patients are named. These may not come under the provisions of the Data Protection Act since they may not form part of a relevant filing system. The Court of Appeal considered the meaning of relevant filing system in the case of *Durant* v. *Financial Services Authority*[7] [2003] and held that the Act intended to cover manual files 'only if they are of sufficient sophistication to provide the same or similar ready accessibility as a computerised filing system'. It stated that:

a 'relevant filing system' for the purposes of the Act, is limited to a system:

1. **in which the files forming part of it are structured or referenced in such a way as to clearly indicate at the outset of the search whether specific information capable of amounting to personal data of an individual requesting it under Section 7 is held within the system and, if so, in which file or files it is held; and**
2. **which has, as part of its own structure or referencing mechanism, a sufficiently sophisticated and detailed means of readily indicating whether and where in an individual file or files specific criteria or information about the applicant can be readily located.**

Further explanation of relevant filing systems is given by the Information Commission in his briefing note on the Durant case in 2006.[8] The ICO in its frequently asked questions on relevant filing system suggested that the 'temp test' was applied to determine whether manual records were in a relevant filing system: i.e. would a temporary administration assistant be able to extract specific information relating to an individual from the manual records without any particular knowledge of the type of work done or documents.[9]

Information Commissioner

The person responsible for the enforcement and overseeing of Data Protection legislation used to be known as the Data Protection Commissioner (originally the Registrar under the 1984 Act), but since that individual is now also responsible for the implementation of the Freedom of Information Act 2000,

he or she is now known as the Information Commissioner (IC). Both the Data Protection and Freedom of Information Acts fall within the Information Commissioner's jurisdiction, together with the Environmental Information Regulations and the Privacy and Electronic Communications Regulations. Good practice notes, codes of practice and technical guidance notes on all this legislation are available on the Information Commissioner's website.[10]

The Information Commissioner's Office (ICO) has legal powers to ensure that organisations comply with the legal requirements and details of cases where these powers of enforcement have been used are available on the ICO website. An application for judicial review by the Secretary of State of an information tribunal decision which had quashed a ministerial certificate claiming exemption from providing subject access on grounds of national security failed. The High Court held that the Information Commissioner had the power to check whether an exemption was properly claimed.[11] The powers of the Information Commissioner were strengthened by the Coroners and Justice Act 2009. The Information Commissioner has the power to order organisations to pay up to £500,000 as a penalty for serious breaches of the Data Protection Act. This is part of the ICO's overall regulatory toolkit which includes the power to serve an enforcement notice and the power to prosecute those involved in the unlawful trade in confidential personal data.[12]

Between August 2011 and August 2012 the ICO enforcement team investigated 23 cases in which the NHS had potentially breached section 55 of the Data Protection Act (section 55 makes it an offence for a person without the consent of the data controller to obtain or disclose personal data or procure the **disclosure** to another person of the information contained in the data). Appendix 4 of the second Caldicott[13] review (see page 206) gives examples of ICO actions in enforcing the Data Protection Act provisions. For example in January 2012 a former health worker was prosecuted and pleaded guilty to unlawfully obtaining patient information by accessing the medical records of five members of her ex-husband's family in order to obtain their new telephone numbers.

Torbay Care Trust was fined £175,000 after personal confidential data relating to 1,373 employees was published on the Trust's website.

In March 2013 a former receptionist at a GP surgery in Southampton was prosecuted under section 55 of the DPA for unlawfully obtaining sensitive medical information relating to her ex-husband's new wife. She was fined £750.

The Information Commissioner stated that people who were convicted of illegally accessing sensitive personal data should face imprisonment rather than just the current maximum fine of £5,000. Powers to jail offenders were included in the Criminal Justice and Immigration Act 2008 but at time of writing had not yet been implemented.[14] The bosses of a private investigation company ICU were convicted of conspiring to unlawfully obtain personal data. They phoned utility companies and the television licensing authority to obtain details of the debtors they were chasing.[15]

In January 2014 the IC published a report on the outcomes from visits to general practitioners and primary healthcare providers, giving examples of good practice and areas for improvement.[16]

Terminology

- 'Personal data' are data that relate to a living person, who can be identified from those data or from those data together with other information in the possession of the data controller.
- 'Sensitive personal data' are personal data consisting of information as specified in section 2 of the 1998 Act. Section 2 includes racial or ethnic origins, political opinions and the physical or mental health or condition or sexual life of the data subject.
- 'Data subject' is the individual who is the subject of the personal data.
- 'Data controller' means a person who, either alone or with others, determines the purposes for which and the manner in which any personal data are, or are to be, processed.
- 'Processing' includes obtaining, recording or holding information or carrying out any operation, including retrieval or consultation or use of the information, and disclosure (definition abbreviated by author).

Human rights

The Data Protection Act 1998 must be read in conjunction with the Human Rights Act 1998 (see chapter 1), since Article 8 recognises an individual's right to private and family life (see website of this book). The Freedom of Information Act 2000 gives a right to access to information held by public authorities, but this is subject to many exceptions, including personal information where the Data Protection Act 1998 applies (Freedom of Information Act 2000 section 40). The courts have issued injunctions to grant people lifetime anonymity. Thus, where two young boys had been convicted of killing James Bulger, a toddler, there was a fear for their safety (and therefore their Article 2 rights were at stake) if their new identities were disclosed, and an injunction was ordered forbidding disclosure of their identities;[17] a woman who had been convicted of manslaughter for killing two young children when she was 11 years old succeeded in obtaining an injunction to protect the privacy of herself and her daughter. There was no real fear of danger to her life (and therefore Article 2 rights), but her right to private and family life under Article 8 was threatened.[18] The Supreme Court held that the automatic release of a person's convictions, cautions and warnings regardless of the length of time that had elapsed, when that person was required to obtain an enhanced criminal record certificate for the purposes of obtaining employment which involved working with children or other vulnerable persons was incompatible with their Article 8 right to respect for their private life.[19] The European Court of Human Rights held that journalists were entitled to protection under Article 10 (freedom of expression) and were not required to disclose the source of their information.[20] The public interest in the protection of journalists' sources was sufficient to outweigh any threat of damage through future dissemination of a company's confidential information. In a case in 2010 the Court of Appeal held that confidentiality of commercial information could be seen as a possession and under the Human Rights Act private and public interests had to be balanced in the interests of proportionality.[21] The dispute about the use of super-injunctions, where the very existence of the application for an injunction cannot be mentioned, is still unresolved despite the Master of the Rolls Lord Neuberger's report in May 2011.

In May 2014 the Supreme Court held that courts had an inherent jurisdiction under the common law and statutory power to depart from the principle of open justice and interfere with the right of freedom of expression by prohibiting the publication of names and other details in court proceedings if that was necessary in the interests of justice or for the protection of an individual. The BBC were prevented from identifying an immigrant who had committed sexual offences and feared for his safety if his identity was known when deported.[22]

In 2014 the European Court of Justice[23] held that Google, as an internet search engine, had a legal duty to remove search results that are 'inadequate, irrelevant or no longer relevant, or excessive', i.e. there is a *right to be forgotten*. The decision has led to a heated controversy over the right of the individual to privacy and the removal of deprecatory facts in their history and the right of freedom of expression.

Data protection principles

The Data Protection Act sets out eight principles that apply to the keeping of computerised data (see Statute Box 8.1). These principles are designed to ensure that personal data shall be accurate, relevant, held only for specific defined purposes for which the user has been registered, not kept for longer than is necessary and not disclosed to unauthorised persons. In addition, a right of subject access is given, i.e. the individual should be able, on payment of a small fee, to see what is contained about him and have a right to rectify that if it is not correct. The Commissioner has the power to enforce the duties under the Act and offenders can be prosecuted. Stronger powers allowing the ICO to impose fines on trusts or individuals up to £500,000 were introduced in April 2010. There are proposals to use powers under the Criminal Justice and Immigration Act 2008 to introduce custodial sentences of up to 2 years for the knowing or reckless misuse of personal information. The individual data subject has the right

to apply to the courts for compensation for damage and any associated distress caused by a breach of these principles by the data user. (The provisions in relation to access to health records are considered below.) An orthopaedic surgeon lost his appeal against the refusal of the High Court to hold that removal of his name from the register of members of the Medical Defence Union breached principle one of the Data Protection Act 1998 in that his personal data was not processed fairly.[24]

Statute 8.1 Principles of the Data Protection Act 1998 Schedule 1

1 Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless:
   (a) at least one of the conditions in Schedule 2 is met, and
   (b) in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.
2 Personal data shall be obtained only for one or more specified and lawful purposes and shall not be further processed in any manner incompatible with that purpose or those purposes.
3 Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
4 Personal data shall be accurate and, where necessary, kept up to date.
5 Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose(s).
6 Personal data shall be processed in accordance with the rights of data subjects under this Act.
7 Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.
8 Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

First data protection principle

This principle, which requires that personal data shall be processed fairly and lawfully, prevents the processing unless at least one of the conditions in Schedule 2 is met and, in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met. One of the conditions in Schedule 3 is that personal data is processed in circumstances specified in an order made by the Secretary of State. Such circumstances were specified in 2012 enabling the disclosure of sensitive personal data when that is necessary to give effect to the protocol on disclosure of information relating to the Hillsborough Stadium disaster.[25] Schedules 2 and 3 are set out in the Department of Health guidance and can be seen on the website of this book.[26] Schedule 2 includes the consent of the patient, contractual purposes and compliance with legal obligations necessary to protect the vital interests of the data subject or necessary for the administration of justice or for the legitimate purposes of the data controller. Schedule 3 includes the explicit consent of the patient, rights and obligations in connection with employment, where the processing is necessary to protect the vital interests of the data subject or another person, where the consent cannot be given by or on behalf of the data subject or where the data controller cannot reasonably be expected to obtain the consent. The Privacy and Electronic Communications (EC Directive) Regulations 2003 controls the sending of unsolicited direct marketing by phone, fax, email and text messages and further information can be found on the ICO website. Guidance is provided by the DH, GMC and the ICO on the use of IT equipment and access to patient data.

EU draft legislation: proposed privacy laws and medical research

Concern was expressed by a government adviser in a report published by Fresh Start that medical research was threatened by privacy legislation pending in the EU. The proposed legislation would ban

companies from selling an individual's data without consent, but could also jeopardise the use of patient records in clinical research.[27] Leading medical research institutions including the Welcome Trust[28] and the head of the Medical Research Council[29] have also expressed concern that prospective changes to the proposed Data Protection Framework which require specific rather than general consent to disclosure will make vital research at worst illegal and at best unworkable. The legislation will also jeopardise the investment in scientific infrastructure such as cancer registers, cohort studies and bio-banks. A letter to *The Times* also points out that it will inhibit knowledge and research on rare disorders.[30]

Proposals known as care.data to share GP records with hospital records in the same database were put on hold in February 2014. NHS England agreed to delay the implementation of care.data for six months to improve the security of patient confidentiality.[31] Each patient in England is to be informed about the scheme and receive an opt-out form. Professor Nick Black and Professor Lord Darzi and others wrote to *The Times* emphasising the value to public health of the data linkage and the value of including GP data in this link,[32] while the head of the Medical Research Council, Professor Sir John Savill, stated that only 'consent fetishists' could truly object to plans to share patient data across the NHS which has huge benefits.[33]

It was reported in the *Sunday Times* on 16 March 2014 that patient information had been sold for thousands of pounds. In response the Secretary of State for Health has promised to introduce legislation to ensure that confidential patient data cannot be sold for commercial insurance purposes.[34]

As already mentioned, in May 2014 the European Court ruled that individuals had the right to be forgotten and to ask search engines to remove links with personal information about them.[35] The European Commission has issued a fact sheet on the ruling.[36]

Information tribunals

The information tribunal hears appeals by data controllers against notices (usually enforcement notices) issued by the Information Commissioner under the Data Protection Act 1998 and also appeals against enforcement notices or information notices issued by the Commissioner under the Freedom of Information Act 2000 (see below). Reports of cases heard by the tribunal can be accessed on the Information Commissioner's website. There is a separate national security appeals panel of the tribunal to hear appeals against exemptions from the Data Protection Act on grounds of national security.[37]

Duty of confidentiality

The patient is entitled to confidentiality of the information about him. There is therefore a duty on every professional and indeed every employee to ensure confidentiality of information. The duty arises:

1. From the duty of care in negligence (discussed in chapter 3).
2. From the implied duties under the contract of employment (see chapter 10).
3. From the duty to keep information that has been passed on in confidence, confidential, even when there is no pre-existing relationship or legally enforceable contract between the parties (a duty based on equity and only recently recognised by the courts and discussed in the case of *Stephens* v. *Avery and Others*).[38]
4. From requirements by professional registration bodies as part of the professional conduct, such as the Nursing and Midwifery Council.
5. From statutory duties such as the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights (Schedule 1 of the Human Rights Act 1998; see the website of this book).

In the case of Naomi Campbell, the House of Lords in a majority decision held that even though she had brought into the public domain the fact that she was being treated for drug addition, certain information could still be kept confidential, including the time, form and place of the drug therapy, and she was therefore entitled to damages against the Mirror Group Newspapers (MGN) for that breach

of confidence.[39] In this respect her right to privacy succeeded against the right to freedom of expression under Article 10. Article 8 rights were also upheld in a case brought by Max Mosley against the *News of the World* which published accounts of his alleged sado-masochistic sex sessions. The judge decided that there was no evidence of Nazi behaviour and his private rights under Article 8 should be upheld. There was no public interest which justified a breach of Article 8.[40] The European Court of Human Rights held that secret interception by the Ministry of Defence of the external communications of Liberty were not dealt with adequately under the Interception of Communications Act 1985 with sufficient clarity to give individuals protection and there was therefore a breach of Article 8 rights.[41]

In a recent case a complaint was made about a consultant psychiatrist who read notes and discussed patients while on public transport. She admitted the confidentiality breaches, apologised and promised not to repeat the conduct. She was referred to a disciplinary panel but argued that the 'fair blame' procedure should be implemented. The Court of Appeal held that the case manager had been entitled to regard a breach in a public place as a potentially serious offence and was justified in referring the case to a disciplinary hearing.[42]

Under the duties implied in the contract of employment, the employee has a responsibility to the employer to keep information acquired from work confidential (see chapter 10). For the nurse, too, that duty is also spelled out by the Code of Professional Conduct: standards for conduct, performance and ethics[43] (see Box 8.1). (See Box 8.2 on page 192 for exceptions to the duty of confidentiality.)

Box 8.1 Code of Professional Conduct of the NMC: Make the care of people your first concern, treating them as individuals and respecting their dignity

Respect people's confidentiality

- You must respect people's right to confidentiality
- You must ensure people are informed about how and why information is shared by those who will be providing their care
- You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising.

While this code is not enforceable in a court of law, it reflects what the law upholds and is used by the NMC and its committees as a guideline in determining whether the nurse is guilty of professional misconduct and therefore whether her fitness to practise is impaired. Difficulties arise not in understanding the duty of confidentiality, but in knowing when the exceptions arise and in what circumstances breaking the duty is permissible. The NMC has produced an advice sheet providing guidance on confidentiality and the circumstances in which disclosure is justified.[44]

In a case brought by Ashworth Hospital against MGN, the judge made an order requiring the newspaper group to disclose to the hospital the identity of the source of their information about a convicted murderer who was a patient at Ashworth. The Court of Appeal upheld this judgment, holding that the protection of patient information was of vital concern to the NHS.[45] MGN disclosed that the clinical notes had been received from a freelance investigative journalist, Mr Ackroyd. He then refused to identify his sources within the hospital. The hospital then sought an order requiring him to disclose the source of the notes. Mr Ackroyd stated that although he had been paid £1,250 from the *Mirror*, his sources at the hospital had not received any payment and were not motivated by financial gain, but to reveal publicly the way in which Ian Brady had been treated.

The Court of Appeal held that the protection of journalistic sources was one of the basic conditions of press freedom and the hospital had to establish an overriding public interest amounting to a pressing

social need to which the need to keep press sources confidential should give way. The current case was different from the original MGN case, since as a journalist he was entitled to present different evidential material from a different perspective. The passage of time since the original case meant that there was no cloud of suspicion that was still blighting activity at the hospital and there had been no breach of confidentiality.[46] On 27 July 2007 the House of Lords refused leave to appeal against the Court of Appeal decision. Robin Ackroyd was thus not forced to disclose the source of his information.

The High Court has also recognised that in exceptional circumstances the court has the jurisdiction to extend the protection of confidentiality of information even to the extent of imposing restrictions on the press where a failure to do so would probably lead to serious physical injury or the death of the person seeking that confidentiality. Thus it granted an injunction to prohibit the publication of the details of the boys who killed James Bulger.[47]

In 2003 the DH issued an NHS Confidentiality Code of Practice.[48] This supersedes the earlier advice on the protection and use of patient information issued in 1996 and is quoted in new guidance from NHS England in a Confidentiality Policy.

In 2013 NHS England published a Confidentiality Policy the purpose of which was to lay down principles that must be observed by all who work within NHS England and have access to person-identifiable information or confidential information. A summary of Do's and Don'ts is set out in Appendix A. Appendix B sets out the legal framework and the Caldicott principles.

The functions of NHS Connecting for Heath were transferred to the Health and Social Care Information Centre (HSCIC) on 31 March 2013 which has a wider confidentiality strategy and a duty to ensure that patient data remains confidential.[49] (See page 207.)

Regulations on the disclosure of patient information

Powers are given to the Secretary of State under sections 60 and 61 of the Health and Social Care Act 2001 (re-enacted in sections 251 and 252 of the NHS Act 2006) to make regulations on the disclosure of patient information. This was subject to the scrutiny of the Patient Information Advisory Group (PIAG (then the NIGB and now the Confidentiality Advisory Group within the Health Research Authority))[50] of the draft regulations and whether they were justified. Regulations were drawn up following scrutiny by the PIAG relating to cancer registers and communicable diseases.[51] As a consequence, disclosure to cancer registers and other specified registers of patient information were legitimated. The use of Department of Health powers should be consistent with human rights. The PIAG supported the processing of the following databases without patient consent:

NHS-Wide Clearing Service
Hospital Episode Statistics
National Health Authority Information System
Patient Episode Database for Wales.

The PIAG was replaced by the National Information and Governance Board for Health and Social Care (NIGB),[52] which was established under section 157 of the Health and Social Care Act 2008. The NIGB website hosted the NHS Care Record Guarantee.[53] Its overall role was to support improvements to information governance practice in health and social care.

On 1 April 2013 the NIGB's functions for monitoring and improving information governance practice were transferred to the Care Quality Commission and on 31 March 2013 all functions that advise on the use of confidential patient information without consent according to regulations made under section 251 of the NHS Act 2006 were transferred to the Health Research Authority (see chapter 18). The HRA convened a Confidentiality Advisory Group to take on responsibility for advising on applications. Further information on the HRA and the effects of the Care Act 2014 can be found in chapter 18.

The Health Research Authority (HRA) which was established in 2011 (see chapter 18) is responsible for the Confidentiality Advisory Group (CAG) which considers applications to use patient data without

consent. The CAG offers advice while the final decision on whether to approve the applications is made by the HRA (for research studies) or the Secretary of State for Health (for non-research studies). (For further information on the HRA see its website[54] and chapter 18.)

The Informatics Services Commissioning Group is a partnership between the Department of Health, Care Quality Commission, MHRA, the Department of Health, NICE and Monitor to manage future investment in informatics in health, healthcare and social care. It can be accessed via the NHS England website.[55]

A children's database was set up under the Children Act 2004,[56] known as ContactPoint. However, after concerns about the security of personal data on it and the view of the Coalition government that it was not the right way to help vulnerable children, it was ended in 2010. The retention of DNA records is considered below.

Exceptions to the duty of confidentiality

In chapter 5 of the Review of Information Governance carried out by Dame Fiona Caldicott in 2012[57] (see page 206) four legal bases for processing personal confidential data are identified. They are: the consent of the patient, statutory provisions, court order and in the public interest. These have been expanded for the purpose of this chapter and are shown in Box 8.2.

Box 8.2 Exceptions to the duty of confidentiality

1 Consent of a patient.
2 Interests of patient.
3 Court orders:
  subpoena
  civil procedure rules.
4 Statutory duty to disclose:
  Road Traffic Act 1988 (as amended)
  Prevention of Terrorism (Temporary Provisions) Act 1988
  Public Health Acts
  Misuse of Drugs Acts
  Health and Social Care Act 2008.
5 Public interest.
6 Police.
7 Data Protection Act 1998 provisions.

Consent of the patient

The duty is owed to the patient and it is therefore in the power of the mentally capacitated patient to authorise disclosures to be made. Thus announcements to the press, notification of relatives and spouses and provision of information to a solicitor or to an insurance company are all legitimate disclosures with the consent of the patient. If the patient is unconscious and an adult, the consent of the relatives is often used to justify disclosure on behalf of the patient, but there may well be little justification for this in law, unless the patient has appointed that relative as his agent and given him that authority. The Court of Appeal held that no confidentiality arose in relation to a decision made by the Law Society on the outcome of a complaint made about a solicitor.[58] Similarly, if a patient wished to give details about a complaint he had made about his healthcare, subject to the laws of defamation, he would be legally able to do so. In contrast, if anyone else published details of the complaint without the patient's consent, this would be a breach of confidentiality.

Practical Dilemma 8.1 Spouse's confidence

Annabel was involved in a serious road accident and admitted to hospital. While on the orthopaedic ward, a telephone request came in asking for information on her progress. The nurse taking the call asked who the caller was. The answer was 'her husband'. The nurse then gave the caller full details of Annabel's progress. She then told Annabel that her husband had phoned, asking for information about her; the nurse was surprised at Annabel's fury. It appeared that she had recently separated from him, she had not notified him of where she was now living and did not want any communication with him because of his violence.

The difficulties of the nurse's position in a situation like this are easily understood. In 99 out of 100 cases, Annabel would be delighted to receive a message of concern and interest. However, it is the 100th case that causes concern and procedures have to be established to prevent any unauthorised information being disclosed. Annabel is entitled to withhold information of her condition from her relatives and friends. In some cases, even an acknowledgement that a patient is on a particular ward, e.g. psychiatric or gynaecology (abortion), might be an unwarranted disclosure. In Practical Dilemma 8.1, the nurse was at fault in not checking with Annabel first and it is now standard practice not to disclose information over the phone unless checks on the caller have been made and the patient is agreeable to the information being given.

There can often be a problem in caring for elderly patients where the patient has made a special request to the nurses that the relatives should not be told about his/her condition. However, it can give rise to additional problems for staff. 'Where do I stand if I do not contact the relatives regarding the condition of the elderly patient because the elderly patient has asked me not to do so?' is a not infrequent question. Applying the principles discussed here, the patient does have the right to refuse to allow this information to be passed on. However, if the relatives are to care for the patient eventually, there may well be information that they need to know for the patient's own safety and thus disclosure is justified in the interests of the patient (see below).

Disclosure refused by the patient

In the following case the patient refused to permit disclosure of her records to her employer.

Case 8.1 *Nicholson v. Halton General Hospital NHS Trust* (1999)

Waiver of patient's right to confidentiality[59]

The claimant issued proceedings against her employer, alleging that she had sustained radial tunnel syndrome in her right wrist as a result of his negligence in requiring her to perform repetitive movements at work. She had undergone a remedial operation and the employer wished to have details of the reasons for the operation and the nature of the condition. She refused to give permission for the employer's legal and medical advisers to discuss the operation with her consultant. The employer sought an 'unless' order from the court, that unless she provided the necessary consent, the proceedings would be stayed. Her consultant also stated that he would not become involved unless instructed by the court. The judge refused the 'unless' order.

The Court of Appeal upheld the appeal and granted the 'unless' order. It stated that the court could not order a claimant to waive her right of confidentiality, but could stay proceedings until the claimant waived the right of confidentiality. Information requested from a claimant in a case of this kind should

be confined to that which was relevant to the issues between the parties and a claimant could not restrict the information requested to a written rather than an oral form.

Disclosure to the press

Exactly the same principles apply when the press are asking for information about a patient. If the patient consents, the information can be given. If the patient refuses, then no information should be given and this includes a condition check, where the press phone up to find out the latest condition of the patient. Where the patient is unconscious, confidentiality should be respected.

Disclosure in the interests of the patient

Disclosure between professionals caring for the patient is justified on the basis that if information obtained by the doctor and relevant to the care of the patient is not passed on to the appropriate professional, then the patient might suffer. An obvious example is the patient's history of allergy to certain medication: if the pharmacist and the nurse were not told of a known allergy or allowed to see the records, they would be unable to ensure that the patient was given appropriate medication. Traditionally, nurses have not usually had difficulties over access to the patient's records. Other professional groups have encountered difficulties: occupational therapists, physiotherapists, social workers and other groups have sometimes been refused access to the patient's records on the grounds that it is unnecessary and also a breach of confidentiality. This is a difficult problem. On the one hand, the wider the range of people who have access to the medical records of the patient, the more difficult it is to maintain the duty of confidentiality. On the other hand, there are many situations where a professional caring for the patient, in ignorance of certain facts known to the doctor, could do the patient considerable harm.

The problem becomes even more complex when we consider the question of how much confidential information should be given to a volunteer who is taking the patient out. For example, if the volunteer is taking a patient with learning disabilities out for the day, it might be vital in the interests of the safety of the patient to advise the volunteer that the patient is epileptic and to ensure that the volunteer would know how to cope should the patient have a fit. Contrariwise, the fact that the patient had an abortion five years ago would be irrelevant and thus would be a disclosure that would not be justified in the interests of the patient.

In conclusion, it could be said that disclosure of confidential information to others is justified if it is necessary in the interests of the health and/or safety of the patient or the professional. Those to whom this information is disclosed would themselves be subject to the same duty of confidentiality. AIDS/HIV has raised many significant problems in this field and these are discussed further in chapter 26. The right to access records in the interests of the patient does not cover 'snooping'. A nurse faced fitness proceedings before the Conduct and Competence Committee because she abused her position by checking the medical records of a patient who was having an affair with her husband, a GP. She looked at the woman's computer records 230 times in two years. She was allowed to stay on the Register because her misconduct was during a sustained period of personal stress and was unlikely to recur.[60]

Court orders

Subpoena

This is an order made by the court, which must be obeyed under threat of punishment for contempt of court.

The court has the power to **subpoena** any relevant evidence or witnesses in a case in the interests of justice. The court can also place conditions on an order for disclosure, as in the case of *A Health Authority* v. X.[61] In this case, the health authority received information about a child protection case from the local authority from which it considered that there had been possible medical malpractice. The health authority sought an order for production of certain case papers, which the judge allowed and ordered the respondent doctor to produce the medical records. The judge placed certain conditions on the order to ensure the confidentiality of the documents and to prevent disclosure to third parties without the per-

mission of the court. The health authority appealed against these conditions, but the Court of Appeal held the judge had been correct to exercise his discretion to impose conditions on the orders for disclosure.

There are only two exceptions to the power of the court to order disclosure and these are known as being privileged from disclosure.

Privilege on grounds of public interest (sometimes known as public interest immunity). An example of public interest protected from an order for disclosure is national security. It would usually be claimed by a minister of the Crown when a certificate is signed to the effect that disclosure of a particular document or information would be contrary to the public interest. Following the Scott Inquiry into the Matrix Churchill case, it was recommended that privilege on the grounds of the public interest should not be claimed when prosecution of a criminal offence was being brought. The House of Lords laid down guidelines for claiming privilege on grounds of public interest in a case in 2004.[62] It stated that withholding information (as an exception to the golden rule of disclosure) may be justified but it always had to be the minimum necessary to protect the public interest in question and could never imperil the overall fairness of the trial. Further clarification of the issue can be found on the Serious Fraud Office website.[63]

Legal professional privilege This second exception to the power of the court to order disclosure covers communications between client and legal adviser where litigation is envisaged or is taking place. In the interests of total disclosure between client and lawyer, and in the advancement of justice, these communications are free from an order of discovery or disclosure. Difficulties have arisen over the disclosure of statements taken from witnesses to an accident that might be used later in any court proceedings. Are such statements protected from disclosure on the grounds of legal professional privilege?

In the case of *Waugh* v. *British Railway Board*,[64] it was held that where a document comes into being after an accident and where there are two purposes for its use (e.g. management purposes to ensure that the accident does not happen again and legal purposes to defend any potential action), then if the dominant purpose is for management purposes, the document is not privileged from disclosure under the rules of professional legal privilege. This ruling by the House of Lords was upheld in the following case.

Case 8.2 *Lee* v. *SW Thames RHA* (1985)

Disclosure[65]

Marlon Lee, a young boy, was severely scalded and was initially treated in a hospital run by one health authority, then subsequently transferred to a burns hospital run by another district authority. Shortly afterwards, he developed breathing problems and was transferred to the first hospital by the ambulance that came under the South West Thames Regional Health Authority. He suffered brain damage, which was considered to be due to lack of oxygen. The mother asked for disclosure of the ambulance report produced by the regional health authority for the first hospital, but was refused it. Her application to the court for disclosure failed on the basis that the report was prepared in contemplation of litigation and to assist the legal advisers and disclosure could not be ordered even though it had been initiated as a result of the request by the first hospital authority, not by the authority responsible for the ambulance service.

This case shows the disadvantages faced by potential litigants since the health authority or NHS trust is, of course, both custodian of the records and a potential defendant, and can use its first function to enable it to have immediate access to all the relevant records. (If the report can be defined as part of the personal health records of the patient, then access may be obtained under the data protection subject access provisions unless the exceptions apply.)

The test to decide whether communication between a solicitor and his client was privileged from disclosure was to consider whether it was made confidentially for the purposes of legal advice, constructing such purposes broadly.[66] A person could agree to a partial waiver of the right to legal professional privilege without having to lose the right entirely.[67] Section 42 of the Freedom of Information Act recognises the exception of legal professional privilege and an Awareness Guidance note is available from the Information Commissioner's website.[68] The court held in March 2008 that the mention of a document in a written statement did not constitute an automatic waiver of legal professional privilege so as to entitle the other party to inspect it.[69] The House of Lords held in March 2009 that covert surveillance of communications between clients and their lawyers was permitted under the Regulation of Investigatory Powers Act 2000 and was not protected by legal professional privilege notwithstanding any statutory rights of persons in custody to consult their lawyers in private.[70]

Apart from these exceptions, the judge has the power to order the production of any evidence relevant to the case. There is no recognition of the privilege of confidential medical information, neither do the courts recognise the secrecy of the confessional. In the case of *Deacon* v. *McVicar*[71] (see Case 4.11, page 87), the judge ordered the production of the records of other maternity patients.

Health visitors are more likely than any other group of nurses to be summoned by subpoena to appear in court. They had adopted a procedure whereby they would normally require service of a subpoena before giving evidence in court. In this way, they were able to make it clear to their clients that they had no option but to attend court and were obliged to disclose confidential information. The Children Act 1989 has led to health visitors giving evidence in the interest of the child without waiting for a subpoena.

Disclosure in personal injury cases

Disclosure can be made of relevant records under the Supreme Court Act 1981, sections 33 and 34: section 33 enables disclosure to be made between parties to a case before litigation commences; section 34 enables an order for disclosure to be made against a third party. In addition, as a result of pressure from the Health Service Commissioner and also from judges in several cases where there has been evidence of unnecessary delay in the production of medical records, NHS trusts nowadays rarely wait to be issued with an order for disclosure, but are more likely to produce the relevant documents when the solicitor requests them. Access by the claimant can be sought under the statutory provisions of the data protection legislation. In addition, the Woolf reforms in civil justice have led to earlier disclosure of relevant information as part of the pre-action protocol (see chapter 6).

Disclosure before trial

In addition to the rules under the Supreme Court Act 1981, the rules of the High Court enable an order for relevant information to be made once the claim form has been issued and the case commenced. This order for the production of documents is part of the exchange of information that takes place between the parties before the hearing takes place in the court. The aim is to ensure that the parties understand the main points in dispute and are not surprised when the oral hearing takes place. The days in court should thus be kept to a minimum and should take place only when there really is an outstanding issue between the parties. As a consequence of the changes to the civil law procedure following Lord Woolf's report on access to justice, the emphasis is on openness between the partners and early disclosure between them of all relevant information, including the reports of experts. Under the new system of case management by the courts introduced under the new Civil Procedure Rules, directions have been given to facilitate the exchange of information and the progress of the case (see chapter 6).

In exceptional circumstances, the court could order disclosure to a person who was neither a party to the case nor a lawyer. Thus, in the case over the alleged harm caused by the drug Opren, the Court of Appeal allowed disclosure to the medical and scientific journalist and writer who was assisting the many claimants in their case against Eli Lilly.[72]

Although not a court, the Health Service Ombudsman has the power to order the production of documents, including personal health records and the attendance and examination of witnesses.

Disclosure to the patient and the right of subject access

The Data Protection Act 1998 gives the right of subject access to health records, subject to several exceptions. (This is considered on pages 211–13.)

Statutory duty to disclose

Whatever the views of the patient, there are certain circumstances in which disclosure of otherwise confidential information must be made by law. The following are the main provisions:

1. *Road Traffic Act 1988 Section 170 as amended by the Traffic Act 1991*: this requires any person to give information to the police relating to a road traffic accident involving personal injuries. A doctor was prosecuted under its predecessor for failing to disclose the relevant information and was fined £5.[73] His claim that he should not be required to give information that would be a breach of the patient's confidence was not accepted either by the trial judge or by the divisional court (see also chapter 21). In a case in 1999,[74] it was held that there was a statutory duty to report a road accident, even when the driver was not actually driving at the time.
2. *Prevention of Terrorism (Temporary Provisions) Act 1988, Section 11 (Continuous Order SI 1993/747)*: this makes it an offence for any person having information, which he believes may be of material assistance in preventing terrorism or apprehending terrorists, to fail without reasonable cause to give that information to the police. This therefore places a burden on staff, for example in A&E departments, to disclose the existence of wounds that may have resulted from terrorist acts.
3. *Public Health (Control of Disease) Act 1984*: as amended in 2010 requires a medical practitioner attending a patient who appears to be suffering from a notifiable disease to notify the medical officer of the district of the name and whereabouts of the patient and the disease. Notifiable diseases include cholera, plague, smallpox and typhus (see chapter 26).
4. *Abortion Act 1967*: requires doctors to inform the Chief Medical Officer of the DH of detailed information relating to the termination of pregnancy (see chapter 15).
5. *Drugs*: The Misuse of Drugs (Supply to Addicts) Regulations 1997 have abolished the requirement for a doctor to notify the Home Office of any patient who appears to be drug-dependent, but a doctor is expected to notify the local drug misuse database (see chapter 28).
6. *Health and Social Care Act 2008*: The Care Quality Commission has powers of inspection, entry and to require documents and information. Sections 76–79 cover its use and disclosure of confidential information. The NHS Act 2006 gives powers to the NHS Counter Fraud Service to require the production of documents to prevent, detect and prosecute fraud in the NHS.

Public interest

Unfortunately, many of the difficulties relating to the exceptions to the duty of confidentiality come under the broad heading of 'public interest' where there is little guidance from the courts.

Practical Dilemma 8.2 An epileptic lorry driver

Bill, a long-distance lorry driver, is diagnosed as having epilepsy, which is not yet under control through medication. The doctor has advised him to notify his employers and cease driving until the epilepsy is under control. Bill does not wish to do this since he has just been interviewed for the job of coach driver on the continent and he has been hoping for this chance for years. April, a nurse in the neurology ward, recognises Bill as her neighbour and is horrified when she hears from Bill's wife that Bill has been given the job of driving a coachload of schoolchildren to France. She knows several children who will be on that trip.

Many would argue that in these circumstances a breach of the duty of confidentiality owed to Bill is justified on grounds of the public interest. Obviously, there are advantages in Bill's being persuaded of the dangers of driving on the trip, but if he fails to disclose this and continues with his plans, then many would justify the doctor making the disclosure. If the doctor is adamant that he will not breach that confidence, does the nurse have any right to do so? The General Medical Council states specifically that it would defend any practitioner who disclosed confidential information in such circumstances. However, it is for each specific practitioner to decide personally if the particular circumstances justify disclosure in the public interest. There is no statutory definition of the public interest. Failure to notify the Vehicle Licensing Authority that a particular driver was not medically fit to drive could even be seen as a breach of a duty of care towards those persons who may be harmed as a result of that person driving. The success of such a hypothetical case would depend on establishing the following:

1 The doctor (or the nurse or other professional) owed a duty of care to the person who was eventually injured.
2 There was a breach of this duty in that the relevant information was not passed to the appropriate authority.
3 The personal injuries or death were a reasonably foreseeable result of that failure and were caused by that failure.

Until such a case is heard, or a law is enacted, a firm decision cannot be made, but some guidance is provided by the Tarasoff case heard in America and considered in Case 8.3. In addition, it should be pointed out that any person who drives a vehicle contrary to medical advice would himself be committing a criminal offence.

Case 8.3 Tarasoff case (USA 1976)

Confidentiality and psychotherapy[75]

A psychologist in California was told by a patient that he intended to kill a girl. The psychologist informed the campus police, who detained the man, but soon after released him. They did not inform the girl's parents of the danger to her. The patient subsequently killed the girl. The parents sued the university for breach of its duty of care to the girl in failing to warn them. They succeeded in a majority verdict. The court held that the therapist owes a legal duty of care not only to his patient, but also to his patient's would-be victim. This duty of care is subject to scrutiny by judge and jury.

A dissenting judge, Judge Clark, was concerned that the very practice of psychiatry vitally depended on the reputation in the community that the psychiatrist would not tell. He considered that assurance of confidentiality was important to ensure patients were not deterred from seeking treatment; to ensure that they made a full disclosure to the doctor and to ensure that the patient maintains his trust in his doctor, which is vital for successful treatment. The NMC recognises that the public interest may be a justification for disclosing confidential information. Box 8.3 shows the NMC advice on disclosure without the consent of the patient.

In a more recent case concerning a psychiatrist, it was reported that a psychiatrist treating a paedophile had broken confidentiality by telling the police her concerns about his intentions. As a consequence of this information the paedophile was arrested, his house searched and he was sentenced to a community order. He was already on the sex register. The psychiatrist's actions in

putting the duty under the Children Act before her duty of confidentiality to her client was commended by the NSPCC.[76]

Box 8.3 What is disclosure without consent? NMC guidance

- The term 'public interest' describes the exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader social concern.
- Under common law, staff are permitted to disclose personal information to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others. Each case must be judged on its merits.
- Examples could include disclosing information in relation to crimes against the person, e.g. rape, child abuse, murder, kidnapping, or as a result of injuries sustained from knife or gunshot wounds.
- These decisions are complex and must take account of both the public interest in ensuring confidentiality against the public interest in disclosure. Disclosures should be proportionate and limited to relevant details.
- Nurses and midwives should be aware that it may be necessary to justify disclosures to the courts or to the NMC and must keep a clear record of the decision-making process and advice sought. Courts tend to require disclosure in the public interest where the information concerns misconduct, illegality and gross immorality.

(NMC Regulation in practice topics: confidentiality. Paragraphing by author)

Reference should be made to chapter 4 and the discussion on whistleblowing. A registered nurse may face allegations of breach of confidentiality if she raises concerns about patient care outside the organisation. See the Haywood case and the new guidance published by the NMC on raising concerns discussed in chapter 4.

The Court of Appeal has given guidance on the public duty of confidence in the following case.

Case 8.4 *W* v. *Egdell* (1989)

Disclosure in the public interest[77]

W, a psychiatric patient, brought an action against an independent psychiatrist, the health authority, the mental health review tribunal and the Secretary of State for breach of confidentiality. The psychiatrist had sent a copy of his report on W's mental condition to the hospital on grounds of public interest on the basis of W's particular circumstances. The High Court judge held that no distinction should be drawn between a psychiatrist who was independent and one employed by the health authority. The report did not come under the heading of legal professional privilege (see page 195). The judge relied on the General Medical Council's Advice on Standards of Professional Conduct and Medical Ethics and refused an injunction against the use or disclosure of the report and dismissed his claims for damage.

The Court of Appeal dismissed W's appeal and held that the balance came down in favour of the public interest in the disclosure of the report and against the public interest in the duty of confidentiality owed to the patient. Unlike the trial judge, the Court of Appeal considered the General Medical

Council's rules as inappropriately relied on by the judge, since Dr Egdell did not have clinical responsibility for W. The Court of Appeal quoted Article 8(2) of the European Convention on Human Rights which permits intervention by a public authority in the duty of professional secrecy in the interests of public safety and the prevention of crime (see website of this book). The same considerations justified Dr Egdell's actions.

Practical Dilemma 8.3 Occupational health

Brenda works as a nurse in the occupational health department and is horrified to discover that a paediatric nurse, Karen, has an unusual bacterial infection which makes it very dangerous for her to work in the unit, particularly with the premature babies. However, she knows that Karen has exhausted all her sick pay allowance from the authority and would be dependent on DSS benefits. She is bringing up two children on her own and would have great difficulty managing without her NHS pay. Karen herself is not ill: she appears to be a carrier rather than a sufferer of this particular germ and is anxious to continue to work and does not want her nursing officer to be notified.

An occupational health department is sometimes caught in the clash between its duty to keep information acquired from its clients/patients confidential and the interest of the employer in being aware of that information, especially where there is danger to the health or safety of other employees as a result of the person's medical condition. (The cases of *X* v. *Y*[78] and *H (A Healthcare Worker)* v. *Associated Newspapers Ltd*[79] and disclosure in relation to HIV/AIDS are considered separately in chapter 26.) Exactly the same principles apply as in the situation described above, with the additional dimension of the employer's duty to other employees in the workplace. There is a clear duty owed by the employer to his employees under an implied term in the contract of employment (see chapter 10), whereas the duty owed in the law of negligence in the situation of the epileptic lorry driver described in Practical Dilemma 8.2 is not at all clear.

In Brenda's case, there is clear justification for advising Karen that the information cannot be withheld. The dangers to the patients and to other staff are such that she cannot continue to work until she is free of the germ. Karen may have the right to claim the statutory right of payment on the grounds of medical suspension (see chapter 10). This breach of confidentiality can be justified by reference to a preceding agreement, namely the contract of employment and the implied terms in it (see chapter 10). Some authorities may well have an express term in their contract of employment authorising the occupational health department to notify the employer of any condition that would be dangerous to patients or other employees. Guidance is given by the RCN on confidentiality and the occupational health nurse[80] and on the general topic of confidentiality in 2013.

The Clothier Report following the conviction of Beverley Allitt[81] made recommendations for occupational health departments. It recommended that they should be involved in the selection of prospective employees and should monitor ongoing health problems of employees, alerting the employers when there were any serious risks to others. (See chapter 12 for a discussion on the National Patient Safety Agency and chapter 4 for whistleblowing.) The recommendations of the Clothier Report were reinforced by the report of an inquiry chaired by Richard Bullock following the case of Amanda Jenkinson, a Nottinghamshire nurse who was imprisoned for harming a patient. Similar recommendations were made to occupational health departments on risks from employees.

Disclosure to a registration body

In some cases, disclosure to a state registration body may be justified in the public interest, as the following case shows.

Case 8.5 *Re L (2000)*

Disclosure to a registration body in the public interest[82]

In care proceedings about a pre-school child, expert psychiatric evidence concluded that the mother was suffering from a severe personality disorder. The mother was a paediatric nurse and the three doctors involved in the case were agreed that there would be concern for any child in the mother's care. The court went on to consider whether the matter should be reported to the UKCC for the protection of any children who might be put at risk by contact with the mother in her professional capacity. The court decided that the court's judgment, the expert medical reports, and the minutes of the experts' two meetings should be given to the UKCC. The court had to decide on the balance of the rights of the mother and the child against the public interest in demanding protection from nurses who were, or who were potentially, unfit to practise.

Disclosures to the police

There are very few occasions on which the citizen is obliged as a duty by Act of Parliament to provide the police with information. The main statutes requiring disclosure are cited above. Many quandaries arise outside those areas and concern the powers of the police to require a professional to disclose confidential information during police investigations. Another difficulty is the position where, by chance, particularly through work in the community, the professional obtains evidence that a crime has been committed or is being committed: for example, stolen goods are seen in a client's home; there is evidence of drug abuse; there is evidence that a child is being physically or mentally ill-treated or sexually abused; there is evidence that a patient has had an illegal abortion; there has been an attempt to conceal the birth of a stillborn child; a wife has suffered a severe battering by the husband.

The police powers are contained in the Police and Criminal Evidence Act 1984. Medical records and human tissue or tissue fluid that has been taken for the purposes of diagnosis or medical treatment and which a person holds in confidence are subject to special procedures (see below).

Statute 8.2 Sections 9, 12 and 14 from the Police and Criminal Evidence Act 1984

Section 9. A constable may obtain access to excluded material or special procedure material by making an application under Schedule 1.

Section 11. Excluded material means:

(a) personal records which a person has acquired or created in course of any trade, business, profession . . . and which he holds in confidence
(b) human tissue or tissue fluid which has been taken for the purposes of diagnosis or medical treatment and which a person holds in confidence
(c) . . .

Section 12. Personal records means documentary or records concerning an individual (whether living or dead) who can be identified from them and relating:

(a) to his physical or mental health
(b) to spiritual counselling or assistance given or to be given to him
(c) to counselling or assistance given or to be given to him, for the purposes of his personal welfare, by any voluntary organisation or by any individual who:

(i) by reason of his office or occupation has responsibilities for his personal welfare; or
(ii) by reason of an order of a court has responsibilities for his supervision.

Section 14. Special procedure material means material other than items subject to legal privilege and excluded material in the possession of a person who:

(a) acquired or created it in course of any trade, business, profession or other occupation or for the purpose of any paid or unpaid office
(b) and holds it subject
(i) to an express or implied undertaking to hold it in confidence or
(ii) to a restrictionor obligation such as is mentioned in S.11(2)(b).

A circuit judge can make an order that the person who appears to be in possession of the specified material should produce it to a constable for him to take it away or give a constable access to it, not later than the end of the period of seven days from the date of the order. The judge must be satisfied that specific access conditions are fulfilled before making the order.

Disclosure where a criminal offence is believed to have taken place

Practical Dilemma 8.4 Rape?

The police arrive at the A&E department one night enquiring about the possibility of a young man in his twenties having been admitted with severe lacerations to his face and neck. About two hours earlier, a girl of 15 had been found in a serious condition having suffered an attack. She had tried to defend herself by hitting the assailant in the face with a mirror. There was blood on the mirror and she believed she had cut him severely. The police arrive in the department and ask the duty nurse if they can go through the admissions during the last two hours.

The information required by the police is related to the medical records and thus comes under the special procedure. The police can make an application to a circuit judge for an order for the production of special procedure material. He will do so only if he is satisfied that certain conditions are present. However, these are the ultimate powers. It is unlikely that the police would be obliged to go to this length against an NHS trust. If it is known that the police can ultimately seek an order for disclosure, then the NHS trust policy is likely to be one of cooperation with them. In a case such as the rape case above, the nurse would be advised to call the medical officer in charge of the A&E department who would identify any patients who come within a fairly detailed description of the likely assailant. Giving the police the admission book would be beyond this duty.

In a case in 1993,[83] an order for disclosure to the police of the social security records giving dates of admission and discharge to the hospital was held not to come within the provisions of Schedule 1 of the Police and Criminal Evidence Act 1984.

Department of Health advice

The Department of Health in its NHS Confidentiality Code of Practice[84] (see page 191) considers disclosure to the police and states:

In the absence of a requirement to disclose there must be either explicit patient consent or a robust public interest justification. What is or isn't in the public interest is ultimately decided by the courts.

Where disclosure is justified it should be limited to the minimum necessary to meet the need and patients should be informed of the disclosure unless it would defeat the purpose of the investigation, allow a potential criminal to escape or put staff or others at risk.

The Department of Health quotes the definition of serious crime used by the GMC, i.e. 'a crime that puts someone at risk of death or serious harm and would usually be crimes against the person, such as abuse of children'.[85]

Practical Dilemma 8.5 Let me know!

The police are investigating a burglary in which the householder came back early and surprised the burglar, who fell from a first-floor window, but still managed to escape. The police have enquired at the various A&E departments in the vicinity. At one hospital, they heard of an admission following a road accident where a man said he fell from a motorcycle when it crashed against a tree. There were no witnesses. They believe that the injuries are comparable to those the burglar might have sustained. Since the patient is not yet fit for interrogation as he has just come from the operating theatre, the police ask the ward sister:

1 to let them know when he can be questioned, and
2 not to let him go until the police arrive.

What is the ward sister's position? Must she obey this order?

Notifying the police of the patient's fitness for questioning There is no clear legal right for the police to insist that this is done. For example, if the ward sister decides that her duty is to the patient, not to the police, and thus fails to notify the police, could she then be prosecuted for obstructing the police in the execution of their duty? The answer is probably not, unless it can be shown that they had express legal powers to demand the information from her. In practice, of course, staff often rely on the help of the police when they have aggressive visitors, or even aggressive patients, and are therefore prepared to reciprocate. What we are concerned with here is the legal duty on the ward sister to provide this information and it is unlikely that this power exists.

Keeping the patient until the police arrive The citizen does have wide powers of arrest, although they are, of course, more limited than police powers. The sister would have no statutory power of keeping the patient (which would, in fact, be arresting him) until the arrival of the police unless either she knows that an arrestable offence has been committed and the patient is guilty of this or she has reasonable grounds for suspecting that he is guilty. In the circumstances described above, it would not appear likely that the ward sister has those grounds since, as far as she knows, the patient could well have fallen from his motorcycle. She would therefore be on very weak ground if she refused to allow him to take his own discharge other than on the basis that she was acting out of her duty of care to save his life. In this situation, the police would have to provide a policeman to wait until such time as the patient could be questioned or taken to the police station under arrest.

Reporting crime to the police

Practical Dilemma 8.6 Discovery in the community

Jane, a health visitor, goes to enquire at a house where there is a young child of 18 months, since she has not seen her in the clinic and the child is due for several vaccinations and tests. While in the house, she notices the following: small burn marks on the child who looks very undernourished; four brand new video recorders in the corner of the room; and a pipe from the gas supply which bypasses the meter. One might question her imagination over the last item, but if this is in fact what she spotted, does she have any duty in respect of them?

1 *Non-accidental injury*: Jane's duty is to the child, so there can be no doubt that if she has reasonable grounds for suspecting that there is any abuse, then she must take the appropriate action to safeguard the child. There is a clear procedure for action if such a situation exists and Jane would have the responsibility to set it in motion. Even if Jane were a district nurse and visiting the mother rather than the child, she would still have a duty to ensure that the appropriate care was taken. (See chapter 13 for child protection procedures.)
2 *Suspected stolen goods*: there is no duty on Jane to act as police informer in such circumstances. If, of course, the goods were subsequently found to be stolen and Jane were summoned to court as a witness, she would have to give evidence of what she had seen. What, however, if the goods were NHS trust property? Does she have a duty to inform her employer that goods are being stolen? The answer depends on whether a term can be implied into the contract of employment that any employee must inform the employer of any thefts from the workplace. It would appear to make business sense of the contract of employment if such a duty could be seen to be implied. (See chapter 10 on implying terms into a contract of employment.)
3 *Gas*: it could be argued that the system for bypassing the meter is simply another case of stolen goods and theft. However, there are additional problems here, since there is a considerable public danger risking fire or an explosion. It could therefore be argued that Jane did have a public duty to notify the police, since her client and others could be in considerable danger.

Reporting suspected child abuse to the police

The Director of Public Prosecutions called for the creation of a statutory duty for teachers, social workers and doctors to report allegations of child sexual abuse to the police. He pointed out that Australia, the US and Canada have mandatory reporting systems. The response from the Department of Education was that mandatory reporting was not the answer to protecting children.[86] However, in July 2014 the Prime Minister said that mandatory reporting was under consideration (see chapter 13).

Disclosure by the police to employers and the NMC

Where a registered practitioner is charged or convicted of an offence, the police would ensure that both the employers and the NMC or other registration body are informed.

Case 8.6 *Woolgar* v. *Chief Constable of Sussex Police* (1999)

Disclosure to the UKCC[87]

Junia Woolgar, a registered nurse and matron of a nursing home, was arrested and interviewed by the police following the death of a patient in her care. The police concluded the investigation without bringing any charges and they referred the matter to the UKCC, which asked for further information. It was the practice of the police to seek the consent of those who had given statements. Ms W refused to give consent and sought an injunction to restrain the police from disclosing to the UKCC the contents of an interview they had taped. She appealed against the High Court judge's refusal to grant the injunction. The Court of Appeal held that the police were entitled to release the information to a regulatory body, if they were reasonably persuaded that it was relevant to an inquiry being conducted by the regulatory body. She lost her appeal.

It is reported that Rebecca Leighton, a nurse who had been cleared of poisoning patients, is preparing to sue the police force on the grounds that they gave the public access to her private Facebook account and leaked her name to the media. She is seeking compensation in a claim for aggravated damages for breach of confidence, misuse of private information, negligence and breach of a statutory duty and her legal costs.[88] The case was due to be heard in May 2014 but at time of writing there had been no decision from the court.

Disclosure to parents

Information can be given to parents about their child's health if it is in the best interests of the child, and if a competent child has consented to the information being given. A mentally competent young person under 16 years has the right to request the withholding of information from the parents. This principle, established in the Gillick case, was upheld in the Axon case. In the Axon case,[89] a mother of teenage daughters applied for judicial review of DH guidelines on advice and treatment of young people under 16 years on contraception, sexual and reproductive health which was based on the Gillick judgment. She claimed that she should have been told that her daughter had given consent to an abortion. The High Court dismissed her application, upholding the guidance laid down by Lord Fraser in the Gillick case (see chapters 13 and 15).

Disclosure of information relating to a mentally incapacitated adult

In a case in 2002[90] the Court of Appeal recognised the duty of confidentiality owed to the mentally incapacitated adult, but in the circumstances, and taking account of the limited information required by his mother, allowed disclosure of information to her. She had applied in her capacity as nearest relative under the Mental Health Act 1983 for access to his medical records. Disclosure of information about those adults lacking mental capacity (who are outside the provisions of the Mental Health Act 1983) would now come under the Mental Capacity Act 2005 and the jurisdiction of the Court of Protection.

Disclosure under the Data Protection Act 1998

The disclosure of personal information should now be checked against the provisions of the Data Protection Act 1998. All personal health records, whether computerised or manually held, come within the definition of sensitive personal data and therefore at least one of the conditions in Schedule 2 and at least one of the conditions in Schedule 3 must be met. (Schedules 2 and 3 of the Data Protection Act 1998 can be seen on the website of this book.)

Disclosure on an anonymous basis

The laws of confidentiality usually apply to the disclosure of information when the identity of the patient is made known. However, the Department of Health challenged a data-collecting company that was using information provided by GPs and pharmacists about prescribing habits.[91] The company believed the information would be useful to drug companies and would provide useful data for those interested in monitoring prescribing patterns. Even though the information would be anonymous, the Department of Health challenged the use of this information as a breach of the guidelines put forward by the Department of Health[92] in 1996. It succeeded before the High Court but the Court of Appeal[93] reversed this decision. It held that GPs and pharmacists providing prescription information that did not identify the patient was not a breach of confidence. Anonymous data did not involve a risk to the patient's privacy, even if, with effort, the patient could be identified.

Disclosure and Article 8 rights

In another case, a health authority sought to obtain disclosure of patient records to consider the compliance of a medical practice with the terms of service of the practitioners. Two patients had not given consent to the disclosure and therefore the GPs involved, not wishing to risk a breach of confidence by disclosing the information, applied to the court for a ruling as to whether they were entitled to make the disclosure. The court considered earlier cases heard by the European Court of Human Rights on medical data and Article 8[94] and ordered the disclosure of the records but on condition that the confidentiality of the personal information should be maintained and the patients' anonymity preserved as far as possible. The court also ordered that the data could not be disclosed more widely than was necessary to deal with the problem.[95]

A claim for privacy protected by Article 8 failed when a judge ordered *The Times* to disclose the name of a blogger who had sought an injunction to stop *The Times* revealing his name.[96] In contrast, the Court of Appeal upheld a claim by a member of the Campaign against the Arms Trade that being photographed and details of his identity obtained by police were a breach of his Article 8 rights. The court held that breach of privacy required compelling justification such as terrorism or serious criminal activity rather than low level crime.[97]

Disclosure in relation to a genetic disease

At present a patient is entitled to keep confidential information relating to a genetic disease such as Huntington's disease even if other family members may benefit from having such knowledge. However, guidance by the GMC on confidentiality suggests that doctors could share genetic information with others who may be at risk if they remain ignorant of a potentially life-threatening condition[98] (see chapter 22).

Caldicott Guardians

Concern about the need to improve the way in which the NHS managed patient confidentiality led to the appointment of a committee chaired by Dame Fiona Caldicott. It reported in December 1997 and included in its recommendations the need to raise awareness of confidentiality requirements, and specifically recommended the establishment of a network of Caldicott Guardians of patient information throughout the NHS. Subsequently, a steering group was set up to oversee the implementation of the report's recommendations. A circular issued in 1999[99] gave advice on the appointment of the Guardians, the programme of work for the first year for improving the way each organisation handles confidential patient information and identified the resources, training and other support for the Guardians.

Caldicott Review on information governance in health and social care 2013

Dame Fiona Caldicott was appointed in 2012 to review the balance between protecting patient information and its sharing, to improve patient care. (The full terms of reference can be found in Appendix 2 of the report.) The review was published in April 2013[100] and it is available on the government website.[101]

The principles set out in the original Caldicott Report of 1997 were revised and are as follows:

1. Justify the purpose
2. Don't use personal confidential data unless it is absolutely necessary
3. Use the minimum necessary personal confidential data
4. Access to personal confidential data should be on a strict need-to-know basis
5. Everyone with access to personal confidential data should be aware of their responsibilities
6. Comply with the law
7. The duty to share information can be as important as the duty to protect patient confidentiality.

The review made 26 recommendations all of which were accepted by the government which published its response in September 2013[102] and in its final chapter drew up a table of commitments to be fulfilled by itself and identified organisations. The Department of Health stated that the duty to share information can be as important as the duty to protect patient confidentiality.[103] The review found that the culture in the health service had unfortunately become one of anxiety, some say fear (over data protection laws). Health workers were scared to share data with other health professionals. It also found that some patients had been denied access to their own records because NHS bosses were so scared of fines for breaching data protection laws. The Department of Health subsequently appointed Dame Fiona

Caldicott as chair of an independent panel to oversee and scrutinise implementation of the review's recommendations and to provide advice on information governance issues.

Guardians

Each health authority, special health authority, NHS trust and primary care group was required to appoint a Caldicott Guardian by no later than 31 March 1999. Ideally, the Guardian would be at board level, be a senior health professional and have responsibility for promoting clinical governance within the organisation. A manual for Caldicott Guardians published in November 2006 and updated in 2010 can be downloaded from the DH website.[104]

Health and Social Care Information Centre (HSCIC)

The Health and Social Care Information Centre (HSCIC) was set up as an executive non-departmental public body in April 2013 with responsibilities set out in the Health and Social Care Act 2012 (sections 252–277 and Schedule 18 and in regulations[105]) which include:

- Collecting, analysing and presenting national health and social care data
- Setting up and managing national IT systems
- Publishing a set of rules (Code of Practice) for the handling and managing of personal confidential information of patients
- Building up a library of indicators that can measure the quality of health and care services
- Acting to reduce paperwork
- Helping health and care organisations improve the quality of the data they collect.

Creating a register of information and publishing it in a range of formats

The Health and Social Care Information Centre (HSCIC) Guide to confidentiality in health and social care September 2013[106] sets out five rules of confidentiality:

1. Confidential information about service users or patients should be treated confidentially and respectfully
2. Members of a care team should share confidential information when it is needed for the safe and effective care of an individual
3. Information which is shared for the benefit of the community should be anonymised
4. An individual's right to object to the sharing of confidential information about them should be respected
5. Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed.

Appendix 1 sets out the Caldicott principles.

In June 2014 the HSCIC published a review which revealed that its predecessor, the NHS Information Centre, had released data 3,059 times to universities, NHS and private companies including private health groups between 2005 and 2013 often without justification. As a result, three insurance companies have been ordered to delete records. The HSCIC has promised to tighten procedures and in June 2014 the HSCIC invited feedback on its draft code of practice for confidential information.

Under section 122 of the Care Act 2014 the general dissemination powers of the HSCIC are clarified to establish the purposes for which the HSCIC may or may not release information and it is required to have regard to particular advice in exercising its publishing or other dissemination functions. It must also have regard to the need to respect and promote the privacy of those receiving health services and adult social care.

Freedom of Information Act 2000

The Act gives a general right of access to information held by public authorities, but this right is subject to significant exceptions. The main exemptions from the duty are set out in Part 2 of the Act. Some of the exemptions are subject to a public interest test and these are shown in Box 8.4. Others are absolute exemptions and these are shown in Box 8.5. In addition to these exemptions, under section 14 a request that is vexatious or that the public authority has already complied with does not have to be complied with. For the exemptions listed in Box 8.4, a public interest test applies. This means that a public authority must consider whether the public interest in withholding the exempt information outweighs the public interest in releasing it. The majority of exemptions fall into this category. For those exemptions listed in Box 8.5, there is no requirement for the public authority to consider the public interest.

Box 8.4 Exempt information where the public interest test applies

Information intended for future publication
National security
Defence
International relations
Relations within the UK
The economy
Investigations and proceedings conducted by public authorities
Law enforcement
Audit functions
Formulation of government policy
Prejudice to effective conduct of public affairs
Communication with Her Majesty, etc. and honours
Health and safety
Environmental information
Personal information
Legal professional privilege
Commercial interests

Box 8.5 Absolute exemptions from the Act

Information accessible to the applicant by other means
Information supplied by or relating to bodies dealing with security matters
Court records
Parliamentary privilege
Prejudice to effective conduct of public affairs
Personal information where the applicant is the subject of the information
Information provided in confidence
Prohibitions on disclosure where a disclosure is prohibited by an enactment or would constitute contempt of court

Data protection and freedom of information legislation

From Box 8.5 it will be noted that personal information where the applicant is the subject of the information is absolutely exempt from the Freedom of Information Act. Section 40 states that:

> **[A]ny information to which a request for information relates is exempt information if it constitutes personal data of which the applicant is the data subject.**

If a data subject wants access to personal information, then the route for that application is the Data Protection Act 1998 and in general the Freedom of Information Act 2000 tries to prevent an overlap between the two Acts.

In a dispute between Health Professions Council (HPC) and the Information Commissioner, the Tribunal[107] held that the ICO was entitled to see information which the HPC had refused to disclose to an applicant under the Freedom of Information Act. Sue Lee had applied to the HPC for information relating to her complaint about a registrant which had been turned down. The HPC refused her request and she then applied to the ICO under section 50 of the Freedom of Information Act. The ICO issued an information notice requesting sight of the information which the HPC had refused to disclose. HPC appealed the Information Notice under section 57(2) of the Freedom of Information Act. The Tribunal upheld the Information Notice and dismissed the appeal. The HPC had argued that it had a duty of confidentiality to its registrants, that its procedures in protecting the public would be jeopardised by such disclosure. However, the Tribunal was of the view that the HPC would be able to revise its procedures to ensure that those providing information were accurately forewarned that the HPC's dealing with this information would be subject to its duties under the Freedom of Information Act and the Data Protection Act. If registrants enquired further they could be provided with a number of reassurances. Failures by a public body to provide information to an applicant under the Freedom of Information Act relying on the grounds of legal professional privilege have been challenged before the Information Tribunal. The applicant succeeded in one case where the application under the Freedom of Information Act was for information related to the withdrawal of treatment from the applicant, and the policy under which the treatment was withheld. The Tribunal held that the trust was in breach of its obligations.[108] In contrast, in another case a widow whose husband had died following a fall from a hospital bed was given a report of the trust's inquiry but she was refused the witness statements. The Commissioner upheld the trust's decision that they were exempt from the Freedom of Information Act under sections 31 and 36, and her appeal to the Tribunal failed.[109] Ann Clywd has complained that a Welsh Health Board illegally gave confidential information relating to her husband, a patient, to a Welsh Assembly member under the Freedom of Information Act. She stated that this information was not covered by the Act and the information was passed on because of political motives as a result of her complaints about her husband's ill-treatment. She has called for an Inquiry[110] which was rejected by the Welsh Assembly government. The rejection of most of her complaints by the University Hospital of Wales was ridiculed by Camilla Cavendish.[111]

In a landmark decision the Supreme Court held in March 2014 that while the Charity Commission did not have to disclose information to *The Times* about a charity involving the MP George Galloway and Iraq under the Freedom of Information Act or under the European Convention on Human Rights, there was at common law a right in the public interest for the information to be disclosed. 'There was a common law presumption in favour of openness.'[112] The Charity Commission stated that it would assess future requests for disclosure of information in the light of the Supreme Court judgment. In its leader, *The Times* said that 'the consequences of this Supreme Court ruling cannot be overstated . . . This newspaper believes that it is both politically healthy and ethically correct that the conduct of any public body be scrutinized closely, confidently and consistently.'[113] The implications for the NHS and its dealings with the public in the light of the Francis Inquiry are obvious (see chapter 5).

The Court of Appeal has held that where a person claims information under the Freedom of Information Act he is entitled to stipulate which software format should be used when the information was provided to him.[114]

The mother of a girl who had died in hospital appealed against the decision of the Information Commissioner to refuse her access to her daughter's records.[115] The trust was unwilling to release the records without the consent of the daughter's husband as her next of kin. The hospital had admitted liability for the daughter's death and had reached a settlement with the husband involving payment of substantial compensation. The mother contended that the records did not fall within the exception for confidential information under the Freedom of Information Act 2000 section 41. The judge refused the application on the following grounds:

1 The public interest ensuring that patients retained trust in confidentiality of information they gave to doctors outweighed, by some way, the countervailing public interest in disclosure of a deceased's medical records.
2 If disclosure would be contrary to an individual's reasonable expectation of maintaining the confidentiality of his or her private information, then the absence of detriment in the sense contemplated by the mother was not a necessary ingredient of the cause of action.
3 The duty of confidence was capable of surviving the death of the confider.
4 The trust would be in breach of confidence owed to the daughter if it disclosed her medical records other than under the terms of the Act, and the breach would be actionable by the daughter's personal representatives. Her records were exempt information under section 41 and should not be disclosed.
5 The rights of the next-of-kin had to prevail where the rights and wishes of family members differed.

A journal sought disclosure of letters written by the Prince of Wales to the government and succeeded before the Upper Tribunal which held that the communications should be disclosed. Subsequently the Attorney General used a ministerial veto to prevent the public seeing the documents. The Court of Appeal ruled that he had no good reason to overrule the decision of the Upper Tribunal and his certificate should be quashed.[116]

Codes of practice

Codes of practice giving practical guidance to public authorities on the discharge of their duties under the Act have been issued by the Lord Chancellor as required under section 45 of the Act[117] (referred to as the Section 45 Code of Practice). In December 2003 a model action plan for preparation for the implementation of the Freedom of Information Act 2000 was published.[118] While this model action plan is not compulsory, it was intended as a tool to disseminate ideas and best practice and to assist public authorities in creating a structured path towards full implementation of the Act in 2005. Freedom of Information Act Awareness Guidance leaflets are available from the Information Commissioner's website.[119]

DNA databases

In a case before the European Court of Human Rights concerning the National DNA database, two men from Sheffield, Michael Marper and S, sought the destruction of their DNA samples. They had been arrested in 2001 and had their fingerprints and DNA samples taken. They were not convicted of any crime and argued that the samples should have been destroyed. Their case was rejected by the British courts and in February 2008 the ECHR gave permission for the case to proceed.[120] The ECHR subsequently held that storage of DNA profiles of suspects who were not convicted was a breach of Article 8 and constituted a disproportionate interference with the applicants' right to privacy.[121] The ECHR considered that the blanket and indiscriminate nature of the powers given to the police could not be regarded as necessary in a democratic society. As a consequence of this judgment more than 1.6 million DNA and fingerprint samples must be destroyed from police databases.[122] The Information Tribunal held that police were breaking rules on the holding of personal details and that

they should remove information about minor crimes from their records because storing it breached data protection laws.[123] However, this decision was overruled by the Court of Appeal.[124] It held that it was for the data controller to determine the purposes for which data were processed and it was a registered purpose to hold information so that it could be supplied to others in legitimate need such as the courts and Crown Protection Service. Liberty has asked the Health Secretary to investigate the holding of secret databases of DNA from newborns by the NHS where the appropriate consent has not been obtained.[125] The annual report for the National DNA Database Strategy Board for 2012–13 is available on the government website.[126] It reports on the progress of the removal of the DNA data of 1.7 million innocent persons and children from the National Database in accordance with the Protection of Freedoms Act 2012 which came into force on 31 October 2013.

A requirement that a man formerly convicted of manslaughter should attend a police station and provide a non-intimate DNA sample was held to be a proportionate and justified interference with his Article 8 rights. Amendments had been made to the Police and Criminal Evidence Act 1984 to provide a scheme for the taking and retention of samples which complied with Article 8.[127]

In May 2013 the Supreme Court held that fingerprints which had been taken by an electronic device which had not been approved as required by statute were admissible in evidence at the suspect's trial. It was a well-established rule of English law that (apart from confessions to which special considerations applied) any evidence which is relevant is admissible even if it has been obtained illegally.[128]

Access to personal health records

The Data Protection Act 1998 gives a statutory right for data subjects to access personal information held on them (subject to exceptions discussed below). The Act applies to both computer records and records held in manual form. The 1998 Act replaces the Access to Health Records Act 1990 which gave access to manual records kept after 1 November 1991. The 1990 Act has been repealed except in respect of records of deceased patients. The definition of 'health record' would include nursing records, physiotherapy records, pathology laboratory records and all other records relating to the patient's health.

The Act enables data subjects:

1. to be informed whether personal data are processed
2. to be given a description of the data held, the purposes for which they are processed and to whom the data may be disclosed
3. to be given a copy of the information constituting the data
4. to be given information on the source of the data.

The data subject also has a right of rectification if the data recorded appear to be inaccurate. He/she can apply to the court for an order or to the Information Commissioner for an enforcement notice. The data controller would be required to rectify the data, block them or erase or destroy them. Alternatively, the court or commissioner could require that the record should be supplemented by a statement of the true facts.

Procedure for access

A request for access to personal health records must be made in writing to the holder of these records or the data controller, most likely the NHS trust or general practitioner or possibly the health authority, together with the required fee. The data controller should verify that the applicant is either the data subject or his authorised proxy acting on behalf of the data subject. A response must be given within 40 days of the full information being given, together with the fee, or the applicant informed that there are grounds for withholding the information. (Recent guidance, changed as a result of a parliamentary debate,[129] from the Department of Health has suggested that NHS organisations should endeavour to comply with subject access requests within 21 days.[130])

The information can be withheld only on the grounds listed below. Failure to provide the fee or the necessary information required by the data controller would justify non-access. It may be that informal access would be permitted outside the legislation. If the Data Protection Act principles are applied, the data subject would pay the required fee and within 40 days he should be given the required information.

Withholding information

The right of access to health records under the Data Protection Act 1998, like its predecessor, is not absolute and restrictions have been made by statutory instrument. The Data Protection (Subject Access Modifications) (Health) Order[131] modifies the right of access to health records in certain circumstances.

1. Where the access 'would be likely to cause serious harm to the physical or mental health or condition of the data subject or any other person (which may include a health professional)'. A data controller who is not a health professional shall not withhold information on these grounds unless he has first consulted the person who appears to be the appropriate health professional on whether this exception applies. The obligation to consult does not apply where the data subject has already seen or knows about the information that is the subject of the request.
2. Where the request for access is made by another person on behalf of the data subject, such as a parent for a child, access can be refused if the data subject had provided the information in the expectation that it would not be disclosed.
3. If giving access would reveal the identity of another person, unless that person has given consent to the disclosure or it is reasonable to comply with the access request without that consent. This does not apply if the third party is a health professional who has been involved in the care of the patient, unless serious harm to that health professional's physical or mental health or condition is likely to be caused by giving access (i.e. it comes within the first exception).

Certain information can be withheld if it is supplied in a report or other evidence given to the court by a local authority, health or social services board, health and social services trust, probation officer or other person in the course of any proceedings to which various statutes apply, including the Family Proceedings Courts, if, under the rules, the information may be withheld.

Correction of records

If a patient uses his right of access under the Data Protection Act to the health records and discovers that they are inaccurate, he can ask for them to be rectified. He also has the right to seek compensation for any harm that he has suffered as a result of the inaccuracy. Some say that the modifications to the right of access have taken much of the power out of the data access provisions. In addition, the data need not necessarily be supplied as a printout. The data user may choose to write or type the information to be supplied with any accompanying explanation. In 2010 the NIGB issued guidance for people who want amendments made to their health and social care records. The guidance outlines the purpose of healthcare and social care records and how the NIGB believes problems around the content of records can be resolved, including explaining what people should do and where they get support if they need it. The NIGB has been abolished and its functions transferred to the Health Research Authority which has established a Confidentiality Advisory Group.

Records of deceased persons

The only surviving provisions of the Access to Health Records Act 1990 are those relating to the records of deceased persons. Under section 3(1)(f) of the Access to Health Records Act 1990 where a person has died, the patient's personal representative and any person who may have a claim arising out of the patient's death may apply for access to the deceased patient's health records. Where such an application is made, access shall not be given if the record includes a note, made at the patient's request, that he did not wish access to be given on such an application. Nor will access be given by the record holder

to any part of the record, if he is of the opinion that it would disclose information which was not relevant to any claim which may arise out of the patient's death.

A life insurance company may seek information to decide whether to make a payment under a life assurance policy and require doctors to give information about the cause of death. Doctors could release information in accordance with the Access to Health Records Act 1990.

Access at common law

The Court of Appeal held in the case of Martin[132] that there is no absolute right to access personal health records.

Access to Medical Reports Act 1988

This Act came into force on 1 January 1989. It gives an individual a right of access to any medical report relating to him that has been supplied by a medical practitioner for employment purposes or insurance purposes. Before any such medical report can be supplied, the individual must be notified that it is being requested and the individual must give his consent to that request. The medical practitioner must not supply the report unless he has the consent of the individual. He is also required to give the individual the opportunity of access to it and to be allowed to correct any errors. These provisions apply unless 21 days have elapsed since the practitioner notified him of his intention to provide a report. The medical report must be retained by the medical practitioner for at least six months from the date on which it was supplied.

There is an exemption from individual access where the medical practitioner is of the opinion that disclosure would be likely to cause serious harm to the physical or mental health of the individual or would indicate the intentions of the practitioner in respect of the individual or where the identity of another person would be made known (unless that person has consented to the disclosure or is a health professional involved in the individual's care).

Concern was expressed by the Information Commissioner that insurers were regularly accessing the full medical records of patients contrary to data protection rules and an investigation has been initiated.

Conclusions

The NHS Confidentiality Code of Practice is of considerable guidance to healthcare staff in deciding whether the disclosure of confidential information is justified. However, the fact that many of the underpinning laws are based on common law, rather than statute, does make for difficulties. For example, whether a disclosure is justified as being in the public interest is determined by case law. The individual nurse practitioner still has to use her professional judgement in determining whether disclosure is justified, and she is personally and professionally accountable for her decision. The Data Protection Act 1998 has tightened up access to and disclosure of personal information, putting more pressure on the decisions of the individual practitioner. Nurses should ensure that they make use of the existence of the Caldicott Guardian in their organisations to advise on issues relating to confidentiality and to assist in protecting the interests of the patient. If necessary, the protection of the Public Interest Disclosure Act 1998 could be sought if concerns on confidentiality need to be made known at a senior level within the organisation (see chapter 4 and whistleblowing). The Human Rights Act, in enabling persons to bring actions against public authorities that have failed to uphold a person's right to respect for private and family life, as set out in Article 8, has led to more litigation on grounds that confidentiality has not been respected.

The protection of patient confidentiality and the rights of access to information on health records thus continue to be a legal battleground. There are fears that the developing computerised system for patient records will provide inadequate protection for patient confidentiality. The Information Commissioner in his dual role as enforcement officer for both Data Protection and Freedom of Information legislation has a major role to play in ensuring that patient confidentiality is respected, but legitimate claims to access information held by public authorities is granted. Regular updating can be obtained via the Information Commissioner's website.[133] Serious losses of data by the Child Support Agency, the Driving Standards Agency, the Ministry of Works and Pensions and the Ministry of Defence in 2007 and 2008 have raised further concerns about the security of NHS information and strengthened the opposition of many doctors to the NHS electronic patient record systems. The Information Commissioner now has powers to fine up to £500,000, and custodial sentences are being considered for the most serious breaches of the data protection laws. The second Caldicott review emphasised that appropriate sharing of patient information can be as important as protecting confidentiality.

Reflection questions

1. Prepare guidelines for a new employee on the duty of confidentiality.
2. Do you consider that there is a breach of confidentiality if a nurse returns home and tells her husband that they are treating a patient with AIDS on the ward? She does not mention the patient's name.
3. Consider the exception to the duty of confidentiality entitled 'public interest' and consider examples from your own experience that may come under that heading. What justifications could you give for and against disclosure?
4. Do you consider that the patient should have an absolute right of access in law to health records? Justify your answer.
5. Hospitals are often seen as the most difficult institutions in which to keep personal matters secret. What action do you think could be taken to enforce the duty of confidentiality in practice?

Further exercises

1. Identify who the Caldicott Guardian is in your organisation and establish the role that he or she plays in maintaining standards of confidentiality.
2. Obtain information on the function of the Confidentiality Advisory Group and the Health Research Authority.

References

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Chapter 9

Record keeping, statements and evidence in court

This chapter discusses

- Record keeping
- Statements
- Evidence in court
- Defamation
- Providing references
- Internet

Introduction

Good standards of record keeping are an essential part of professional practice and the duty of care owed to the patient. This chapter provides guidance on record keeping and advice on statement and report writing and giving evidence in court.

Record keeping

General principles

Record keeping is part of the professional duty of care owed by the nurse to the patient. As the NMC says in its 2009 guidance *Record keeping: guidance for nurses and midwives*:[1]

Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.

Failure, therefore, to maintain reasonable standards of record keeping could be evidence of professional misconduct and subject to professional conduct proceedings. The NMC has set out guidance for good practice to assist the practitioner in fulfilling this professional duty.

NMC: *Record keeping: Guidance for nurses and midwives*

This guidance was issued in 2009, replacing the guidelines issued in 2002 and the NMC advice sheet on record keeping issued in 2007. It identifies the many functions of record keeping, naming the most obvious types of healthcare records, sets out the principles of good record keeping and considers confidentiality, access, disclosure, information systems and personal and professional knowledge and skills. Further notes and answers to frequently asked questions are available on the NMC website.

Guidance is also provided by the Department of Health.[2] The Audit Commission made recommendations to improve the standard of record keeping in hospitals in 1995.[3] It reviewed the situation in 1999 and concluded that, although progress had been made, there was still scope for further improvements.[4] Guidance is also available from the NHS Litigation Authority (NHSLA), which has published a risk management handbook which includes standards of record keeping[5]. The Clinical Negligence Scheme for Trusts monitors standards of record keeping and risk management by NHS organisations as part of its work in setting levels for membership of the NHS pool for sharing liability for compensation claims (see chapter 6). The standards set by the NHSLA include in their criteria principles relating to documentation. For example, criterion 8 for the governance standard relates to health records management. This states that chief executives and senior managers of all NHS organisations are personally accountable for records management within their organisation. These standards for 2013/14 can be seen on the NHSLA website.[6] Records are now kept of the many assessments which have to be carried out, including risk assessment, manual handling assessment, tissue viability assessment, social care, nutrition, and many others.

Increasingly, the records include a care pathway tracked out for that particular patient and nurses would be expected to identify the progress of the patient along that pathway.

Department of Health *Essence of Care*[7]

One of the benchmarks of the fundamental areas of patient care identified in the Department of Health *Essence of Care*, updated in 2010, is record keeping. The guidance sets out the general indicators for best practice in record keeping, covering access to health records, single record, practice and evidence and security.

Common errors noted in record keeping

These are listed in Box 9.1 and are the most common errors noted by a group of health visitors in record keeping.

Box 9.1 Common errors in record keeping

- Times omitted
- Illegible handwriting
- Lack of entry in the record when an abortive call has been made
- Abbreviations were ambiguous
- Record of phone call (e.g. to social services) that omitted the name of the recipient (e.g. social worker)

Use of Tippex and covering up of errors
No signature
Absence of information about the child
Inaccuracies, especially of the date
Omission of date of medical check-up and hearing test and records for immunisation
Delay in completing the record; sometimes more than 24 hours elapsed before the records were completed
Record completed by someone who did not make visit
Inaccuracies of name, date of birth and address
Unprofessional terminology, e.g. 'dull as a doorstep'
Meaningless phrases, e.g. 'lovely child'
Opinion mixed up with facts
Reliance on information from neighbours without identifying the source
Subjective not objective comments, e.g. 'normal development'

The errors shown in Box 9.1 are not of course exhaustive and each practitioner could add others she has noticed to the list. However high a standard of record keeping is maintained, this is of little value if the records are not read. An inquest heard in 2010 that a diabetic patient died in hospital because the nurses had failed to read the records and to ensure that she received her insulin.[8] The CQC criticised Manchester Royal Infirmary in its inspection in December 2013 because notes were illegible which meant that records were incomplete and increased the chance of patients failing to get the treatment they needed. In its report the Manchester Children's Hospital was told that 'we found that many entries in the medical notes were illegible'. In a news item in May 2014 it was reported that the wrong notes were used for a patient with the same name. An arm operation was carried out based on the records of another patient with the same name at Westmorland General Hospital Cumbria.[9]

Clarity

Records should be meaningful, clear accounts of the patient's care. 'Had a good day', which is one of the most unhelpful statements, should not feature in the records. Why did she have a good day? Had her appetite returned? Had she spent most of the time sleeping? Alternatively, had she spent most of the day awake? Had she been of minimal trouble to the nursing staff? Had she in contrast been lively and interacted with the nursing staff? All these situations, many of them incompatible, are within the meaning of those words.

Comprehensiveness

Some nurses might see this paperwork as a distraction from the real task of nursing, i.e. caring for the patient. However, records are an integral part of nursing care. Failure to record an important item, e.g. administration of a drug, may mislead other professionals, such as those on a later nursing shift, and the patient could consequently be given an overdose. Accurate, comprehensive information relating to the care and the condition of the patient is a vital part of the professional role of the nurse. In addition, the information could be used for many other purposes of which the nurse may not be aware at the time.

Use of abbreviations

The NMC makes it clear in the principles of good record keeping set out in its guidance that:

5 **Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.**

This is a move away from the NMC earlier advice that abbreviations should not be used. There are of course dangers in the use of abbreviations:

1 PID: pelvic inflammatory disease or prolapsed intervertebral disc?
2 pt: patient, physiotherapist or part time?
3 CP: cerebral palsy or chartered physiotherapist?
4 MS: multiple sclerosis or mitral stenosis?
5 NFR: not for resuscitation or neurophysiological facilitation of respiration?
6 NAD: nothing abnormal discovered or not a drop!

It is therefore good practice for an agreed list to be set up by each directorate or trust and it should be a disciplinary matter for anyone to use an abbreviation that is on that list but for another meaning or to use an abbreviation that is not on that list. The approved list should be reviewed at regular intervals. A list of the approved abbreviations could be attached to the front of the patient's records. Eventually there may be a recognised list of nationally agreed abbreviations, but this may be some time away. All that has been said about abbreviations also applies to the use of symbols and signs and other hieroglyphics. Their use can certainly assist record keeping, especially in spinal care, but there must be a clearly approved list available for both patients and health professionals to access.

Who should sign or write the records?

Any individual, and this would include unregistered staff or learners who have first-hand knowledge of any events regarding the care of the patient, should write up the relevant record and initial or sign it. Countersigning might be required by trained staff in certain circumstances and the procedure for this would be laid down locally. Any member of staff, registered or not, could be summoned to court to give evidence of what took place.

What about errors and mistakes?

If it is necessary to change what has been written, it is good practice for a line to be put through the incorrect statement and the correct statement made underneath rather than heavily scoring out the incorrect sentence or using correction fluid. Tippex and other such deletions should not be used on records. It should always be clear what was originally written and any corrections should be signed and dated. If the records are then used in evidence, it should be clear what was originally written and why it was changed. It must be emphasised that these records are not proof of the truth of what they contain, but the writer of the records could be summoned to court to give direct evidence as to their accuracy and reliability.

Audit

Maintaining high standards in record keeping requires constant vigilance. Regular audit is necessary to identify errors and ensure that standards are met. The NMC Guidance states:

> **34 By auditing records and acting on the results, you can assess the standard of the record keeping and communications. This will allow you to identify any areas where improvements might be made.**

The Clinical Negligence Scheme for Trusts (see page 151, chapter 6) carries out regular monitoring of the standards of record keeping for those participants in the scheme. Their recommendations should assist in establishing and maintaining high standards. In addition, practitioners can learn from colleagues who have had to face questioning on their records before court or similar hearings.

Use in court

What constitutes a legal document?

There is sometimes confusion over what is a legal document. For example, are the nursing care plans legal documents? The answer is that any document requested by the court becomes a legal document. The court could subpoena the disclosure of care pathway records or the nursing process documents, medical records, X-rays, pathology laboratory reports, social workers' records, any document in fact that may be relevant to the case. If they are missing, the writer of the records could be cross-examined as to the circumstances of their disappearance.

While the main purpose of record keeping is the care of the patient, considerable reliance will be placed on the records in any court hearing. Any weaknesses in record keeping will hamper the professional when it comes to giving evidence in court and will render her vulnerable in cross-examination, especially when there has been a considerable delay between the events recorded and the court hearing.

On some occasions, records may be looked at in a matter unconnected with the treatment of that particular patient. For example, in the case of *Deacon* v. *McVicar*[10] (see Case 4.11, page 87), there was a dispute as to the priority that a particular patient should have been given and the judge ordered the records of the other patients on the ward at the time to be disclosed in order to assess whether or not they would have been making demands on medical and nursing time at a particular point in time.

The preceding chapter considers the rules relating to the disclosure of medical records in cases of personal injury litigation, and the powers of the court to order the discovery of any relevant documents, with only privileged records being exempt from disclosure. Health records are not proof of the truth of the facts stated in them, but the maker of the record must be called to give evidence as to the truth of what is contained in them. There are exceptions under civil evidence legislation that permit the records to be used in evidence without the presence of the maker (where, for example, the maker is dead or overseas), but due warning of the intent to use the records in evidence must be given to the other side.

Maintaining high standards of record keeping

The pressures of work and the lack of adequate time for record keeping make it extremely difficult to ensure that standards of record keeping are kept high. Constant vigilance is required. Clinical governance requires each NHS organisation to have a clear system of setting and maintaining high standards of record keeping on a multidisciplinary basis.

Computerised records

The 1997 White Paper on the NHS[11] envisaged a vast investment in information technology within the NHS that would ultimately link GP surgeries and hospitals to an NHS-wide information network. Despite an investment of many billions of pounds neither the time scale nor the full implementation of the strategy has been achieved.

The Department of Health pledged guarantees in May 2005 relating to patients' control over access to their health records.[12] The Care Record Guarantee, drawn up by the Care Record Development Board, included the commitments that access to records by NHS staff will be strictly limited to those having a need to know to provide effective treatment to a patient; patients will be able to block off parts of their record to stop it being shared with anyone in the NHS, except in an emergency, and individuals will be able to stop their information being seen by anyone outside the organisation which created it.

The Information Governance Toolkit can be obtained from the website of the Health and Social Care Information Centre which took over the functions of NHS Connecting for Health.[13]

In April 2007 the House of Commons Public Accounts Committee concluded that the 'NHS IT project was the biggest in the world and it is turning into the biggest disaster'. In 2010 it was running four years late and the budget had grown from £2.3 billion to £12.7 billion. Increasingly, there were concerns about patient consent to the inclusion of records on a national database and the fact that the

pack sent to 12 million persons did not contain an opt-out form. In 2014 it was reported that the failed £11.4 billion plan to digitise medical records in the NHS had led to an arbitration decision that the NHS should pay Fujitsu £400 million in addition to the £250 million already paid.[14] The Public administration select committee were due to open an investigation. In 2013 the Department of Health issued a press release which challenged the NHS to go paperless by 2018.[15] The Information Governance Review (led by Fiona Caldicott) supported plans for patients to have online access to their GP records by 2015 and recommended sharing information across hospitals, social care and public health. Jeremy Hunt, the Secretary of State for Health, stated that patients should have compatible digital records so their health information can follow them around the health and social care system. The Professional Records Standards Body (PRSB)[16] has been established to provide structure and contents standards for health and social care records so that the information can be recorded for the purposes of direct care and reused for management, policy and research purposes, maximising the benefits of information technology. The establishment of the PRSB was supported by the Health and Social Care Information Centre (HSCIC).

Health and Social Care Information Centre (HSCIC)

The HSCIC was set up as an executive non-departmental public body in April 2013. Its responsibilities were set out in the Health and Social Care Act 2012 and are considered in chapter 8. HSCIC is promoting the Summary Care Record (SCR) to improve the safety and quality of patient care. It will enable important information to be available in an emergency or out of hours. Further information is available on the HSCIC website. The SCR will store a defined set of key patient data for every patient in England except those who elect not to have one.

While computerisation will resolve some of the problems arising from manually held records, e.g. illegible spelling, the principles of good record keeping in terms of the content, clarity and accuracy of the information put on to the computer will still apply. Data protection requirements on security and access to the data are enforced through the criminal law (see chapter 8).

In its record keeping guidance, the NMC states the following on information systems:

> **29 You should be aware of, and know how to use, the information systems and tools that are available to you in your practice.**
>
> **30 Smartcards or passwords to access information systems must not be shared. Similarly, do not leave systems open to access when you have finished using them.**
>
> **31 You should take reasonable measures to check that your organisation's systems for recording and storing information, whether by computer, email, fax or any other electronic means, are secure. You should ensure you use the system appropriately, particularly in relation to confidentiality.**

The law relating to DNA databases is considered in chapter 8.

An NHS plan to make anonymised data available to researchers has come under attack, especially from GPs with Pulse reporting that in a survey of 400 doctors, 41 per cent would exercise their rights as patients to opt out.[17] Amendments to draft legislation of the European Parliament to be debated in March 2014 which would require specific rather than general consent to the use of medical records in research have been criticised (see chapter 8) and there are fears that databases such as the cancer registers would become illegal. This is significant at this time since in June 2013 it was announced that personalised cancer files are to be harnessed into a single database to create the biggest cancer registration service in the world. The new service has taken five years to develop and collects detailed clinical information on all 350,000 cancers diagnosed across the 50 million people in England as well as containing more than 11 million historical records on cases going back 30 years.[18] The data will be managed by Public Health England.

There is also a dispute over the GP records going into the national database known as care.data. The implementation has been delayed by six months because of consent and confidentiality issues (this is discussed in chapter 8).

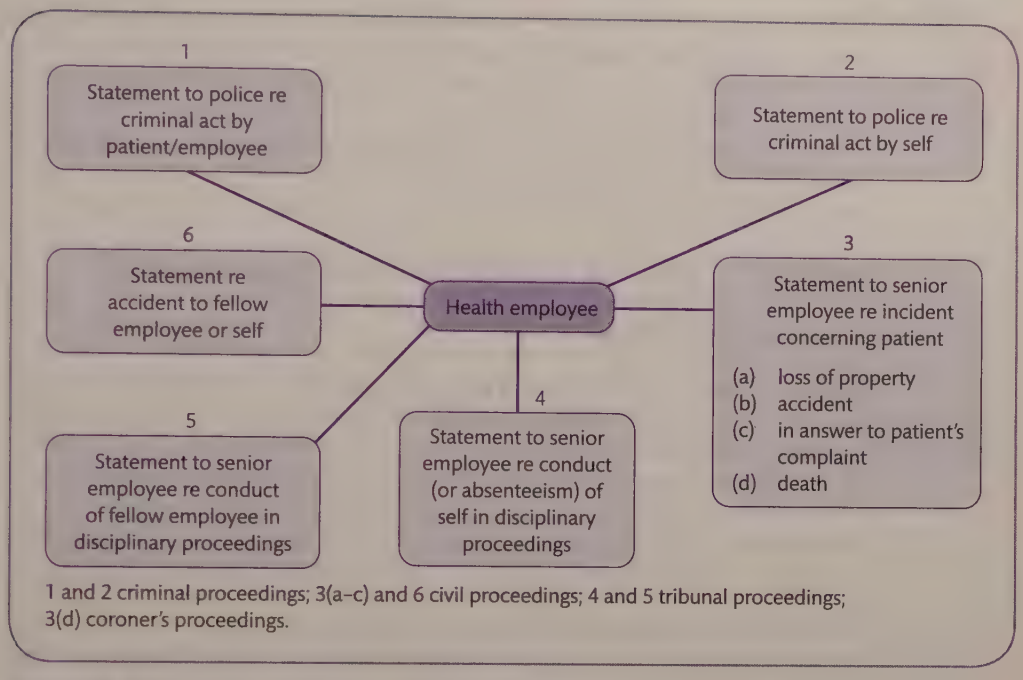


Figure 9.1 Occasions when a statement might be requested

Statements

Figure 9.1 illustrates some of the many occasions on which staff may be required to produce a statement. The statements produced on different occasions have very different purposes and effects. For example, where a statement is taken by the police, it can be used as formal evidence in criminal proceedings and the person who made the statement can be questioned on it. Where it has been made under caution, it can be used in evidence against an accused. In civil proceedings, the statement is not regarded as formal evidence, although the civil court now has the power to order disclosure of witnesses' statements.

The purpose of this section is to explore the principles of statement making and highlight some of the dangers.

Does one have to make a statement?

The one occasion on which one can refuse to make a statement is if it criminally implicates one. No one can be forced to answer a question if the effect of the answer is to incriminate her. There is a right to remain silent when questioned by the police about an alleged offence and also if a defendant is in a criminal court, but failure to reply or remaining silent can result in an adverse conclusion being drawn about this failure in an address to the jury.

There are considerable advantages in setting out exactly what took place as a record, although help and guidance are clearly essential. In general, a statement is required, not for self-defence, but as evidence of the events to which one was a witness. There have been examples where hospital staff have refused to participate in an inquiry set up by the health authority. For example, in the Shewin case, where a patient went into hospital for a gall bladder operation and suffered irreversible brain damage, the doctors initially refused to take part in the health authority inquiry. They eventually did so and were exonerated.[19]

In general, it could be argued that provided a member of staff is given appropriate guidance in making a statement, then the statement should be a valuable reminder at a later date of the details of what took place. It would seem to be reasonable to imply a term into the contract of employment that a National Health Service employee, in the course of his or her employment, would cooperate with the police and the coroner's court and would give a statement and information relevant to civil claims. It could also be argued that the employee should have assistance from senior managers or from the employer's solicitors in preparing a statement.

What is the status of a statement as evidence in court?

In criminal proceedings

Where the statement forms part of a police investigation and a caution has been given as to its effect, it could be used in evidence against the person who gave it, especially where the account they are now giving is entirely different from the statement.

Where the statement has been given by a person who is a witness to the events, then the statement, if it was made contemporaneously with the events described, can be used as an aid to memory. It must be emphasised that the statement is not in itself proof of the truth of the events therein described. Any number of lies or exaggerations can be recorded in a statement. However, except for certain exceptions, the person who made the statement would be expected to give evidence in court and could be cross-examined on the statement, from which the court could deduce the weight to be attached to the statement. Documentary evidence is permissible under the Criminal Justice Act 1988 sections 23–28 (as amended by the Criminal Justice Act 2003).

In civil proceedings

The statement can be used by its maker to refresh her memory. The court now has access to the statement; it can order disclosure of the witness statements. Written documents can be entered as evidence under the provisions of the Civil Evidence Act 1968. Further details relating to statements and documents can be found in the Civil Procedure Rules, which are available online.[20]

Can the court always insist on the statement being produced?

In chapter 8, the occasions on which documents are regarded as privileged were discussed. Where the statement, document, letter, etc. has come into existence as a result of and for the purposes of proposed or existing litigation, they are covered by professional legal privilege and the courts cannot enforce disclosure.

Should one make a statement?

A distinction must again be made between the criminal and the civil courts. Where the police are investigating a crime and seeking information from witnesses, then it could be an offence to refuse to cooperate with them. There is, however, no duty to incriminate oneself. Recent legal advice to the NMC suggests that registered nurses are not under a duty to provide a statement to the police if it would incriminate them[21] (see chapter 5).

In potential civil cases, there is no duty to make a statement, except possibly under the contract of employment.

However, if one considers the time it takes for a case to come to court – in the civil courts sometimes as long as five or six years – it is highly unlikely that anyone would have a detailed recollection of the facts when they finally come under cross-examination or are giving evidence in chief. A detailed

comprehensive statement of the events, drawn up at the time of the incident or events, is essential to refresh one's memory. In addition, a detailed, sensibly prepared statement may eliminate the chance of a nurse being called as a witness and thus save a needless attendance in court.

What points should be followed in making a statement?

Purpose

Before a statement is made, it is always advisable for its maker to have an idea of the purposes for which it is being made. Is it going to the coroner's office? Is it for internal information only? Is it to be used in a criminal prosecution? The purpose will affect the detail, style and content of the statement. The maker should therefore find out from the person who has asked for the statement who will read it and to what varied purposes it will be put. If there is any danger that the maker would incriminate herself, she should ask for legal advice before making the statement. It is not necessary to wait for a request before writing a statement about a certain occurrence. In some situations, it may be wise for a witness or participant to write down a brief account of the events immediately.

Guidance

Even in circumstances where there is no question of self-incrimination, it is always advisable to seek advice in making the statement. An objective reader can see gaps, ambiguities and confusion in a statement and give much valuable assistance.

Who should provide the guidance?

Normally, a senior nurse manager or the solicitor to the employer should provide this assistance. There will be occasions, however, where advice from a union officer is sought. In disciplinary proceedings, this depends on how far the proceedings have been taken. It would, for example, be contrary to the guidelines for good practice for management to refuse to allow an employee to receive the advice of the union representative prior to any formal disciplinary action being taken (see chapter 10).

The essential elements in a statement are shown in Box 9.2.

Box 9.2 Essential elements of a statement

1. Date and time of incident.
2. Full name of maker, position, grade and location.
3. Full name of any person involved, e.g. patient, visitor, other staff.
4. Date and time the statement was made.
5. A full and detailed description of the events that occurred.
6. Signature.
7. Any supporting statement or document attached.

Principles to be followed

Box 9.3 sets out the nine principles to be followed in preparing a statement.

Box 9.3 Principles to be followed in preparing a statement

1 Accuracy
2 Factual
3 Avoid hearsay
4 Conciseness
5 Relevance
6 Clarity
7 Legibility
8 Overall impact
9 Keep copy.

Accuracy

It is essential that the statement should set out clearly the facts that took place. There should be no exaggeration or minimisation. The statement should be read through carefully to ensure that there are no inconsistencies, mistakes or other faults. There should be access to the relevant records so that the statement maker does not rely on memory in preparing the statement. If the record keeping has been of a high standard, this will facilitate the writing of the statement.

Keeping to the facts

The maker should, if at all possible, avoid value judgements and should keep to the facts. For example, a health visitor might have formed the opinion that one of her clients was lazy. If this is relevant to the statement, it is of far more value if she were to write down a description of the facts that led her to that opinion than to make value judgements. Thus 'there were 12 dirty milk bottles on the living room floor and piles of papers on every seat, etc.' is more useful than expressing an opinion that may or may not be acceptable and is not on its own very meaningful. The facts on which those opinions are based are more useful. There are occasions where it is necessary to express opinions, especially where they led one to act in a particular way. Even here, however, it is still necessary to record the facts that led to those opinions. For example: 'Because I felt she was a danger to herself I put the cot sides up.' This statement needs to be amplified to expand on what has caused the nurse to believe that the patient was a danger to herself. For example, had she fallen out of bed? Had she tried to leave the ward? Was she in a confused state and, if so, how did she show it?

Where it is possible to check facts before making the statement, this should be done. For example, a statement that a patient had a high temperature should be checked against the patient's record; similarly, a description that the patient had been written up for a particular form of medication should be checked against the drug card. Sometimes it is helpful to draw a sketch of the ward layout or where the patient was found or where there is a need to identify the exact location, but only if the plan is a help rather than a further source of confusion.

Avoidance of hearsay

Hearsay is the recording or repetition of what someone else has seen or heard. If possible, it is best to avoid this as the person making the statement is only repeating what someone else has said and cannot give first-hand evidence of what was heard or seen. Imagine a situation where a nurse hears a fall in the night and runs in to the ward to find a patient on the floor. It is better for her statement to cover what she herself saw and heard rather than to repeat what another employee heard and saw. This other person should be asked to provide a statement of what she witnessed at first hand. Where the only witness to the events may have been another patient, it may be possible to obtain a statement from that patient, but that does depend on his physical and mental condition.

Conciseness

The statement must not ramble. It must be to the point in a logical sequence. Padding, waffle, meaningless generalisations should all be avoided. However, essential detail should not be sacrificed on the altar of brevity. The amount of detail required will, of course, depend on the facts described.

Relevance

It is a useful exercise to question oneself on the events to establish what detail a stranger to the situation would require. This questioning would have to take place in the context of the purpose for which the statement is required. In some circumstances, it may be important to describe the colour, material and style of the patient's clothes – in other circumstances, this may be entirely irrelevant. If there is any doubt as to what is relevant or not, one should err on the side of inclusion. What is in can always be omitted on the grounds of relevance at a later stage; what is left out is left out for good, because such details would soon be forgotten if not recorded.

Clarity

It is essential that the maker should read through the statement to ensure that it is clear and meaningful. If there are any doubts as to what is meant, it should be rewritten until one is sure that it is an exact clear record of what happened. Substitutes for any misleading or ambiguous words or phrases should be found. The use of clichés should be avoided. Abbreviations should be used only after the full terms are set out in full, with the abbreviation set out in brackets after the words. They should not be used for any other meaning. The level of technical language used should relate to the likely readership. In some circumstances, it will be necessary to explain technical procedures in full. In others, there will be no need. Emphasis should be on simplicity rather than complexity. The writer should make sure that he or she understands the statement.

Legibility

If the statement is handwritten, it should be legible. If it is typed at a later date, then the typed copy must be checked for errors.

Overall impact

The statement should be read through and its overall impact assessed. Does it give sufficient detail? Is it clear exactly what happened? Is it accurate? Is there any further information that should be included? Is it internally consistent? Have any facts been checked?

Any necessary changes should be made and the maker should not sign the statement unless he or she is entirely satisfied with it. The maker must be satisfied with every aspect of the statement. The maker must not allow herself to be browbeaten into including information that is not within her knowledge or that she knows is not entirely accurate. Personal accountability must be accepted for the statement. Putting a signature to a statement implies that the maker is satisfied that it is accurate in every detail and she takes personal responsibility for it. A copy should always be kept. The confidentiality of the statement should be protected in accordance with the principles considered in chapter 8.

Practical Dilemma 9.1 Statement writing

Consider any incident which has occurred in recent days and draft a statement including all the points made in Box 9.2 and 9.3.

If possible ask your tutor or mentor to read through your draft and comment on it. Imagine that the events become subject to a court hearing in 10 years' time. What questions could be asked and to what extent does the statement provide the answers?

Evidence in court

Reference should be made to chapters 2 and 6 for procedures followed in criminal and civil courts, respectively.

Fears of giving evidence in court

There are few health professionals who relish the possibility of being required to give evidence in court. Preparation and guidance in facing the ordeal are essential, whether it is a criminal court, coroner's court, civil court, conduct and competence committee hearing or employment tribunal. Of equal importance, however, are comprehensive, clear and accurate records. Box 9.4 sets out some of the fears expressed by health visitors (probably the most likely of the nursing profession to face a court appearance).

Box 9.4 Fears over a court appearance

Fear of the unknown
Hearing the client call one a liar
Publicity
Waiting and the build-up in tension that can arise
Remembering the detail of what took place
Fear of being made to look a fool
Being unable to express oneself concisely
Contradicting oneself
Omissions in one's statement on which one could be cross-examined
Being made to feel guilty
Downright rudeness and offensiveness of the others in court, especially the barristers
Tension and nerves
Being turned into the betrayer of the client
Waste of time
Being cross-examined by the client when he is not represented but is conducting his case personally
Failure to understand the legal jargon, procedure and gestures
Manipulation under cross-examination and being forced to change one's evidence.

Preparation for a court appearance

Experience in giving evidence in court will undoubtedly clear some of the anxieties illustrated in Box 9.4. Many can be solved by a private visit to a court hearing (they are all open to the public except for the few cases, such as children's and matrimonial proceedings, which are heard in private), and going on one's own or in a group without any personal involvement gives a sense of the procedure and language used and provides a chance of familiarising oneself with the process.

Witnesses are of two kinds: a witness of fact and an expert witness. The witness of fact is required to describe what she saw and did and give direct evidence of the facts in dispute. Her opinion is not usually required. An expert witness, by way of contrast, provides evidence of opinion of professional practice and approved standards of care or of causation or the appropriate level of compensation. The expert will be chosen because of her personal standing within a particular specialty.

Witness of fact

If a nurse were asked to attend court as a **witness of fact**, a solicitor would normally assist in explaining the procedure and in preparing the nurse for giving evidence. Considerable expertise can often be built up within a department and the lessons learnt passed from one to another. Confidence in the records that have been kept and the statements made should ensure that nerves are kept under control. The nurse should know the contents of the original records and where the entries appear so that there is no fumbling through the original records in the course of giving evidence.

Advice on court procedure and giving evidence in court is available from the county courts or High Court and also from the website at the Ministry of Justice.[22] Forms and guidance are also available from Her Majesty's Courts Service.[23] Failure to respond to a witness summons can lead to the person being in contempt of court and a fine of up to £1,000. A witness could apply to have the summons withdrawn.

Expert witness

The Civil Procedure Rules Part 35, which can also be accessed via the internet, set down detailed rules relating to the role of the **expert witness** and the contents of the expert's report. Rule 35.3 on expert witnesses states:

1 It is the duty of experts to help the court on matters within their expertise.
2 This duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid.

Practical issues such as 'What do I call the judge?' often worry potential witnesses.

- A High Court judge is called 'My Lord' or 'My Lady'
- A circuit judge is called 'Your Honour'
- A district judge is called 'Sir' or 'Madam'.

Expert evidence has come into focus recently following the discrediting of evidence given in the trial of mothers accused of causing the deaths of their babies. Dr Meadows, a paediatrician, gave evidence for the prosecution in the trial of C for the murder of her two sons and she was convicted. Her second appeal to the Court of Appeal against the conviction succeeded on the grounds that the verdicts were unsafe because of material non-disclosure by the Crown's pathologist. A complaint was made to the GMC about the evidence of Dr Meadows, which the Court of Appeal had indicated was also probably unsafe. The GMC concluded that he was guilty of serious professional misconduct and ordered his name to be struck off the register. Meadows appealed against this striking off to the High Court, which found for him on the grounds that an expert witness should be immune from subsequent legal proceedings. The GMC appealed to the Court of Appeal, which held that immunity from suit did not apply to disciplinary, regulatory or fitness to practise proceedings. However, Meadows's mistake had not amounted to serious professional misconduct. He had not intended to mislead the trial court and he had honestly believed in the validity of his evidence when he gave it.[24]

Cross-examination

As far as the cross-examination is concerned, it should be remembered that following a few guidelines should limit the damage to one's evidence in chief.

Go prepared to the court hearing with the relevant records and documentation.
Read through the contemporaneous notes beforehand.
Go through the evidence with a senior nurse manager.

In court, be honest; do not exaggerate; do not be drawn into saying something that is not true; do not rush the answers; take time to think.

Be aware of the 'Catch 22'-type question:

Q. You are a nurse?
A. Yes.
Q. You are therefore observant?

How do you answer this? If you say, 'Yes', the next questions could be:

Q. How fast was the car going?
A. Er . . . I'm not sure.
Q. But I thought you said you were observant?

If you say, 'No', the next question could be:

Q. Then your observations in this case are entirely useless?
A. Er . . .

If you answer the original question, 'Sometimes, it depends on what I am observing', it is likely to lead to a question or comment such as, 'Then we cannot rely on your evidence in this case'.

Such tactics are unlikely to have any effect on the judge's view, but they can sometimes influence the jury's thinking. (It must be remembered, however, that there is usually no jury in the civil court and the nurse's involvement in a jury trial in the Crown Court is likely to be rare.) What is more likely, however, is that the tactics used unnerve the person being cross-examined and cause difficulties for the future. The witness feels discredited. One way of avoiding the Catch 22 question is to expand on the answer so that one is answering fully and accurately.

Q. You are therefore observant?
A. My training has taught me to observe a patient's condition.

It is important under such pressure to avoid becoming angry or upset.

It is likewise important to avoid commenting on the relevance of the question. 'Do I have to answer that question, my Lord?' is fine on a TV drama, but unnecessarily dramatic in court. In most circumstances, one can rely on one's own lawyer or the judge to protect one from unnecessary harassment.

It must be remembered that in cross-examination there are two purposes. One is to discredit the witness's potentially hostile evidence against a client by showing the witness to be unreliable, dishonest, exaggerated, given to imagination, inconsistent (either internally, i.e. within her own evidence, or externally, i.e. in contrast to what another witness has said or what other evidence shows), unclear, confused, suffering from amnesia or (and this may be the most effective) irrelevant.

The other purpose of cross-examination is to build up the strength of the side undertaking the cross-examination. Thus, the witness being cross-examined can be used to bolster the good character and reputation of the defendant. 'What were his good qualities?' 'Was she a good mother?' 'Did you see her show any kindness to the child?' 'Did you like her?' is another Catch 22 question since once again to answer negatively implies that the witness being cross-examined is prejudiced; to answer affirmatively shows that the client has likeable qualities.

It is important in this context for the professionals to remember that in cases where they are giving evidence as witnesses as a result of their professional work, they are not on a particular side. They are called to give evidence of facts that they themselves witnessed. Their reputation does not hang on getting a particular outcome in a negligence case or in a non-accidental injury case. Where the client is personally cross-examining the professional, there should be no sense of betrayal since the professional would have been subpoenaed to attend court and is not there voluntarily.

Defamation

One concern of anyone asked to provide a statement or give evidence is that he or she could face an action for defamation. The main principles of such an action will be discussed very briefly here. The Defamation Act 2013 has introduced some significant changes to the law. A statement is not defamatory unless its publication has caused or is likely to cause serious harm to the reputation of the claimant. Where an organisation which trades for profit is the claimant, then harm to its reputation is not serious harm, unless it caused or is likely to cause serious financial loss.

The Defamation Act 2013 provides the following defences to an action for defamation:

Truth: the defendant can show that the imputation conveyed by the statement complained of is substantially true.

Honest opinion: the following conditions must be met:

1 the statement complained of was a statement of opinion;
2 the statement complained of indicated, whether in general or specific terms, the basis of the opinion;
3 an honest persons could have held the opinion on the basis of
   (a) any fact which existed at the time the statement was complained of was published;
   (b) anything asserted to a fact in a privileged statement (see below) published before the statement complained of.

The defence of honest opinion is defeated if the claimant shows that the defendant did not hold the opinion.

Publication of a matter in the public interest: the defendant must also reasonably believe that publishing the statement complained of was in the public interest.

Operators of websites: it is a defence for the operator to show that it was not the operator who posted the statement on the website. This defence, however, can be defeated if:

(a) it was not possible for the claimant to identify the person who posted the statement,
(b) the claimant gave the operator notice of complaint in relation to the statement, and
(c) the operator failed to respond to the notice of complaint.

Regulations provide further details of this defence.

Peer-reviewed statement in a scientific or academic journal: subject to specified conditions including that there has been an independent review of the article. This makes statutory provision for the defence recognised by the Court of Appeal in the case of Dr Singh (see chapter 18).[25]

Reports protected by privilege

Another significant change is that trial is to be without a jury unless the court directs.

The court has the power to order the defendant to publish a summary of the judgment when giving judgment for the claimant.

While Article 10 of the European Convention on Human Rights recognises the right of freedom of expression, this is qualified by the need to protect the reputation or rights of others. This is examined in the discussion of the case of Dr Simon Singh, a science writer who successfully defended an action for libel brought against him by the British Chiropractic Association (BCA) (see chapter 18).[26,27]

Practical Dilemma 9.2 Providing references

A ward sister is asked to provide a reference for a staff nurse who has been working on her ward. The staff nurse came under suspicion of theft shortly before this request and the ward sister felt that she would not be honest or accurate if she omitted this fact. The staff nurse failed to get the job she was applying for and subsequently learnt of the contents of the reference. In the meantime, a cleaner was charged and found guilty of the theft. The staff nurse is threatening to sue the ward sister for defamation. Would she succeed?

There is no doubt that to say someone is guilty of theft would be a defamatory statement if it were untrue and had caused or was likely to cause serious harm. However, writing a reference would probably be regarded as an occasion of qualified privilege. If the ward sister wrote the reference without any improper motive, she should have a good defence in an action for defamation. If, however, she made that statement for some other purpose, then the privilege is destroyed by malice. What if she merely stated that the nurse was under suspicion for theft, which would be true? If the words conveyed the impression that there were grounds for considering the nurse to be guilty of theft, then they could be regarded as defamatory and therefore actionable, unless protected by qualified privilege.

Liability for references

Any person asked to provide a reference owes a duty of care to both the subject of the reference and also to the recipient of the reference. In the case of *Hedley Byrne* v. *Heller*, the House of Lords[28] held that a duty of care was owed where a person gave advice that he knew would be relied on by the person seeking that advice. If the person suffered harm as a result of reliance on advice that was given negligently, then an action for compensation could be brought against the person who gave the advice. An employer who suffered harm from relying on a reference, which had been given negligently, could sue for compensation. Alternatively, if the reference contained inaccuracies and had been prepared negligently, the subject of the reference could sue the person providing the reference for harm, including financial loss, arising from the breach of the duty of care owed to him or her. To win the case the employee would have to show that the reference was misleading and led the recipient to act to the disadvantage of the subject of the reference and as a consequence he or she has suffered harm.[29] The Court of Appeal has held that an employer has a duty to undertake a reasonable inquiry into the factual basis of statements in a reference in order to discharge its duty to provide an accurate and fair reference.[30] The Information Commissioner's Office (ICO) has published a Data Protection Good Practice Note on access to employment references which is available on the ICO website.[31] The Court of Appeal has held that writing a bad reference for a former employee could, under the Equality Act 2010 (see chapter 10), be seen as victimisation of the person even after the employee had left work. An employee failed in his claim against his employers for providing him with a unsatisfactory reference. The High Court held that the employers were protected by qualified privilege and there was no malice shown by the employer[32].

Internet

The use of technology at work raises serious legal issues and the RCN has published helpful advice for its members on the do's and don'ts for using the internet and information on the risks and repercussions if used inappropriately.[33]

Conclusions

Litigation and complaints within the NHS have continued to increase, so it is inevitable that greater and greater emphasis is placed on records and record keeping in the context of the nurse giving evidence and the nurse is increasingly likely to have to appear in court. However, it must not be forgotten that the most important aspect of record keeping is the fulfilment of the duty of care to the patient and ensuring that others who care for the patient are fully informed through the records of the action that has been taken or that still needs to be done. If the standard of record keeping meets the needs for patient care, then the records will be of sufficient quality to protect the practitioner should she have to defend her practice in any forum or court of law. Regular audit and monitoring are essential for standards to be set and maintained. If records are maintained at a high standard, then the making of statements and giving evidence in court are greatly facilitated. The NHS strategy for electronic patient records has had immense problems in keeping to its timetable, but eventually it should lead to a significant improvement in standards of documentation within the NHS. Constant audit and monitoring will continue to be essential.

Reflection questions

1. What errors have you noticed in record keeping? In what ways do you consider that standards of record keeping could be raised?
2. Consider the implications of electronic patient recording systems for your speciality and analyse its benefits for patient care.
3. Prepare a statement concerning an incident that has recently occurred. Read it through and consider if there are any errors.
4. What is meant by hearsay? Give several examples of it.

Further exercises

1. Arrange a visit to court. Write up the points that any potential witness should be aware of in relation to the procedure, formality and language used. If you have the chance to visit more than one court (e.g. Crown or magistrates' or county or High Court), draw up a list of the differences between them.
2. What most concerns you about the possibility of giving evidence in court? Prepare a list of your concerns, then consider ways of meeting some of these anxieties.

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Chapter 10

The nurse and employment law

This chapter discusses

- Human rights
- Contract of employment
- Statutory provisions covering employment
- Unfair dismissal
- Trade union rights
- Public and private employees
- Discrimination: The Equality and Human Rights Commission
- Equality Act 2010
- Agenda for Change

Introduction

The complexities of employment law can be bewildering, yet the nurse needs to know her way through the maze for two basic reasons: on the one hand, she is an employee and therefore should be acquainted with the rights of an employee; on the other hand, she may be or become a manager in which case she will need to be able to advise her staff on their rights and also to understand the relevant employment law covering her role as manager. The areas discussed in this chapter are set out above. No attempt is made to give the full detail of all the employment statutes but instead the basic principles are set out together with the statutory framework. References are provided so that more detailed information can be obtained. Discussion on the organisation NHS Improving Quality (which replaced the NHS Institute for Innovation and Improvement which had hitherto replaced the NHS University) can be found in chapter 11.

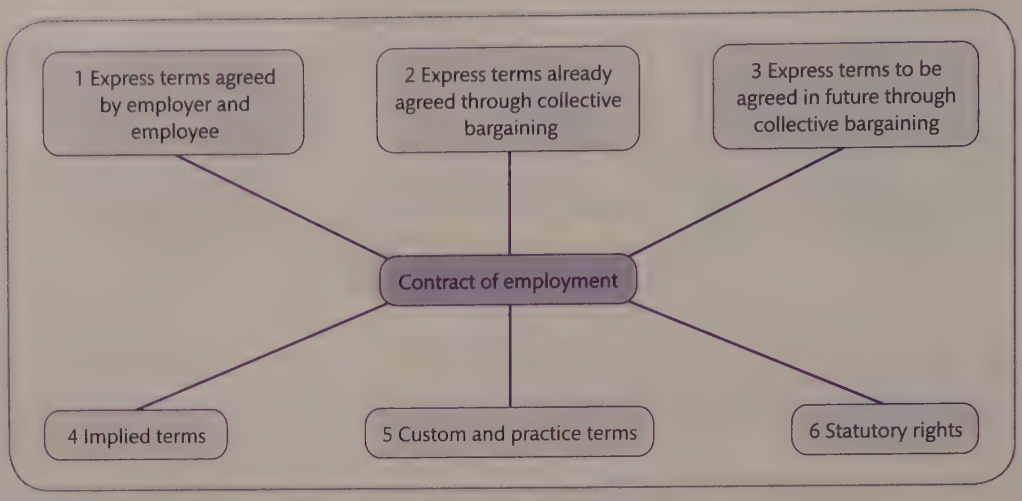


Figure 10.1 Sources of a contract of employment

The legal relationship of employee/employer is composed of many terms drawn from a variety of sources. These are shown in Figure 10.1. First we look at human rights and then how the contract of employment comes into existence.

Human rights

Since October 2000 the European Convention for the Protection of Human Rights and Fundamental Freedoms has been directly enforceable in the UK courts. (See the website of this book for Schedule 1 to the Human Rights Act 1998.) Employees in the NHS are entitled to have their rights as set out in the Schedule respected by their employers. Of particular significance to the employment situation are:

- Article 3 and the right not to be subjected to inhuman or degrading treatment or punishment
- Article 6, which gives a person a right to have their civil rights and obligations determined in a fair and public hearing within a reasonable time by an independent and impartial tribunal
- Article 8, which gives a person a right to personal and family life, home and correspondence (subject to specified qualifications) and has implications for any monitoring by the employer of emails, telephone conversations and video surveillance
- Article 9 and the right to freedom of thought, conscience and religion (subject to specified qualifications)
- Article 10 and the right to freedom of expression (subject to specified qualifications)
- Article 11 and the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests
- Article 14 and the right not to be discriminated against in the exercise of other rights (examples are given of forms of discrimination, but these are not intended to be exhaustive).

A claim before the European Court of Human Rights under Article 8 succeeded when a transsexual complained that the refusal by the Department of Social Security to pay her a state pension on reaching her 60th birthday violated her right to respect for her private life under the Charter Article 8[1].

If a court considers that any existing legislation is incompatible with the European Convention on Human Rights, it can make a declaration of incompatibility, so that Parliament can decide what action to remove the incompatibility is necessary. A court cannot overrule statutory provisions (see chapter 1).

The Equality and Human Rights Commission replaced the Commissions covering equal opportunities, disability rights and race equality on 1 October 2007, and its website[2] is a useful source of information about human rights and discrimination. The Information Commissioner's website covers human rights and the duties of an employer in relation to data protection and freedom of information[3] (see chapter 8).

Contract of employment

Formation of contract

Stages leading to formation of a contract of employment

When a nurse accepts the offer of a post, a contract then comes into existence and the nurse will be bound by its terms. In this sense the contract is an abstract concept; there may be nothing in writing but the relationship of the parties is radically altered by that agreement.

In any negotiation leading up to a contract of employment many documents may be circulated: an advertisement, an application form, perhaps a job description and certainly an interview. All these stages are known as an '**invitation to treat**'. Neither party is bound by them and can usually pull out of the negotiations at any stage. Thus an employer is not bound to appoint after advertising a post. Similarly, someone who has sent in an application form can withdraw at any stage from the field prior to **acceptance** of an offer. A contract only comes into being once an offer has been accepted. The offer is usually made by the employer. This could be in writing (for example, after holding interviews the applicants could be sent away without knowing the results and be told that they will be notified) or it could be at the actual interview when the applicants wait until the successful one is summoned and offered the post. Sometimes, this might be a conditional offer: it might, for example, be an offer dependent on a satisfactory medical examination or references, or the selection panel might not have the power to offer the post but can only recommend to the authority that X be appointed. The candidate should be absolutely clear as to the nature of the offer since if it were subject to approval by a higher authority, which did not agree to that appointment or indeed to any appointment, the candidate would have no remedy if she has undergone expenses believing that she had a contract or has even terminated her existing job. If the candidate accepts an unconditional offer then and there, she is bound by that contract.

Practical Dilemma 10.1 Better prospects

A ward sister applies for, is offered and accepts a post in a neighbouring NHS trust. She then sees a nursing officer post advertised in her own trust, applies and is accepted before she has commenced work in the new post. What is her position in law?

Technically, she is in breach of contract with the neighbouring NHS trust. She is bound by the contract she has agreed with that trust. In practice, the trust is unlikely to take action against her; certainly the publicity that would arise would do little to enhance the reputation of that trust and the courts are unlikely to order the ward sister to commence work with the new trust, preferring to compensate by an order for damages to be paid rather than make what is known as an order for specific performance of the contract. The amount payable would be minimal, simply the loss incurred by the trust as a result of her breach of contract, taking into account the fact that she would have been entitled to give notice immediately.

Failure to declare a particular medical condition or criminal record

Pre-employment checks

It is for the prospective employer to ascertain the good and bad about any prospective employee. There is no obligation on the candidate to present her inadequacies. However, if the applicant is questioned about medical history or criminal record and lies or fails to disclose relevant information and if this information is later discovered after the applicant has been offered the post and accepted, then the employer is entitled to terminate the contract on the grounds of the misrepresentation provided that he would not have offered the post had he known of the facts. In addition, a lie can also be a criminal offence.

The Rehabilitation of Offenders Act 1974 protects those who have a past criminal record from being compelled to disclose it. The rehabilitation periods were changed in 2012.[4] Former prisoners sentenced to six months or less will have to admit their criminal history on job application forms for only two years from the end of their sentence instead of the current seven years from the date of conviction. A person sentenced to up to 4 years in jail will have to declare their conviction for seven years after the end of their sentence compared with the current provision of disclosure for the rest of their lives. However, this Act does not apply to most health service posts and thus the applicant would have to disclose a criminal record when asked. Where the appointment involves working with children or vulnerable adults, then the employer would be required to check that the person's name is not contained on lists of those considered unsuitable for such work. The Disclosure and Barring Service (which was formed from the merger of the Independent Safeguarding Authority (ISA) with the Criminal Records Bureau on 1 December 2012) should be contacted to ensure that the individual is not on its list (see page 246).

Practical Dilemma 10.2 Undisclosed epilepsy

An applicant for a post of nursing auxiliary is not asked and fails to disclose that she suffers from epilepsy. This is discovered subsequently when she has a fit at work. The employers send her a letter dismissing her. What are her legal rights?

The employers can either give her the requisite notice or they could dismiss her instantly on the grounds that she is not capable of performing the job safely. However, this is subject to the laws on disability discrimination as re-enacted in the Equality Act 2010, which is considered below. If the applicant had lied about her health, this would be taken into account in determining whether a dismissal would be fair. (For her rights to apply for unfair dismissal, see pages 255–9.) See also the definition of good health by the NMC (discussed in chapter 18).

Are terms agreed at an interview binding?

It sometimes happens that at an interview an applicant is given certain assurances about the conditions of work: shifts, hours, days off, holiday dates, location of the workplace, etc. These terms can be made **conditions** of the contract. Thus an applicant who had already booked a holiday can obtain an agreement that one of the terms of the contract is that these dates can be retained. Failure to keep to this agreement would constitute a breach of contract by the employer. However, it is a question of fact as to whether the discussion leads to an agreed term or is merely a working arrangement that can be changed by the employer at a later date. In order to safeguard her position, the nurse, in accepting the

post in writing, could confirm that certain terms have been agreed as part of the contract. A job description is not regarded in law as setting out terms of the contract. The list of duties contained therein can be changed unilaterally by the employer (within the overall contractual title) and the job description will usually end with a final requirement of 'and any other reasonable instructions of the employer'. This is perfectly lawful since it is an implied obligation on the part of the employee to obey the reasonable instructions of the employer. (See pages 241–3 for implied terms.)

Content of contract

Figure 10.1 (on page 238) shows sources of the various terms that comprise a contract of employment.

Express terms agreed between employer and applicant

These would include the starting date, the grade and title of post, the point on the salary scale at which the employee would start and many others. It is a matter of interpretation as to how many of the details in the advertisement become terms of the contract.

Express terms already agreed for the post

The bulk of the terms and conditions of posts in the National Health Service were nationally agreed and contained in the Whitley Council Agreements and the health service bodies were bound by these. The Agreements comprised the General Council Conditions, and conditions relating to particular staff groups are negotiated by the NHS Staff Council. The employee's contract should make it clear that it is subject to nationally negotiated conditions. They should be available for inspection by any employee or applicant. NHS trusts have the power to negotiate terms locally. The Agenda for Change has set up different negotiating arrangements and these are discussed below.

Future terms agreed or set by the review body

Even though an employee is not a member of a trade union and not represented on the NHS pay negotiations, the changes and modifications to the terms of employment will be binding on all employees and will usually be incorporated into the individual's contract of employment. The NHS pay scheme, the Agenda for Change (see page 271), envisaged the expansion of the remit of the NHS Review Body for Nurses, Midwives, Health Visitors and the professions allied to medicine (the NPRB) to include a wider number of qualified health professionals and their support staff. The General Whitley Council and the separate functional Whitley Councils were replaced by a NHS Staff Council[5] which oversees the operation of the Agenda for Change pay system and has responsibility for NHS-wide terms and conditions of service. A Pay Negotiating Council negotiates pay for staff on the third pay spine.

Statutory terms

Additional terms are added by Act of Parliament which are binding on the employer (see statutory rights for employees on pages 247–54).

Implied terms

Additional terms are also implied in a contract of employment which place obligations on the employer or employee. Past court rulings by judges have decided whether certain specific terms should be implied and also what tests should be used to decide if a particular term is implied.

Box 10.1 sets out implied terms placing obligations on the employer. Box 10.2 sets out implied terms placing obligations on the employee.

Box 10.1 Implied terms binding on the employer

1 A duty to take reasonable care for the health and safety of the employee.
2 A duty to pay and to provide work.
3 A duty to treat the employee with consideration and support him.
4 A duty to deal promptly and properly with grievances.

Box 10.2 Implied terms binding on the employee

1 A duty to obey the reasonable orders of the employer.
2 A duty to act with reasonable care and skill.
3 A duty not to compete with the employer's enterprise.
4 A duty to keep secrets and confidential information.

Practical Dilemma 10.3 Implied terms

An emergency arises in Y Hospital following a multiple pile-up on the nearby motorway. A call is put out to those off duty in the nurses' home, which is onsite, that help is urgently required. Mavis, a staff nurse who has just come off duty after an eight-hour shift, is asked to return. She refuses, saying she is too tired. She has actually arranged to go out with her boyfriend. Her absence is noted and she is subsequently disciplined. She argued that her off duty was her own time and she had no obligations to the employer during it. Also she was far too tired to be of any assistance and in fact would have been positively dangerous to the patients. The employers, in contrast, might argue that there is an implied term in the contract that even when the employee is off duty, she can still be summoned to assist in an emergency.

The outcome of a case such as Practical Dilemma 10.3 will hinge on whether such a term should be implied and also whether a nurse is correct in refusing to help when she is tired and therefore a potential hazard to the patient. A paramedic who refused to take a woman to hospital for an emergency Caesarean section because he was on his break was sacked by his employers and was struck off by the HPC.[6]

What tests are used to determine if a term will be implied? The courts have decided that the following tests are appropriate in determining whether a term will be implied. One is known as the officious bystander test. Imagine the following situation: nurse and NHS trust are discussing the possibility of establishing a contract between them. They are outlining the terms, hours, pay, holidays, etc., and someone overhearing them asks what happens in an emergency. Does the employer have the right to summon any nurse to return to work? If the negotiating couple were to turn to the questioner and say, 'Of course, that goes without saying', then the term would be implied.

Another test used is whether the term is necessary to make business sense of the contract. There is no decided case on the situation in Practical Dilemma 10.3, but most nurses would probably agree that such a term would be implied subject to the question of the physical and mental fitness of the nurse to continue to work. The NMC set out an express duty to provide care in or outside the work setting in an emergency in its Code of Professional Conduct published in 2004, but this was not repeated in the 2008 edition[7] (see chapter 3 and duty of care).

What about Mavis's fitness to work? It is true that an employee who is unfit to work and is likely to be a danger to fellow employees and patients should stay away. However, in an emergency situation,

risks might have to be taken and the risk of potential harm to the patient balanced against the value of that additional pair of hands. It would be a question of fact as to where the balance lay.

Terms resulting from custom and practice

This overworked phrase has been used by trade unionists to give contractual force to certain work practices and privileges that were not original terms of the contract. However, the judicial meaning is much narrower and is confined to special trades and works where the nature of the work has led to special terms being implied. To be legally recognised by the courts, a custom must be 'reasonable, certain and notorious'.

Can an employee see or have a copy of her contract?

A statutory right is given to employees to receive a written statement of particulars of employment. Previously, NHS employees, as Crown employees, were excluded from these provisions. However, under section 60 of the NHS and Community Care Act 1990, health service bodies lost the status of being Crown bodies and all NHS employees now have this statutory right. Employers are required within two months of the commencement of employment, and as soon as possible after any change in the contract, to give written particulars of the terms set out in Box 10.3. This statement is not the contract itself, but provides *prima facie* evidence of the contractual terms. While the written statement can refer to another document or manual for sickness, sick pay or pensions and the length of notice, all other particulars must be specifically included in the single written statement of employment particulars. Further information on employment contracts can be found on the government website.[8]

Box 10.3 Written statement of employment particulars

Name of employer and employee
Date when employment (and the period of continuous employment) began
Remuneration and the intervals at which it is to be paid
Hours of work
Holiday entitlement
Notice entitlement
Job title or brief job description
Period of employment, or date of ending fixed term, if post not permanent
Place of work or locations if more than one, and the employer's address
Details of collective agreements affecting employment
Additional detail if employee is expected to work abroad
How to complain about a grievance or disciplinary/dismissal decision
Where information about disciplinary and dismissal procedures, grievance procedures, pensions and pension schemes and sick pay and procedures can be found.

Changing the contract

Practical Dilemma 10.4 Job title

A staff nurse was appointed on the basis that she worked on the surgical ward at Roger Park Hospital. After two years, she was asked to work on the medical wards at Green Down Hospital. She was unwilling either to change her specialty or to move from the present hospital. Could she refuse to move?

The answer depends on whether the location and the specialty are terms of the contract. If they were, then it would be a breach of contract for the employer to change the contract unilaterally. This is because one of the basic principles of contract law is that one party cannot change the terms without the agreement of the other party to the contract (unless there is specific contractual agreement for this, as in the terms and conditions of senior civil servants). Thus, if these issues are seen to be contractual conditions, then the nurse is entitled to retain them. However, care must be taken in insisting on legal rights since it may be that a redundancy situation exists in which case a nurse who refused unreasonably to accept suitable alternative work would lose both her job and the right to obtain compensation. In addition, if someone has been unfairly dismissed, she has a duty to mitigate the loss.

Often, however, the location and ward are not contractual terms, but simply a working arrangement, in which case they can be reasonably altered by the employer without the consent or the right of refusal of the employee. How does one know if the issue in dispute is a contractual term or not? This would depend on the nature of the agreement between them, on the letter (if any) offering the post and on other evidence of the understanding between the parties as to the nature of the contract. Contracts cannot usually be changed unilaterally. Where, however, the employee seeks to obtain promotion or change her post she may be asked to accept new contractual provisions which may not be based on NHS terms and conditions of service.

Privity of contract

There used to be a rule of contract law known as **privity** of contract whereby only the parties to a contract could enforce it, even though the contract was agreed for the benefit of a third party. However, the Contracts (Rights of Third Parties) Act 1999 enables a third party to enforce the contract in either one of two situations: where the contract expressly provides that he may, or where the contract purports to benefit him (unless there is clear provision to the contrary in the contract).

Breach of contract

By employee

The employee, as has been seen, has an implied duty to take reasonable care and skill in his work and to obey the reasonable orders of the employer. If he is in breach of these terms, he can be disciplined. In extreme cases, the employee's actions may justify summary dismissal by the employer. Other sanctions by the employer include suspension, demotion, warnings, etc.

By employer

The duty to abide by the contractual agreement is reciprocal and the employee is therefore entitled to expect that he will be treated with consideration and that there will be no unilateral change of contract conditions. If it is apparent that the employer is in fundamental breach of contract, then the employee may be able to consider himself constructively dismissed (see unfair dismissal on page 255). The recent change in the law whereby breach of health and safety regulations can no longer be the basis for an action for compensation may lead to an increase in claims for the failure of the employer to respect the duty to take reasonable care of the employee's health and safety (see chapter 12).

Statutory provisions covering employment

The Protection of Children Act 1999, the Protection of Vulnerable Adults scheme and the Sexual Offenders Act 1997 enabled employers to establish if there are grounds for not employing prospective employees. Consequently there were three separate lists of persons who were barred from working with

children or vulnerable adults. The lists operated under different legislation with different criteria and procedures. Following a public consultation[9] undertaken in the light of the Bichard Inquiry[10] (which was set up following the murders of Holly Wells and Jessica Chapman), the Safeguarding Vulnerable Groups Act 2006 was passed to provide the legislative framework for a revised vetting and barring scheme for people who work with children and vulnerable adults. It aimed at minimising the risk of harm to children and vulnerable adults by barring unsuitable individuals not just on the basis of referrals but also at the earliest possible opportunity as part of a centralised vetting process that all those working with children and vulnerable adults must go through. Subsequently the Disclosure and Barring Service (DBS) has been established (see page 246).

Sexual Offenders Act 1997 and 2003

The Sexual Offenders Act 1997 was passed to ensure that once a sex offender had served his sentence and was about to be released, he would still be subject to some form of supervision to protect persons against the risk of his reoffending. Part I of the Act requires the notification of information to the police by persons who have committed certain sexual offences.

Sex Offences Act 2003 required relevant offenders to notify certain personal information to the police. New 2004 regulations[11] set out travel notification requirements which were further amended in 2012.[12]

Protection of Children Act 1999

This legislation had four purposes.

1 It made statutory the Department of Health's Consultancy Service Index list and it required childcare organisations to refer the names of individuals considered unsuitable to work with children for inclusion on the list.
2 It provided rights of appeal against inclusion.
3 It required regulated childcare organisations to check the names of anyone they propose to employ in posts involving regular contact with children with the list and not to employ them if listed.
4 It amended Part V of the Police Act 1997 to allow the Criminal Records Bureau to act as a central access point for criminal records information, List 99[13] and the new Department of Health list. In other words, the Criminal Records Bureau would act as a one-stop shop in the carrying out of checks.

The effect of the legislation was that organisations working with children, such as local authorities and health trusts, had a statutory duty from 2 October 2000 to vet prospective employees, paid or unpaid, for work involving contact with children.

Protection of vulnerable adults

Provision was made in the Care Standards Act 2000 for a scheme to protect vulnerable adults. The protection of vulnerable adults (POVA) scheme enabled a list to be kept of anyone who has harmed or placed at risk of harm a vulnerable adult in their care, and providers of care are not able to offer employment to such individuals. Those on the list who sought employment in care positions would be committing a criminal offence. Checks against the POVA list were requested as part of disclosures from the Criminal Records Bureau.[14] Care workers who had challenged their provisional placement on the POVA list as being contrary to their Article 6 and 8 rights won their case in the High Court, which held that the provisions of the Care Standards Act 2000 in relation to provisional listings were not compatible with their human rights.[15] The Court of Appeal held that those who worked with vulnerable adults should be given the opportunity to make representations before being placed on the POVA list. That would prevent section 82(4)(b) of the Care Standards Act being incompatible with Article 6 of the European Convention on Human Rights.

Safeguarding Vulnerable Groups Act 2006

This Act set up a new scheme for barring those unsuitable for work with children and vulnerable adults. Vulnerable adult is defined in section 59 and includes many categories of adults, such as those in residential care, those receiving healthcare or a welfare service of any description and those who require assistance in the conduct of their affairs. Regulations which came into force in October 2009[16] amplify the definition of a welfare service by stating that it includes the provision of support, assistance or advice by any person, the purpose of which is to develop an individual's capacity to live independently in accommodation, or sustain their capacity to do so. The regulations also prescribe the circumstances in which driving children and adults can become a regulated activity.

The Supreme Court held that the absence of an individual review of the notification requirements on a sex offender who had been placed under lifelong notification duties constituted a disproportionate interference with Article 8 rights.[17]

Protection of vulnerable adults: No Secrets

No Secrets guidance[18] was issued in 2000 for the protection of the elderly and vulnerable adults against abuse. In 2008–09 an extensive consultation exercise was carried out with both professionals and service users, and in January 2010 the government published its response in a written ministerial statement. This stated that the following action would be taken:

- an inter-departmental ministerial group (IDMG) would be set up to determine policy and work priorities; provide a strategic and coordination role and provide public and parliamentary advocacy;
- Safeguarding Adult Boards would be put on a statutory footing by legislation;
- a programme of work with representative agencies and stakeholders would be launched to support effective policy and practice in safeguarding vulnerable adults.

Disclosure and Barring Service

The Protection of Freedoms Act 2012 section 87(1) established the Disclosure and Barring Service (DBS) with the transfer of functions from Independent Safeguarding Authority.[19] The functions of the Secretary of State performed by the Criminal Records Bureau are also transferred to the DBS, which can be accessed on the government website.[20] The DBS processes requests for criminal records checks; decides whether it is appropriate for a person to be placed on or removed from a barred list and places or removes people from the DBS children's barred list and adults' barred list for England, Wales and Northern Ireland. It has published a code of practice for recipients of DBS certificates. Part 5 of the Protection of Freedoms Act 2012 defines the scope of the regulated activities in relation to children and vulnerable adults and sets out the information required for the purposes of making barring decisions; the review of barring decisions; information about barring decisions and the duty to check on whether a person is barred. Sections 21 to 27 of the Safeguarding Vunerable Groups Act 2006 covering controlled activity and monitoring are repealed. Regulations implement the changes.[21] Access to the Disclosure and Barring Service is through the government website.[22]

The Child Sex Offender Disclosure Scheme (known as Sarah's Law – resulting from the campaign by Sara Payne whose daughter Sarah was murdered by a convicted paedophile in 2000) enables parents to inquire about any person who has access to their children and has led to 4,754 applications since the launch of the scheme in 2011 with the disclosure of more than 700 paedophiles to parents.[23]

The Supreme Court has ruled that the automatic release of a person's convictions, cautions and warnings regardless of the length of time that had elapsed, when that person was required to obtain an enhanced criminal record certificate for the purposes of obtaining employment which involved working with children or other vulnerable persons, was incompatible with their Article 8 right to respect for their private life.[24]

Statutory rights for employees

Certain Acts of Parliament provide additional rights to employees.[25] The most significant Acts are the Employment Rights Act 1996, Employment Relations Act 1999, Employment Act 2002, Employment Relations Act 2004, Employment Act 2008, the Equality Act 2010, Enterprise and Regulatory Reform Act 2013 and the Children and Families Act 2014. Table 10.1 sets out some of the statutory rights and the minimum time of **continuous service** that the employee must have in order to claim these rights. They include medical suspension payments, guaranteed pay, rights for the pregnant employee, time off work provisions, rights in relation to trade unions and many others. In addition, after 2 October 2000, those employees working for a public organisation or an organisation that exercises functions of a public nature may have grounds for claiming a breach of their human rights if the employer does not respect the rights set out in the European Convention on Human Rights (see chapter 1, pages 14–19 and the website of this book).

Table 10.1 Statutory rights

Right	Period of continuous employment
Flexible working	26 weeks
Not to be dismissed because of medical suspension	4 weeks
Written statement of terms and conditions of employment	4 weeks
Written reasons for dismissal	1 year (2 for those employed after 6.04.12)
Not to be unfairly dismissed	2 years
Maternity rights	
1 Paid time off work to receive antenatal care	No minimum period
2 Right to return to work after pregnancy	No minimum period
3 Not to be unfairly dismissed on grounds of pregnancy	No minimum period
Redundancy pay	2 years
Not to be dismissed because of trade union activities	No minimum period
Time off for trade union duties, trade union activities and public duties	No minimum period

Some of the main employment rights are shown in Box 10.4.

Box 10.4 Statutory rights

1 Employment particulars
2 Protection of wages
3 Guaranteed payments
4 Sunday working for shop and betting workers
5 Protection from suffering detriment in employment
6 Time off work
7 Suspension from work
8 Maternity rights
9 Termination of employment
10 Unfair dismissal rights
11 Redundancy payments, etc.
12 Insolvency of employers
13 Whistleblowing
14 Part-time workers' rights
15 Notice of dismissal
16 Itemised pay slip
17 Right not to be discriminated against
18 Holiday and holiday pay

Rights of the pregnant employee

The employment rights set out in Box 10.4 have been strengthened by the implementation of the European Pregnant Workers Directive and recent implementation of rights for parents and those with dependants. No continuous service is required to obtain these rights. The rights include:

1 The right not to be dismissed on grounds of their sex, pregnancy or maternity leave.
2 The right to receive 26 weeks' ordinary maternity leave and 26 weeks' additional maternity leave. Pregnant women who meet qualifying conditions may receive up to 39 weeks' Statutory Maternity Pay (those not entitled may receive 39 weeks' Maternity Allowance) (see page 250).
3 The right to return to work after confinement.
4 The right to attend antenatal classes.
5 The right to be offered suitable alternative work or be paid during suspension from work on maternity grounds.
6 The right to have their health and safety protected when they are pregnant, have recently given birth or are breastfeeding (see chapters 12 and 14).

Further details on all these rights are to be found on the government website[26] and also the ACAS website.[27] The Citizen's Advice Bureau also has useful information on employment rights[28] as well as the government website NIDirect.[29]

In addition to the statutory rights, NHS conditions covering the same field often exist. The employee usually has the right to choose whichever benefits are more favourable to her. The RCN has provided guidance for nursing, midwifery staff and students.[30]

From April 2009 all pregnant women were entitled to the new Health in Pregnancy grant which was introduced as part of the Health and Social Care Act 2008. However, this was one of the measures removed by the Coalition government to reduce public expenditure.

Right not to be unfairly dismissed on grounds of pregnancy

Practical Dilemma 10.5 Morning sickness

Barbara is two months pregnant and suffering very badly from morning sickness and hypertension. Her absence from the ward is causing considerable difficulties and she is not popular with the other staff. She has worked with the authority for three years. It has been agreed that she should be dismissed because of the continual absences. What are her rights?

She is pregnant, a full-time employee for three years and is therefore able to claim the right of not being unfairly dismissed on the grounds of pregnancy. The authority might argue that her pregnancy is making it impossible for her to do her job adequately, there is no suitable alternative work and therefore they are justified in dismissing her. This is, however, no longer an acceptable defence to an application for unfair dismissal on grounds of pregnancy and the employee would probably succeed in her application. No continuous service is required. Furthermore, the employee is entitled to receive pay during a time of suspension from work on maternity grounds, if suspension results from a health ground specified by statute (i.e. pregnancy, birth or breastfeeding) or to be offered suitable alternative work. If suitable alternative work is not available, the employee can claim pay during the time of suspension from work. Claims in relation to dismissal on grounds of pregnancy can also be brought under the Equality Act (see pages 261–70) under which there is no upper limit to the amount of compensation. (In 2010 a banker who was not allowed to return to work after her maternity leave was awarded £1.5 million for sex discrimination and unfair dismissal.)[31]

Maternity right to return to work

In *Halfpenny* v. *IGE Medical System Ltd* 1999,[32] a woman who had left work to have a child exercised her statutory right to return to work after her maternity leave by giving the appropriate notice. She then sought to delay her return to work on grounds of sickness. The employers allowed a first extension, but then notified her that her job was no longer available. At an industrial tribunal she lost her application for unfair dismissal, wrongful dismissal and unlawful sex discrimination, and her appeal before the employment appeal tribunal was also unsuccessful. Her appeal to the Court of Appeal, however, succeeded on the grounds that the exercise of her statutory right to return to work was made complete and effective by the giving of the appropriate notice at the appropriate time. The employers were guilty of unfair dismissal, wrongful dismissal and unlawful sex discrimination.

The European Court of Justice held that a woman who gave up work or looking for work because of the physical constraints of the late stages of pregnancy and the aftermath of childbirth retained the status of worker within the meaning of Article 45 of the Treaty on the Functioning of the European Union, provided she returned to work or found another job within a reasonable period after the birth of the child.[33]

Dismissal of maternity leave replacement

The European Court in Luxembourg has ruled[34] that where an employee who was taken on to replace an employee during maternity leave herself became pregnant and was dismissed, it was an unfair dismissal on the grounds of pregnancy. Its decision was therefore that EEC Directive 76/207 precluded dismissal of an employee who had been recruited for an unlimited term with a view initially to replacing another employee during maternity leave and could not do so because, shortly after her recruitment, she was herself found to be pregnant. Subsequently, the Sex Discrimination Act 1975 was amended in 2005 and again in 2008 to clarify the protection provided to the pregnant employee. The provisions are now re-enacted in the Equality Act 2010.

Antenatal visits

There is a statutory right to attend antenatal examinations with paid leave. For the first visit, there is no requirement to show the certificate for the expected date of confinement or the appointment card, but for subsequent visits the employer can insist on seeing both. The right is not absolute, however. It depends on the reasonableness of the request and it may be reasonable to refuse such time off if an employee can reasonably make arrangements for an appointment outside normal working hours. There is no statutory right for the father to have paid leave to accompany his wife on antenatal visits, but the government is encouraging employers to adopt a flexible approach and has published a fathers-to-be and antenatal[35] appointments good practice guide. Under the Children and Families Act 2014 fathers have a right to unpaid leave to attend up to two antenatal appointments.

In a case reported on 18 March 2014 the European Court ruled that a woman, who had made arrangements with a surrogate to have a child for her, was not entitled to receive maternity benefits.[36] Changes introduced by the Children and Families Act 2014 make it easier for intended parents in a surrogacy arrangement to access adoption leave and pay, and shared parental leave and pay.

Parental leave for caring for a child (including adopted child)[37]

A right was given by the Employment Relations Act 1999 to enable either parent to be absent from work for the purpose of caring for a child or making arrangements for the child's welfare.[38] Following an EU Directive, amendment regulations were passed which enable a qualifying employee's entitlement to parental leave to be increased from 13 weeks to 18 weeks.[39] Under the Children and Families Act 2014 all parents of children under 18 are able to take up to 18 weeks of unpaid parental leave per parent per child.

Emergency leave can be taken to deal with an emergency involving a dependant. There is not a set amount of time and there is no right to paid time off, but some employers might be prepared to give paid time off. An emergency includes illness, injury, assault, having a baby, disruption of care arrangements, if a child is involved in an incident during school time.

Statutory maternity leave and pay

Statutory maternity leave of 52 weeks is made up of 26 ordinary maternity leave for the first 26 weeks and additional maternity leave for the last 26 weeks. The earliest date it can commence is 11 weeks before the expected week of the childbirth or the day after the birth if the baby is early. It will automatically start if the employee is off work for a pregnancy-related illness in the 4 weeks before the week that the baby is due. Statutory maternity pay (SMP) is paid for up to 39 weeks. Ninety per cent of average weekly earnings (before tax) for the first 6 weeks, then £138.18 or 90 per cent of average weekly earnings (whichever is the lower) for the next 33 weeks. To be eligible for leave, employees must be an employee, give the employer the correct notice, earn on average at least £111 a week, give proof of the pregnancy and have worked for the employer continuously for 26 weeks up to the qualifying week – the 15th week before the expected week of childbirth. Further details of the statutory maternity pay scheme are available.[40]

Maternity allowance

This is payable to those employees who do not qualify for statutory maternity pay. The higher amount is payable for 39 weeks for employees who are not eligible for SMP, for the self-employed and those who have recently stopped working. Employees must have worked for at least 26 weeks in the 66 weeks before the week the baby is due and have earned at least £30 a week over any 13 week period. Allowance at present is £138.18 a week or 90 per cent of average weekly earnings (whichever is less) for up to 39 weeks.

Maternity allowance at the lower level is paid for 14 weeks if for at least 26 weeks in the 66 weeks before the baby is due the person is married or in a civil partnership, is not employed or self-employed, worked with a spouse or a partner in a business and is not paid. The person must not be eligible for statutory maternity pay or the higher amount of maternity allowance. The amount payable is £27 a week for up to 14 weeks if the baby is due on or after 27 July 2014.

Paternity leave and pay

Statutory paternity pay (SPP) is payable by employers to eligible employees to take paid leave to care for his baby or support the mother following birth. He can take either 1 week's or 2 consecutive weeks' paternity leave and during this time he may be entitled to SPP. From 5 April 2015 the baby's mother and father will be able to share leave between them and alternate, discontinuous periods of time off can be taken by both parents with the employer and employee agreeing the pattern of leave. The mother could transfer all her leave to the father except for the two weeks' compulsory leave she must take. The maximum entitlement is 52 weeks to be shared between them. Further details are available on the government website.[41]

Time-off provisions

Paid or unpaid time off (depending on the benefit) is also a statutory right and can be seen in Box 10.5. Again, there are comparable NHS rights and the employee is entitled to choose whichever is more advantageous.

Box 10.5 Time-off provisions

Time off for:

1. Trade union duties (officer): reasonable paid time off to carry out duties in connection with industrial relations and for training relevant to carrying out those duties (as a learning representative) (reasonable defined in ACAS Code of Practice No. 3).
2. Trade union activities (member): reasonable unpaid time off during working hours to take part in TU activities (see ACAS Code of Practice No. 3).

3 Public duties – local authority member, school governor, JP: reasonable unpaid time off (take into account time off given in relation to 1 or 2 above and other public duties).
4 To seek job in redundancy situation: reasonable paid time off to seek work or seek retraining.
5 Jury service: unpaid time off.
6 Health and safety representative: reasonable paid time off to perform function and train for it.
7 Time off for dependants.

In Practical Dilemma 10.6, Mary took the case to an industrial tribunal and won since it was held that rearranging a timetable was not giving time off. However, Mary was still receiving her full pay and the time-off provisions were only for unpaid time off. (The school could have reduced her workload, reduced her salary accordingly and then employed a locum to teach in Mary's place with the money saved. Mary might have preferred the existing arrangements!)

Practical Dilemma 10.6 Rearranging a timetable

Mary Briggs was a nurse tutor. She was also very involved in local government and had recently been elected as leader of the opposition on the county council. She was appointed to several subcommittees. She applied for time off to attend the meetings. The principal was extremely helpful and rearranged her timetable so that she would not have to teach in the afternoons when the council meetings took place. Mary complained that her workload had not decreased and she now found that she was having to spend several evenings doing work that normally she would have done during her free periods, which had now been lost.

Time off for dependants[42]

From 15 December 1999, reasonable time off is permitted where it is reasonable for an employee to deal with an emergency involving a dependent. This includes when a dependant is ill, gives birth or is injured; dies; where there is unexpected disruption of arrangements for the care of the dependant; or an incident at school. The employee must notify the employer of the reason for his absence as soon as is reasonably practicable and how long he is likely to be off. Dependants include a spouse, a child, a parent, a person who lives in the same household as the employee (other than a tenant or lodger) and includes any person who reasonably relies on the employee for assistance when ill or injured. An employer's refusal to give time off for dependants could be followed by an application by the employee to an employment tribunal.

Flexible working

Section 47 of the Employment Act 2002 introduced a statutory right from April 2003 for an employee to request a variation in her contract, known as making a statutory application. Only employees who have worked continuously for the same employer for 26 weeks are eligible to make a statutory application and only one a year can be made. The employer has a statutory duty to consider the request but can refuse the request if a refusal is justified. Clear procedures for dealing with requests by employees for changes in their contracts are essential. From 30 June 2014 all employees with 26 weeks' continuous service are able to apply for flexible working, thus removing the previous restriction of those with children under 17 years or those with caring responsibilities. The statutory process and all its deadlines are removed and new regulations replaced the 2002 regulations for applications after 30 June 2014.[43] Employers are required to consider the request in a reasonable manner and within a reasonable time and can legitimately refuse if a refusal is justified. A code of practice to assist employers on flexible working came into force on 30 June 2014.[44]

Statutory sick pay scheme

Most NHS employees enjoy 6 months' full pay and 6 months' half-pay while absent on grounds of sickness. The employer is able to recover some of this from the statutory sick pay (SSP) scheme. Details of the operation of the scheme are available from the government website. All employers can offset any contractual liability to pay sick pay against their payments under SSP.

Redundancy

The NHS has its own redundancy scheme set out in the general conditions of service. It broadly follows the statutory scheme from the point of view of consultation when redundancies are envisaged. However, the NHS has a much wider definition of suitable alternative work. The Information and Consultation with Employees Regulations[45] came into force in April 2005 and require consultation with and information to be given by employers where there are decisions likely to affect future employment[46]. Initially this applied to organisations where there are more than 150 employees. From 2008 the regulations apply to organisations of 50 or more employees. Employees could also seek personal information about themselves from the employer under the Data Protection Act 1998 and general information under the Freedom of Information Act 2000 (see chapter 8).

Working Time Directive (WTD)

A Directive had been adopted by the member states of the European Union on 23 November 1996, but implementation in the UK was delayed until 1 October 1998, when the Working Time Regulations[47] came into force.[48]

Main principles

The fundamental provision is that a worker's working time, including overtime, should not exceed an average of 48 hours for each 7 days over a specified period of 17 weeks. Regulations also specify provisions for rest breaks and annual leave. Night work should not normally exceed an average of 8 hours for each 24 hours. The employer has a duty to ensure that no night worker, whose work involves special hazards or heavy physical or mental strain, works for more than 8 hours in any 24-hour period. Before assigning a worker to night work, the employer has to ensure that the worker has the opportunity of a free health assessment before he takes up the assignment. There should be a weekly rest period of not less than 24 hours in each 7-day period: alternatively, two rest periods each of not less than 24 hours in each 14-day period or one rest period of not less than 48 hours in each 14-day period.

Employers are required to keep records relating to the hours of work, which can be inspected by enforcement agencies. The Health and Safety Executive and local authority environmental health officers are responsible for enforcing the working time limits. Individual employees can, if internal appeals mechanisms fail, apply to the employment tribunal for alleged infringements of their statutory rights. The application must be made within 3 months of the infringement and the Advisory, Conciliation and Arbitration Service (ACAS) will provide conciliation services. The European Court of Justice has held the UK requirement of 13 weeks' work before being eligible to have annual leave illegal.[49] In a later case, the European Court of Justice held that UK guidelines on the WTD were incompatible with the Directive, in that the guidelines did not make clear that employers had to ensure that workers actually did take a rest break according to the regulations.[50]

Working longer than 48 hours a week

Individual employees can, if they wish, agree to work more than the average of 48 hours a week. However, this must be an individual decision. It cannot be negotiated as part of the collective agreement and

it must be agreed in writing by the employee. The employee should not be placed under pressure to agree to a longer time. The employee can end the agreement by giving notice to the employer, as specified in the agreement, or, if no notice time is specified, then 7 days' notice must be given. The employer is required to keep records of this agreement and the term of notice and the number of hours worked since the agreement came into effect.

National Minimum Wage (NMW) Act 1998

From 1 April 1999, employers have been obliged to pay a minimum wage to employees, with those aged between 18 and 21 years receiving a lower figure. Employees can appeal to an employment tribunal without any continuous service requirement if they are dismissed because they qualify for the NMW or because they have attempted to enforce the NMW right.[51] The Court of Appeal has held that a restaurant cannot use tips to achieve the minimum wage level.[52] The House of Lords held that non-payment of holiday pay is an unlawful deduction from wages; employees who were entitled to statutory holiday pay were also entitled to claim its non-payment as an unlawful deduction from wages.[53] The current national minimum wage (from October 2014) is £6.50 per hour for adults and £5.13 per hour for those aged between 18 and 20 years. Care workers won a significant victory when a firm was successfully prosecuted by HM Revenue and Customs for refusing to pay staff for the time it takes them to travel between appointments. HMRC claimed the practice breached minimum wage legislation. The firm concerned has to pay staff £600,000 in arrears.[54] In another case an employee successfully appealed to the Employment Appeal Tribunal claiming that her employer had failed to pay her the national minimum wage for sleepovers and the time she spent travelling between clients' homes. The EAT held that the sleepovers were part of time work, irrespective of the level of activity and that time spent travelling was working time.[55]

Part-time employees

On 1 July 2000 regulations came into force to prevent part-time workers being treated less favourably than full-time workers,[56] implementing the EU Part-time Work Directive.[57] Paragraph 5 of the UK regulations gives the part-time worker:

> **[T]he right not to be treated by his employer less favourably than the employer treats a comparable full-time worker as regards the terms of his contract, or by being subjected to any other detriment by any act, or deliberate failure to act of his employer.**

The right applies only if the treatment is on the grounds that the worker is a part-time worker and the treatment is not justified on objective grounds. The part-time worker has to compare himself with full-time workers working for the same employer. The right also applies to workers who become part-time or, having been full-time, return part-time after absence, to be treated not less favourably than they were before going part-time. It does not give an employee the right to insist on having part-time work.

The regulations (paragraph 6) also entitle a worker, who considers that he has been treated in a manner that infringes this right, to request from his employer a written statement giving particulars of the reasons for the treatment. The worker must be provided with a statement within 21 days of his request. Failure to provide a statement at all or only in an evasive or equivocal way will enable the tribunal to draw any inference that it considers just and equitable to draw, including an inference that the employer has infringed the right in question. The regulations also protect the part-time worker from unfair dismissal and give a right not to be subjected to any detriment (paragraph 7).

Any worker who considers that his rights have been infringed can present a complaint to an employment tribunal within 3 months of the day of less favourable treatment or detriment taking place. This is subject to the right of the tribunal to consider out-of-time cases, if in all the circumstances it is just and equitable to do so.

The European Union issued a Directive[58] giving new rights for temporary workers, including workers hired through agencies. After 12 weeks in a given job, an agency worker will be entitled to equal treatment (at least the basic working and employment conditions that would apply to the worker concerned if s/he had been recruited directly by that undertaking to occupy the same job). Regulations implementing this Directive were passed in 2010 and come into force on 1 October 2011.

Dismissal and professional conduct and competence

Where a registered practitioner has been dismissed by his or her employer this will be reported to the NMC and the investigating committee or other practice committees may look into the situation with a view to deciding whether the practitioner is fit to practise (see chapter 11). Other disciplinary action may or may not be reported to the NMC depending on the extent to which the fitness to practise of the practitioner is impaired. The NMC is concerned to ensure that employers take greater responsibility over the competence of their registered practitioners to practise and that issues relating to contractual matters are dealt with by employers rather than being referred to the NMC. It has issued guidance to employers on their responsibilities in relation to professional registration.[59] (This replaces the earlier publications on reporting unfitness to practise and lack of competence.) The National Audit Office[60] considered the management of suspensions of clinical staff in NHS hospital and ambulance trusts in England and suggested significant reforms, highlighting concerns about the length of suspensions of clinical staff on full pay and the fairness, openness and transparency of existing procedures. The National Clinical Assessment Authority (NCAA) was established in April 2001 to review standards of medical and dental staff and consider alternatives to suspension. As the National Clinical Assessment Service (NCAS)[61] it became a division of the National Patient Safety Agency (NPSA) and from April 2013 it has been an operating division of the NHS Litigation Authority (see chapter 12). It has been suggested that its remit should be extended to other professions. One of the new powers introduced in 2002 for the NMC was to permit a registrant to remain on the Register subject to specified conditions (see chapter 11). This would require monitoring of the practitioner, but there is no service comparable to the NCAS for practitioners registered with the NMC. (See chapter 12 for changes to the NCAS and the NPSA.)

Surveillance by employers

The European Court of Human Rights, in the case brought before it by Alison Halford, held that her rights of privacy had been invaded when her employers, the Merseyside Police Authority, intercepted the private telephone calls she made from the office. The court held, however, that provided that the employer warned the employees that their calls could be tapped, there would be no breach of the right to privacy as guaranteed by the European Convention.[62] Article 8 of the Convention recognises the right to respect for private and family life, home and correspondence (see chapter 1). The Information Commissioner's Office has published, as part of its Employment Practices Data Protection Code, a code of practice relating to the monitoring of employees' emails by employers.[63] The Regulation of Investigatory Powers Act 2000[64] and the Telecommunications (Lawful Business Practices) (Interception of Communications) Regulations 2000[65] enable emails to be monitored without consent in specified circumstances such as the prevention or detection of crime or the investigation of unauthorised use of the system. The employer must have taken reasonable steps to inform users of the monitoring or have reasonable grounds to believe that employees are aware that this may happen. There are considerable advantages for employers to have a code of practice covering all aspects of surveillance and ensure that it is regularly updated, that employees are aware of its existence and that consent to the monitoring is a term of the contracts of employment. The Information Commissioner's office has published the Employment Practices Code, Part 3 of which includes a section on monitoring at work.[66]

Unfair dismissal

General principles

One of the most important of the statutory rights is the right not to be unfairly dismissed. Every employee has a right by virtue of his contract, statute or the common law to receive notice unless the employee is himself in breach of contract and is summarily dismissed. Thus, without a concept of unfair dismissal, a nursing officer who has worked for 20 years with that employer could lawfully be given her requisite notice under the contract with no particular reasons for the notice being specified and be lawfully dismissed. This would be contractually acceptable, but highly unjust. The right not to be unfairly dismissed protects employees who meet certain conditions against this unjust treatment. There is also a right not to suffer a detriment or dismissal in health and safety cases. It is unfair to dismiss an employee in circumstances arising out of health and safety matters, e.g. carrying out health and safety activities at the request of the employer, being a safety representative or a member of a safety committee, bringing the employer's attention to harmful circumstances, refusing to work in dangerous conditions or taking appropriate steps to protect himself or others from damage.

There is now a continuous service requirement of 2 years for unfair dismissal unless the application is based on the specific grounds shown in Table 10.1.

The Public Interest Disclosure Act 1998 extends these provisions and protects an employee from victimisation where the employee has made a protective disclosure in accordance with the provisions of this Act and its subsequent amendments (see chapter 4).

Under new rules the employee must apply to ACAS and seek conciliation. From April 2014 individuals wanting to bring a tribunal claim must inform ACAS first. Claims are no longer made direct to the tribunal. If conciliation is unsuccessful, the individual can continue with a tribunal claim. If employers lose a claim, tribunals will have the power to fine them, with a minimum of £100 in addition to the award made to the claimant and fee reimbursement.

The conditions that the employee must satisfy to bring an action for unfair dismissal are set out in Box 10.6. If these conditions are met, the employee can then, within 3 months of the dismissal, apply to the employment tribunal for an unfair dismissal hearing. The 3-month time limit can be extended if the tribunal considers that it was not reasonably practicable for the employee to comply with it. Reforms introduced under the Enterprise and Regulatory Reform Act 2013 (ERRA) include capping the compensation payable – payouts to be limited to up to one year's pay or £74,200 whichever is the lower; and fees to be introduced to restrict spurious cases. Claimants have to pay fees of between £390 and £1,200 if the case goes to a tribunal. The time limit for bringing an unfair dismissal application is extended (by the 2013 Act section 8 and Schedule 2) to allow time for conciliation.

Figures suggest that the fees to bring an application to the employment tribunal have led to an 80 per cent reduction in the number of applications. The Chair of the Industrial Law Society wrote to *The Times* deploring the consequential injustices for many employees who could no longer afford to bring action for breach of their statutory rights. He called on the government to review the effects of the fees urgently.[67]

Box 10.6 Conditions for bringing an unfair dismissal action

1. Two years' continuous service with that employer (except for example in cases of trade union activity or discrimination and dismissal on grounds of pregnancy or childbirth or health and safety (see Table 10.1).
2. Eligibility under the legislation.
3. Being below retirement age.
4. Dismissal (i.e. termination by employer, expiry of fixed-term contract or constructive dismissal).

Unfair dismissal and record keeping

Case 10.1 *Barchester Healthcare Ltd v. Tayeh 2013*

False entry in records[68]

Tayeh was a registered nurse employed in a care home run by the defendant. In disciplinary proceedings she admitted making a false entry on a patient's drip-feed record and failing to make proper observations in respect of a patient who had fallen, she was summarily dismissed for gross misconduct. She succeeded before the employment tribunal which held that the falsification of records did not amount to serious misconduct, she had not been promptly suspended after the incident and the employer had not taken into account mitigation available to her in relation to the fall and the dismissal was therefore unfair. The employers appealed to the employment appeal tribunal (EAT) which upheld the appeal holding that the dismissal was fair and that the employers had been entitled to dismiss Tayeh for gross misconduct. Tayeh appealed to the Court of Appeal which upheld the decision of the EAT. The falsification of written records was a serious matter capable of meriting dismissal.

Unfair dismissal and length of continuous service and compensation

From 6 April 2012 the qualifying period for bringing unfair dismissal claims was increased from 1 year's continuous service to 2 years' continuous service. The compensation comprises a basic award based on a maximum week's pay (£464) multiplied by the number of years of continuous service (depending on age) (with a maximum of 20 years), and a compensatory award designed to compensate the employee for the financial results of losing his or her job. In April 2014 the ceiling was £76,574. This ceiling does not apply to awards under sex discrimination, equal pay and whistleblowing victimisation claims. Furthermore, an additional award can be made under section 117 of the Employment Rights Act 1996 (ERA) where the employer refuses a tribunal order to reinstate or re-engage the employee. The additional award is limited to between 26 and 52 weeks' pay with a ceiling on the maximum week's pay which can be used in the calculation. The ceiling is raised each year. Further information is available from the government website.[69] The Court of Appeal reviewed the compensation payable to a nanny who had been unfairly dismissed while off sick and held that if she had not been dismissed she would have been paid statutory sick pay, so that was the measure of her loss. The Court of Appeal accepted that it was good employment practice for an employer who has dismissed an employee without notice to make a payment in lieu of notice which should not be subject to any deduction for sums earned elsewhere.[70]

The Court of Appeal held that costs could be awarded against an unreasonable claimant by an employment tribunal.[71]

Constructive dismissal

Practical Dilemma 10.7 Dangerous conditions

Kay was a nursing officer in charge of the acute wards of Roger Park Hospital. She had warned the senior managers that the situation was dangerous since, owing to an acute shortage of nurses which coincided with a vigorous attempt to reduce the waiting lists, with extra beds being put up on all the wards, there was a danger that accidents could happen. No notice was taken of her warnings and, in fact, more patients were admitted. She advised the consultants that nurses would not be able to carry out certain tasks normally undertaken by doctors and that the junior doctors would be expected to

add the drugs to intravenous transfusions. Her senior nurse manager was advised by the consultants that this was unacceptable and Kay was asked to withdraw that instruction and notify the nurses that they must continue to undertake such tasks. She pointed out that they did not have the time to do these. She was warned that she would face disciplinary proceedings if she continued to defy the managers. She said she would prefer to leave than endanger the lives of patients and stated that the managers were in breach of contract in failing to support her attempt to maintain professional standards. She left and subsequently brought an action for unfair dismissal.

Assuming that Kay qualifies as far as the conditions set out in Box 10.6 are concerned, she needs to establish as a preliminary point that she was dismissed and did not resign. The employers are likely to argue that they did not dismiss her, that she left work of her own free will and that she is therefore ineligible to bring an unfair dismissal action.

The question is: Have the managers acted in such a way that she is entitled to see the contract as at an end? It will be remembered that one of the implied terms in a contract of employment is that the employer will act reasonably towards the employee and support him/her. It could be argued here that in failing to support Kay's endeavours in this situation, the employers are in fundamental breach of contract. If this can be established, then Kay can argue that there is a constructive dismissal, she is entitled to bring her action before the tribunal and it is then for the managers to establish that the dismissal was fair. By the same token, the employers will be arguing that Kay was not dismissed, that she had failed to do all she could to work with them and that she had defied reasonable orders from them. Kay should also refer to the Public Interest Disclosure Act 1998 to show that her concerns about health and safety come under the disclosures protected by that Act and that she followed the procedure required by the Act (see chapter 4 on whistleblowing). Ultimately, the outcome will depend on the evidence from both sides: Kay would have to show evidence, both documentary and through witnesses, of earlier attempts to persuade management that the situation was dangerous and that the managers were acting in fundamental breach of contract. An example of constructive dismissal is the case of a professor who complained that degrees were being cheapened and a complete mockery was being made of the examination process. Professor Buckland protested when exam papers were marked a third time and higher marks awarded and subsequently won his case for unfair dismissal. In 2008 the employment tribunal decided that there had been a fundamental breach of the implied term of trust and confidence in his employment contract and he had been constructively dismissed. Bournemouth University won its appeal to the employment appeal tribunal but the Court of Appeal restored the original ruling, holding that the university had undermined his position. If damages could not be agreed between the parties then the employment tribunal would be asked to assess them.[72]

Case 10.2 *Atkin v. Enfield Group HMC* (1975)

Fair dismissal[73]

The Court of Appeal heard a case where a senior nurse had been dismissed for failure to wear the appropriate uniform. They held that the dismissal was fair.

Procedure in an application for unfair dismissal

The employee is normally expected to exhaust the internal appeal machinery set up by her employer before an application to an employment tribunal is heard. But owing to time limits (an application for unfair dismissal should be brought within three months of the date of dismissal, if reasonably practicable,

which now takes into account mediation through ACAS), the employee should instigate the application in any case and ask for an adjournment pending the outcome of the internal appeal. In this way, she will not be out of time. The application must first be made to the Advisory, Conciliation and Arbitration Service (ACAS) who will attempt to resolve the dispute.[74] ACAS has published a Code of Practice on the disciplinary and grievance procedures in employment (in 2009 which replaced the statutory dispute resolution procedure).[75] Employers must comply with the Code which requires that disciplinary rules and procedures are clearly set out and accessible to the employees. Failure by any employer to follow the ACAS guidelines will not make the employer liable to proceedings in itself, but evidence of this failure could be used against the employer in evidence before an employment tribunal. Since September 2000 employees have had a statutory right to be accompanied at any disciplinary or grievance hearing. Failure by the employer to permit the employee to be accompanied or to postpone (for up to 5 days) a hearing to enable the person to attend can lead to up to 2 weeks' compensation payable to the employee. Employees seeking to bring applications before an employment tribunal can brief a barrister direct without having to hire a solicitor first. New regulations for employment tribunals came into force in July 2013 which simplified the procedure.[76]

Automatically unfair dismissals

Some dismissals are automatically unfair and whether the employer acted reasonably or not is irrelevant. These have been expanded recently and include dismissals connected with:

pregnancy or childbirth;
parental leave and time off for dependants;
jury service;
health and safety;
exercise of a right under the Working Time Regulations;
making a protected disclosure;
performing a function of an employee representative;
assertion of a statutory right;
membership or non-membership of a trade union;
taking of protected industrial action;
acting in connection with an employee's rights under the Part-time Workers (Prevention of Less Favourable Treatment) Regulations 2000;
Fixed-term Employees (Prevention of Less Favourable Treatment) Regulations 2002;
an application for flexible working;
the Tax Credits Act 2002;
the Information and Consultation of Employees Regulations 2004;
a request not to retire;
discrimination – relating to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation; and
failure by the employer to comply with the relevant statutory disciplinary and dismissal procedures.

Hearing

If the employee is able to show that she satisfies the conditions set out in Box 10.6, the burden will be on the employer to show that the dismissal was based on a statutory reason. These are set out in Box 10.7. The tribunal must then decide if the employer has acted reasonably in treating this reason as sufficient to justify dismissal. The criteria that have been considered by the tribunals in determining the reasonableness of employers' actions are set out in Box 10.8. Every circumstance must be taken into account, and the fact that the tribunal might not have acted in the way in which the particular employer acted is not relevant. The crucial question is: Was *that* employer acting reasonably? One important point is whether the disciplinary Code of Practice and the guidelines prepared by ACAS were followed.

Box 10.7 Statutory reasons to dismiss

1 Capability or qualifications
2 Conduct
3 Some other substantial reason
4 Redundancy
5 Statutory prohibition
6 Lock out or participation in strike or industrial action
7 National security.

Box 10.8 Criteria for the reasonableness of the employer

1 Code of practice
2 Nature of employment situation, e.g. size and resources of organisation, type of work
3 Consistency of employer
4 Timing of dismissal
5 Length of service of employee
6 In cases of dishonesty and other misconduct:
   - the employer must show that he genuinely believes the employee to be guilty of the misconduct in question
   - he must have reasonable grounds on which to establish that belief
   - he must have carried out such investigation into the matter as was reasonable in all the circumstances (see *British Home Stores* v. *Birchell* 1978 IRLR 379)
7 Principles of natural justice.

Outcome

If the employee's application for unfair dismissal is upheld, the following remedies are available to the tribunal:

1 Reinstatement/re-engagement.
2 Compensation – basic award; compensatory award; special award.

In assessing compensation, the tribunal will take into account any fault on the part of the employee. In a case in 2004,[77] the House of Lords held that compensation for injury to feelings and other non-economic loss could not be awarded in unfair dismissal cases.

Trade union rights

It is impossible in a work of this nature to be other than superficial in relation to the status and powers of trade unions. (Reference should be made to the Further Reading section for special books in this field.) Box 10.9 illustrates some of the present rights of the independent trade union. Information on the rights of trade union representatives to have paid time off for training and for carrying out their duties is available on the government website.[78] The members, however, only have the right of reasonable unpaid time off work for union activities. Employees have the right not to be dismissed for being, or refusing to be, union members or for taking part in union activities.[79]

Box 10.9 Trade union rights and the role of safety representatives

1 A union is independent if it is not under the domination or control of an employer and not liable to interference by an employer. Its independence can be certified by the certification officer and his certificate is conclusive evidence that the union is independent.

2 Independence is an essential feature if the union is to enjoy the following statutory rights:
- to take part in trade union activities
- to be given information and be consulted over 'transfers of undertaking'
- to gain information for collective bargaining
- to secure consultation over redundancies
- to insist on time off for trade union duties and activities
- to appoint health/safety representatives.

3 A trade union is fully liable for any of its acts that constitute a tort (civil wrong) *except* where it acts in contemplation or furtherance of a trade dispute. The meaning of these words has been narrowed since 1980 so that, in general, secondary action (e.g. where employees of A go on strike to support the employees of B) is not covered and therefore the union would be liable for the damage that results from the unlawful action.

4 Safety representatives are appointed by a recognised trade union from among the employees. Names are to be notified to the employer in writing. They represent employees in consultation with the employer under section 2(4) and (6) of the Health and Safety at Work Act 1974. Functions are set out in Regulation 4 of statutory instrument 1977 No. 500:
- Investigate potential hazards and dangerous occurrences at workplace and examine cause of accidents at work.
- Investigate complaints of employees relating to health, safety or welfare at work.
- Make representations to employer under (a) and (b).
- Make representations to employer on general matters affecting health, safety or welfare.
- Carry out inspections under Regulations 5, 6 and 7.
- Represent employees in consultation with Health and Safety Inspectorate.
- Receive information from inspectors under section 28(8).
- Attend meetings of safety committees.

'No function given to a safety representative by this paragraph shall be construed as imposing any duty on him.'

The trade union officers do not have any management rights: they have no power as part of their function as union officials to give orders to the employees. Obviously, they might advise their members to follow a particular course, but it is up to the members' own judgement whether they follow the advice or not. The Employment Act 1988 gave additional protection to the employee: he has the right not to be denied access to the courts by union rules; the right not to be unjustifiably disciplined by a union; the right to complain to an employment tribunal and obtain compensation if this latter right is infringed.

Public and private employees

Those nurses who work as employees in the private sector enjoy much the same rights as those who work in the NHS. There are, however, some major differences. If the nurse is only one of a few employees, then she may not enjoy all those statutory rights enjoyed by those working for employers of large concerns. This also applies to those NHS nurses who work for single-handed general practitioners or group practices.

In addition, they may not be subject to NHS conditions of service. In this case, there will be other provisions relating to holidays, pay, sick pay, pensions, time off, etc., which will either have been laid down in advance or which will have to be agreed with the employer. The nurse should make sure that she is aware of these provisions before she accepts the post.

Discrimination: The Equality and Human Rights Commission

The Equality and Human Rights Commission (EHRC) was established on 1 October 2007 under the Equality Act 2006, replacing the Equal Opportunities Commission, the Disabilities Rights Commission and the Commission for Racial Equality. It also assumed responsibility for promoting equality and combating unlawful discrimination in three new areas: sexual orientation, religion or belief and age. It also has responsibility for the promotion of human rights. The Commission has a general duty under section 3 to exercise its functions with a view to encouraging and supporting the development of a society in which:

(a) people's ability to achieve their potential is not limited by prejudice or discrimination;
(b) there is respect for and protection of each individual's human rights;
(c) there is respect for the dignity and worth of each individual;
(d) each individual has an equal opportunity to participate in society; and
(e) there is mutual respect between groups based on understanding and valuing of diversity and on shared respect for equality and human rights.

More specific duties relate to equality and diversity (section 8), human rights (section 9), groups (section 10), monitoring the law (section 11) and monitoring progress (section 12). It has powers to publish or disseminate ideas or information, undertake research, provide education or training, give advice or guidance, and issue codes of practice. It also has the power to carry out an investigation, to apply to court for an injunction against a person who it believes to be committing an unlawful act, to bring proceedings in its own name and to give legal assistance to an individual who alleges that he is a victim of behaviour contrary to the equality enactments. The following sections consider the basic provisions in law against discrimination, and further information can be obtained from the EHRC website.[80] In November 2011 the EHRC published the report of an inquiry into older people and human rights in home care. It uncovered areas of real concern in the treatment of some older people and significant shortcomings in the way that care is commissioned by local authorities. The report is available on its website. In May 2014 it called for clear national and local guidance on the Do Not Resuscitate Notices.

Equality Act 2010

The Equality Act 2010, which was rushed through Parliament before the general election in 2010, had the aims of harmonising discrimination law and of strengthening the law to support progress on equality. It places duties in relation to discrimination on to a new statutory footing. The major legislative enactments of the past 40 years were repealed (Equal Pay Act 1970; Sex Discrimination Act 1975; Race Relations Act 1976 and the Sex Discrimination Act 1986). Nine key characteristics were recognised as requiring protection from discrimination. In time case law on the 2010 Act will develop, but where the 2010 Act simply repeats the earlier legislation, the case law before 2010 will still be relevant.

Key characteristics which are protected

The Equality Act recognises nine characteristics for protection against discrimination:

age
disability
gender reassignment
marriage and civil partnership
pregnancy and maternity care
race
religion or belief
sex
sexual orientation.

Six of these characteristics are further defined below.

Disability

A person has a disability if he or she has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. In the case of *J v. DLA Piper*,[81] the employment appeal tribunal overruled the employment tribunal and held that depression could be a disability under the Disability Discrimination Act 2005. The House of Lords has held that in determining whether a person was disabled under the Northern Ireland Disability Discrimination Act 1975 by reason of having an impairment which, although capable of being controlled by measures taken to treat it, would be likely to have substantial adverse effects but for those measures, the word 'likely' did not mean 'probably' but 'could well happen'. The employee whose propensity to develop vocal nodules was controlled by a strict management regime based on avoiding raising her voice, was a disabled person for the purposes of the Act. The employers who placed her in a noisier work environment in spite of her claim that it would require her to speak louder and jeopardise her voice management regime, had to answer her claim that they had failed to make reasonable adjustments for her disability.[82] The Ministry of Justice accepted that there was a breach of the Equality Act 2010 when there was a failure to provide a disabled prisoner with a wheelchair-accessible toilet and bath.[83] An action is being brought before the European Court of Justice to determine whether EU law bans discrimination on grounds of obesity. A child-minder, weighing more than 25 stone, in Denmark was sacked because he was no longer able to perform his duties. He needed the help of a colleague to tie a child's shoelace. A preliminary ruling by the advocate general on 17 July 2014 stated that obesity could be seen as a disability. The full case was due to be heard in the autumn of 2014.

The limitations of the powers of the court were shown in the Supreme Court decision that a disabled air traveller could not obtain damages from the airliner because the terms of the Montreal Convention unifying rules for international carriage by air adopted by the EU excluded an award of damages.[84]

Gender reassignment

A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.

Race

Race is defined to include (a) colour; (b) nationality; (c) ethnic or national origins.

The Supreme Court held in 2009 that the admissions policy of a Jewish School which, in the event of oversubscription, gave priority to children of matrilineal descent was discriminatory on the ground of ethnic origin and was thus racial discrimination.[85]

The employment appeal tribunal held that there had been discrimination on grounds of race and ethnic origin when a North Sudanese was refused promotion because she would have been exposed to safety risks when visiting Sudan and Eastern Chad. The employment appeal tribunal held that Amnesty

International's defence that the appointment would have breached the Health and Safety at Work Act discriminated against her on the grounds of her race and ethnic origin.[86]

The Supreme Court refused to allow an employer to raise the fact that the employee was an illegal immigrant in an action brought by the employee for racial discrimination. The Court of Appeal had set aside the tribunal decision, holding that the illegality of the contract of employment formed a material part of the complaint and that to uphold it would be to condone the illegality. The Supreme Court held that to apply the defence of illegality would be an affront to the public policy of protecting the victims of human trafficking. The claimant had been employed as a home help after the defendant had helped her obtain false identity papers and worked illegally in the UK. She had been subjected to serious physical, emotional and verbal abuse and been unfairly dismissed.[87]

Religion

Religion means any religion and a reference to religion includes a reference to a lack of religion; belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief. The employment appeal tribunal held that belief based on science was covered by the religion and belief regulations and was entitled to protection under equal treatment legislation.[88] In this case the claimant had a philosophical belief that mankind was heading towards catastrophic climate change and that he had a moral duty to lead a life in a manner that mitigated that catastrophe for the benefit of future generations and to persuade others to do the same.

The Court of Appeal[89] held that it was not indirect discrimination for an employer's dress code to prevent a staff member from wearing a cross as a visible neck adornment when her Christian religion did not require adherents to wear a public display of their faith. She took her case to the ECHR which ruled that British Airways had breached her human rights: her right to freedom of thought, conscience and religion. The government was ordered to pay her £26,600 in damages and costs. However, the ECHR[90] ruled that three other Christians were not discriminated against: an NHS nurse who had been banned from wearing a cross on health and safety grounds; a marriage counsellor and a registrar who refused to deal with same-sex couples on religious grounds.

Dispute over prohibitions on religious conventions such as the wearing of veils have emerged. For example, in September 2013 a judge ruled that a Muslim woman could wear a veil in court, but must remove it when giving evidence. The Lord Chief Justice subsequently announced in November 2013 that guidance is to be issued on the wearing of veils in court following a consultation. A Private Members' Bill, the Face Coverings (Prohibition) Bill, which would have prohibited face coverings in public, failed to complete its passage through Parliament in 2013–14 and therefore made no further progress. In July 2014, however, the ECHR ruled that the French ban on burkas in a public place was not a breach of human rights. The court held that promoting respect for the conditions in which people live together in public places was legitimate.

In other developments the Supreme Court held that the Church of Scientology was a religion for the purposes of marriage law and the conducting of weddings.[91] While the Marriage (Same Sex Couples) Act 2013 makes amendments to the Equality Act 2010 to provide that it is not unlawful discrimination for a religious organisation or individual to refuse to marry a same-sex couple in a religious ceremony.

Sex

In relation to a protected characteristic of sex, a reference to a person who has a particular protected characteristic is a reference to a man or to a woman. A nurse won her case against the Ministry of Defence (MoD) when an employment tribunal found that the MoD discriminated against women when recruiting to senior military roles filled by doctors and nurses.[92] The Supreme Court[93] held that in considering whether men and women worked in the same employment the hypothesis was that the chosen male comparators be transferred to do their present jobs at the location to where the woman were working, but there was no requirement that there be a real possibility that such a transfer would occur.

Sexual orientation

Sexual orientation means a person's sexual orientation towards (a) persons of the same sex, (b) persons of the opposite sex, or (c) persons of either sex. The Supreme Court held that guest house owners who turned away a gay couple were guilty of discrimination under the Equality Act.[94]

The ECHR held that a divorced partner living with a same-sex partner was discriminated against because her child support contributions were higher than they would have been had she been living in a heterosexual relationship.[95] In another case the House of Lords found in favour of a transsexual whose application to be a constable had been turned down because she could not perform full searching duties.[96]

Nature of the protection

The Act protects those with the key characteristics from direct discrimination, indirect discrimination, harassment and victimisation. The Act prohibits conduct which amounts to direct and indirect discrimination, harassment and victimisation in the providing of a service, disposing or managing premises, work or employment services and the other areas shown in Box 10.10, which provides an overview of the Act.

Statute 10.1 Equality Act 2010

An overview

Providing a service

Part 3 (+ Schedules 2 and 3) Makes it unlawful to discriminate against, harass or victimise a person when **providing a service** (which includes the provision of goods or facilities) or when exercising a public function.

Disposing or managing premises

Part 4 (+ Schedules 4 and 5) Makes it unlawful to discriminate against, harass or victimise a person when **disposing** of (for example, by selling or letting) **or managing premises**.

Work or employment services

Part 5 (+ Schedules 6, 7, 8 and 9) Makes it unlawful to discriminate against, harass or victimise **a person at work or in employment services**. Also contains provisions relating to equal pay between men and women; pregnancy and maternity pay; provisions making it unlawful for an employment contract to prevent an employee disclosing his or her pay; and a power to require private sector employers to publish gender pay gap (the size of the difference between men and women's pay expressed as a percentage) information about differences in pay between men and women. It also contains provision restricting the circumstances in which potential employees can be asked questions about disability or health.

Education bodies

Part 6 (+ Schedules 10, 11, 12, 13 and 14) Makes it unlawful for **education bodies** to discriminate against, harass or victimise a school pupil or student or applicant for a place.

Associations

Part 7 (+ Schedules 15 and 16) Makes it unlawful for associations (for example, private clubs and political organisations) to discriminate against, harass or victimise members, associates or guests and contains a power to require political parties to publish information about the diversity of their candidates.

Other forms of conduct

Part 8 Prohibits **other forms of conduct**, including discriminating against or harassing of an ex-employee or ex-pupil, for example: instructing a third party to discriminate against another; or helping someone discriminate against another. Also determines the liability of employers and principals in relation to the conduct of their employees or agents.

Enforcement of the Act's provisions

Part 9 (+ Schedule 17) Deals with **enforcement of the Act's provisions**, through the civil courts (in relation to services and public functions; premises; education; and associations) and the employment tribunals (in relation to work and related areas, and equal pay).

Terms in contracts

Part 10 Makes **terms in contracts**, collective agreements or rules of undertakings unenforceable or void if they result in unlawful discrimination, harassment or victimisation.

General duty on public authorities

Part 11 (+ Schedules 18 and 19) Establishes **a general duty on public authorities to have due regard, when** carrying out their functions, to the need: to eliminate unlawful discrimination, harassment or victimisation; to advance equality of opportunity; and to foster good relations. Also contains provisions which enable an employer or service provider or other organisation to take positive action to overcome or minimise a disadvantage arising from people possessing particular protected characteristics.

Taxis, other private hire vehicles, public service vehicles

Part 12 (+ Schedule 20) **Requires taxis, other private hire vehicles, public service vehicles** (such as buses and rail vehicles) to be accessible to disabled people and to allow them to travel in reasonable comfort.

Reasonable adjustments to premises

Part 13 (+ Schedule 21) Deals with consent to **make reasonable adjustments to premises and improvements to let dwelling houses**.

Exceptions

Part 14 (+ Schedules 22 and 23) Establishes **exceptions** to the prohibitions in the earlier parts of the Act in relation to a range of conduct, including action required by an enactment; protection of women; educational appointments; national security; the provision of benefits by charities and sporting competitions.

Family property

Part 15 Repeals or replaces rules of family property law which discriminated between husbands and wives.

Power for a Minister of the Crown

Part 16 (+ Schedules 24, 25, 26, 27 and 28) Contains a power for a Minister of the Crown to harmonise certain provisions in the Act with changes required to comply with EU obligations. It contains general provisions on application to the Crown, subordinate legislation, interpretation, commencement and extent. It also contains amendments to the Civil Partnership Act 2004 to allow civil partnership registrations to take place on religious premises that are approved for that purpose.

Section 15 provides that a person (A) discriminates against a disabled person (B) if:

(a) (A) treats (B) unfavourably because of something arising in consequence of (B)'s disability; and
(b) (A) cannot show that the treatment is a proportionate means of achieving a legitimate aim.

This does not apply if (A) shows that (A) did not know, and could not reasonably have been expected to know, that (B) had the disability.

Section 16 covers gender reassignment discrimination in cases of absence from work. A person (A) discriminates against a transsexual person (B) if, in relation to an absence of (B)'s that is because of gender reassignment, (A) treats (B) less favourably than (A) would treat (B) if:

(a) (B)'s absence was because of sickness or injury; or
(b) (B)'s absence was for some other reason,
(c) and it is not reasonable for (B) to be treated less favourably.

A person's absence is because of gender reassignment if it is because the person is proposing to undergo, is undergoing or has undergone the process (or part of the process) mentioned in section 7(1).

Under section 17 pregnancy and maternity discrimination in non-work cases are protected characteristics in relation to:

(a) Part 3 (services and public functions);
(b) Part 4 (premises);
(c) Part 6 (education);
(d) Part 7 (associations).

Discrimination can arise if a person (A) discriminates against a woman if (A) treats her unfavourably because of a pregnancy of hers or, in the period of 26 weeks beginning with the day on which she gives birth, (A) treats her unfavourably because she has given birth (including, in particular, a reference to treating her unfavourably because she is breastfeeding). Giving birth includes giving birth to a stillborn child (i.e. after 24 weeks' gestation).

Under section 18 pregnancy and maternity discrimination in employment, a person (A) discriminates against a woman if, in the protected period in relation to a pregnancy of hers, (A) treats her unfavourably:

(a) because of the pregnancy, or
(b) because of illness suffered by her as a result of it.

Person (A) also discriminates against a woman if he treats her unfavourably because she is on compulsory maternity leave, or because she is exercising or seeking to exercise, or has exercised or sought to exercise, the right to ordinary or additional maternity leave.

Direct discrimination

Section 13 defines direct discrimination as where a person (A) discriminates against another (B) if, because of a protected characteristic, (A) treats (B) less favourably than (A) treats or would treat others. The European Court of Justice (ECJ) held in January 2008 that direct discrimination existed when a woman with a disabled son claimed that she was discriminated against at work because of her child. The ECJ held that there was direct discrimination where a person suffered discrimination and/or harassment because he or she is associated with a disabled person. It was described as a landmark case, which could bring new rights for the 6 million carers in the UK.[97]

Combined discrimination

Section 14 provides protection when there is combined discrimination, i.e. dual characteristics. A person (A) discriminates against another (B) if, because of a combination of two relevant protected characteristics, (A) treats (B) less favourably than (A) treats or would treat a person who does not share either of those characteristics. For example, an employer may treat a Muslim woman differently than he would treat a Christian woman or a Muslim man. The protection applies to the key characteristics except for civil partnership and marriage and pregnancy and maternity care.

Indirect discrimination

The Equality Act 2010 defines as indirect discrimination where a person (A) applies to another (B) a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of (B)'s. A provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of (B)'s if:

(a) (A) applies, or would apply, it to persons with whom (B) does not share the characteristic;
(b) it puts, or would put, persons with whom (B) shares the characteristic at a particular disadvantage when compared with persons with whom (B) does not share it;

(c) it puts, or would put, (B) at that disadvantage; and
(d) (A) cannot show it to be a proportionate means of achieving a legitimate aim.

The relevant protected characteristics are: age; disability; gender reassignment; marriage and civil partnership; race; religion or belief; sex and sexual orientation (i.e. pregnancy and maternity are not included).

Duty to make adjustments for disabled persons

Section 20 of the Act specifies three requirements in making adjustments for a disabled person. The first requirement is a requirement, where a provision, criterion or practice of (A)'s puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage.

The second requirement is a requirement, where a physical feature puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage.

The third requirement is a requirement, where a disabled person would, but for the provision of an auxiliary aid, be put at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to provide the auxiliary aid.

A person who has a duty to make reasonable adjustments is not entitled to require a disabled person, in relation to whom (A) is required to comply with the duty, to pay to any extent (A)'s costs of complying with the duty. The Equality and Human Rights Commission welcomed the decision of the Supreme Court in the case[98] where disabled persons lacking mental capacity were held to be entitled to have the same protections of their liberty as the non-disabled. Lady Hale stated that a gilded cage is still a cage. (The case is considered in chapter 17.)

Harassment

The Act defines harassment as where (A) engages in (a) unwanted conduct related to a relevant protected characteristic, and (b) the conduct has the purpose or effect of:

(a) violating (B)'s dignity, or
(b) creating an intimidating, hostile, degrading, humiliating or offensive environment for (B).

(A) also harasses (B) if:

(a) (A) engages in unwanted conduct of a sexual nature, and
(b) the conduct has the purpose or effect referred to in subsection (1)(b).

(A) also harasses (B) if:

(a) (A) or another person engages in unwanted conduct of a sexual nature or that is related to gender reassignment or sex,
(b) the conduct has the purpose or effect referred to in subsection (1)(b), and
(c) because of (B)'s rejection of or submission to the conduct, (A) treats (B) less favourably than (A) would treat (B) if (B) had not rejected or submitted to the conduct.

In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account:

(a) the perception of (B),
(b) the other circumstances of the case,
(c) whether it is reasonable for the conduct to have that effect.

The relevant protected characteristics for harassment are: age; disability; gender reassignment; race; religion or belief; sex and sexual orientation (i.e. civil partnership and marriage and pregnancy and maternity are excluded).

The Protection from Harassment Act 1997 provides additional protection and remedies against harassment and has wider coverage. (The 1997 Act is not restricted to the nine characteristics, there is a six-year limitation period rather than three months under the 2010 Act and there is no employer's defence that it took all reasonable steps to avoid it) (see chapter 12).

Victimisation

1 A person (A) victimises another person (B) if (A) subjects (B) to a detriment because:
   (a) (B) does a protected act, or
   (b) believes that (B) has done, or may do, a protected act.
2 Each of the following is a protected act:
   (a) bringing proceedings under this Act;
   (b) giving evidence or information in connection with proceedings under this Act;
   (c) doing any other thing for the purposes of or in connection with this Act;
   (d) making an allegation (whether or not express) that (A) or another person has contravened this Act.
3 Giving false evidence or information, or making a false allegation, is not a protected act if the evidence or information is given, or the allegation is made, in bad faith.
4 This section applies only where the person subjected to a detriment is an individual.
5 The reference to contravening this Act includes a reference to committing a breach of an equality clause or rule.

The Court of Appeal held that a former employee could claim that he had been victimised when the former employer wrote a bad reference because he had initiated employment tribunal proceedings.[99] The court interpreted the Equality Act 2010 to give effect to the UK's obligations under European Union law which aimed to proscribe post-employment victimisation.

Positive action

Section 158 applies where a person (P) reasonably thinks that:

1 persons who share a protected characteristic suffer a disadvantage connected to the characteristic,
2 persons who share a protected characteristic have needs that are different from the needs of persons who do not share it,
3 participation in an activity by persons who share a protected characteristic is disproportionately low,

then positive action may be permissible under section 158.

Person (P) is not prohibited by the Equality Act from taking any action which is a proportionate means of achieving the aim of:

(a) enabling or encouraging persons who share the protected characteristic to overcome or minimise that disadvantage,
(b) meeting those needs, or
(c) enabling or encouraging persons who share the protected characteristic to participate in that activity (section 158(2)).

Exclusions to this can be made by regulations.

(This section does not apply to selection and recruitment, which is covered by section 159, nor to selection of candidates which is covered by section 104.)

Positive action in relation to recruitment and promotion

Under section 159(1) positive action is permissible in relation to recruitment and promotion if a person (P) reasonably thinks that:

(a) persons who share a protected characteristic suffer a disadvantage connected to the characteristic, or
(b) participation in an activity by persons who share a protected characteristic is disproportionately low.

However, positive action is not permissible if the person without the protected characteristic is better qualified. The positive action must be a proportionate means of achieving the specified aim.

Under section 159(2) Part 5 (work) does not prohibit (P) from taking action within subsection (3) with the aim of enabling or encouraging persons who share the protected characteristic to:

(a) overcome or minimise that disadvantage, or
(b) participate in that activity.

Section 159(3) stipulates that action is treating a person (A) more favourably in connection with recruitment or promotion than another person (B) because (A) has the protected characteristic but (B) does not.

But under section 159(4), subsection (2) applies only if:

(a) (A) is as qualified as (B) to be recruited or promoted,
(b) (P) does not have a policy of treating persons who share the protected characteristic more favourably in connection with recruitment or promotion than persons who do not share it, and
(c) taking the action in question is a proportionate means of achieving the aim referred to in subsection (2).

Public sector equality duty

Specific duties are imposed on public authorities (as defined in Schedule 19) under Section 149 of the Act. The first duty of eliminating discrimination, harassment, victimisation or any other prohibited conduct applies to the nine characteristics listed above. The other two duties, advancing equality of opportunity and fostering good relations, apply to all those characteristics except civil partnership and marriage.

Statute 10.2 Public sector equality duty

Section 149 of the Equality Act 2010

1 A Public authority must, in the exercise of its functions, have due regard to the need to:
   (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
   (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
   (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
2 A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned above.

3 Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
   (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
   (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
   (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
4 The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
5 Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
   (a) tackle prejudice, and
   (b) promote understanding.
6 Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

The Mental Health (Discrimination) Act 2013 repealed section 141 of the Mental Health Act 1983 which disqualified MPs and members of devolved bodies on grounds of mental illness and any rule of common law which disqualifies a person from membership of the House of Commons on grounds of mental illness and also changed the rules in relation to jurors and company directors.

A claimant who was visually impaired successfully sought judicial review of a local authority's failure to fulfil its public equality duty when it failed to follow national guidance in relation to the design and specification of tactile paving. The High Court held that there was no justification for departing from national guidance.[100]

Discrimination in the NHS

A plan called 'Tackling Racial Harassment' in the NHS was launched in February 1999 by the then Health Minister Alan Milburn. He described it as 'the most concerted drive the NHS has ever seen on the issue'. The plan envisaged that by April 2000 every NHS employer would need to be in a position to tackle racial harassment whether committed by staff or by patients. NHS England has stated that it will work to ensure that advancing equality and diversity is central to how it conducts its business as an organisation. There is, however, evidence that racism is endemic in the NHS. A former NHS manager was awarded £1 million in a racial discrimination case against Central Manchester University NHS Foundation Trust in January 2012.[101]

Male midwives

Originally midwifery was one of the exemptions to the Sex Discrimination Act 1975 and the employment and training of men as midwives was restricted. However, under Order 1983 SI No. 1202 the exemptions were brought to an end. The health authorities were notified that when implementing these legislative changes they must make appropriate arrangements to ensure that:

(a) women have the freedom of choice to be attended by a female midwife;
(b) where male midwives are employed, provision is made for them to be chaperoned as necessary.

Subsequently it was held that the requirement that a male nurse be chaperoned which did not apply to female nurses was unlawful direct discrimination.[102]

Agenda for Change

The Agenda for Change was a radical reorganisation of the NHS pay system and applies to most NHS staff with the exception of doctors, dentists and senior managers. Detailed information can be obtained from the Agenda for Change website.[103] To support personal development and career progression, NHS Knowledge and Skills Framework was established which enabled each member of staff to have a personal development plan. The RCN has provided guidance on the Knowledge and Skills Framework;[104] on preparing for the first personal development review (PDR) for those within the NHS[105] and also for those working outside the NHS.[106] It has also published guidance on making a pay claim, in keeping with the agenda for change for those working outside the NHS.[107] The RCN Commissioned research published in 2006 into the effect on morale in the NHS of the Agenda for Change.[108] In June 2009 the Commons Public Accounts Committee stated that there was no evidence that the Agenda for Change had produced the £1.3 billion in savings predicted by the government, despite being in place for almost three years.

Conclusions

It is inevitable that there are constant changes to the law relating to employment, human rights and equality. It is hoped that the Equality Act 2010 – in replacing previous legislation and with the Equality and Human Rights Commission monitoring the implementation of the law and taking legal action where appropriate – will ensure that the law is clearer and more easily enforceable. The duty placed upon public bodies to eliminate discrimination, harassment, victimisation and any other prohibited conduct has unfortunately not yet ensured that the NHS has been able to rid itself of the reputation for being a racist organisation.

Reflection questions

1. If you have a letter that purports to be your contract of appointment, compare it with the particulars set out in Box 10.3.
2. Take any statutory right and contrast it with the comparable rights given in your contract of employment by national NHS conditions. Which right would be of most benefit to the employee?
3. A manager is both an employee and the representative of the employer. In what way, if any, is there likely to be a conflict between these two roles?
4. If you were preparing to interview prospective employees, what questions do you consider would be unlawful under the Equality Act 2010?

Further exercises

1. Obtain a copy of your employer's disciplinary procedure and apply the procedure to any of the situations of alleged negligence by a nurse set out in this book.
2. Visit an employment tribunal and prepare a brief guide for a potential applicant on the procedure and formalities.

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Chapter 11

The nurse as a registered professional

This chapter discusses

- Background to the establishment of the Nursing and Midwifery Council
- Nursing and Midwifery Council
- Registration and removal
- Professional standards and codes of practice
- Education and training
- Post-registration education and practice (PREP)
- Fitness to Practise Annual Report 2012–2013
- Professional Standards Authority for Health and Social Care (formerly the Council for Healthcare Regulatory Excellence (CHRE))
- NHS Improving Quality (formerly NHS Institute for Innovation and Improvement)
- Framework for assessing national competence standards
- Health and Care Professions Council

Introduction

It will be recalled from chapter 1 that there were four fields of accountability to be faced by the nurse: the civil and criminal courts; the disciplinary proceedings of the employer; and the Conduct and Competence Committee (CCC) of the Nursing and Midwifery Council (NMC). This chapter considers the procedure for a hearing before the CCC and the other practice committees. First, however, the constitution of the NMC will be considered. Significant changes came into force in April 2002, when the United Kingdom Central Council for Nursing, Midwifery and Health Visiting was replaced by the NMC and in 2004 new procedures for Fitness to Practise were introduced.[1]

Background to the establishment of the Nursing and Midwifery Council

The Nurses, Midwives and Health Visitors Act 1979 had set up the previous framework for the United Kingdom Central Council, the national boards and the professional register, and Statutory Instruments passed in the exercise of powers conferred by the principal Act provided the detail. At the request of the Department of Health, a review of the statutory regulation of nurses, midwives and health visitors was undertaken by JM Consulting. It reported in 1999[2] and made significant recommendations for a major reorganisation of the work, functions and organisation of the statutory regulation machinery. Its main recommendations were accepted by the government and the necessary legislative beginning was made in the Health Act 1999. In August 2000, the government issued a consultation paper[3] giving three months for feedback. The amending regulations were passed by order under section 60 of the Health Act 1999, with a new Nursing and Midwifery Council replacing the UKCC and the four national boards, maintaining a professional register with some 640,000 entries. Contrary to initial suggestions, health visitors continued to have separate registration and representation within the new Council, but were absorbed into the new profession of specialist community public health nurses.

New procedures for Fitness to Practise, new rules for midwives and new regulations relating to the local supervising authorities came into force on 1 August 2004.[4] They can be downloaded from the NMC website or obtained from the legislation website.[5]

The Health Act 1999 Schedule 3 paragraph 8 defines four fundamental functions of the new Council, which cannot be transferred by order to another body. These are:

1 keeping the register of members admitted to practise
2 determining the standards of education and training for admission to practise
3 giving guidance about standards of conduct and performance
4 administering procedures (including making rules) relating to misconduct, unfitness to practise and similar matters.

The Nursing and Midwifery Order 2001[6] provided detailed rules on the constitution of the Council and its functions.

Following extensive consultation by the NMC, new rules were enacted in Statutory Instruments, which can be downloaded from the NMC or legislation websites.

Nursing and Midwifery Council

The constitution of the NMC is given in Box 11.1 and its functions can be seen in Box 11.2. The Nursing and Midwifery Order requires the NMC to have specific statutory committees and these can be seen in Box 11.3.

Box 11.1 Constitution of the NMC (Schedule 1 of the Nursing and Midwifery Order 2001 as amended[7])

The Nursing and Midwifery Council shall consist of:

(a) 7 members who are appointed by the Privy Council (registrant members)
(b) 7 members who are appointed by the Privy Council (lay members).

At least one member shall be elected from each of the national constituencies for each part of the register.

Box 11.2 Functions of the NMC[8]

Article 3(2) The principal functions of the Council shall be to establish from time to time standards of education, training, conduct and performance for nurses and midwives and to ensure the maintenance of those standards.

Article 3(3) The Council shall have such other functions as are conferred on it by the Order or as may be provided by the Privy Council by order.

Article 3(4) The main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants.

Article 3(5) In exercising its functions, the Council shall:

(a) have proper regard for:
- **(i)** the interests of persons using or needing the services of registrants in the United Kingdom, and
- **(ii)** any differing interests of different categories of registrants;

(b) co-operate, in so far as is appropriate and reasonably practicable, with public bodies or other persons concerned with:
- **(i)** the employment (whether or not under a contract of service) of registrants,
- **(ii)** the education or training of nurses, midwives or other health care professionals,
- **(iii)** the regulation of, or the co-ordination of the regulation of, other health or social care professionals,
- **(iv)** the regulation of health services, and
- **(v)** the provision, supervision or management of health services.

Article (5A) In carrying out its duty to co-operate under paragraph (5)(b), the Council shall have regard to any differing considerations relating to practising as a nurse or midwife which apply in England, Scotland, Wales or Northern Ireland.

A new Article 6A[9] enables the Registrar, on advice from the Secretary of State that an emergency has or is occurring, to annotate in the Register against the name of a registrant to indicate that the registrant is qualified to order drugs, medicines and appliances in a specified capacity, notwithstanding that the registrant is not so qualified. The Registrar must consider that the registrant is a fit, proper and suitably experienced person to order drugs, medicines and appliances in that capacity with regard to the emergency. Once the emergency is over, the annotation must be removed.

Box 11.3 Statutory committees of the NMC

There shall be four committees of the Council, to be known as:

1 the Investigating Committee
2 the Conduct and Competence Committee
3 the Health Committee
4 the Midwifery Committee.

These are referred to as the statutory committees.

The Investigating Committee, the Conduct and Competence Committee and the Health Committee are also referred to as the 'practice committees'. (The work of the Midwifery Committee and local supervising authorities is considered in chapter 14.)

Registration and removal

Council has the duty of preparing and maintaining a register of qualified nurses, midwives and health visitors and setting out rules in relation to the entry on to, removal from, and restoration to the Register. These rules are set out in Part III of the Nursing and Midwifery Order 2001.

False representation

Practical Dilemma 11.1 False qualifications

Brenda had always wanted to be a nurse, but lacked the educational background. When she left school, she worked as a nursing auxiliary for many years and was given much responsibility. She then left the district when her husband moved jobs. She applied for the job of a night nurse in a private nursing home. At the interview, she was asked where she trained and she gave false information about her background. Because of her great experience, they were very impressed with her and failed to take up her references. After she had worked there for two years, a former colleague from her previous hospital came to visit a relative in the home and was surprised to discover that Brenda was referred to as 'sister'. The colleague made some enquiries and realised that Brenda was being treated as a registered nurse when in fact she was not one. She felt that it was her duty to point this out to the owners of the home because of the possibility that a patient could suffer harm. When the owners discovered the truth, Brenda was dismissed on the spot.

In a situation like this, as well as a loss of job, Brenda could face a criminal charge of falsely representing that she was on the Register or falsely representing that she possessed qualifications in nursing, midwifery or health visiting. These are offences under Article 44 of the Nursing and Midwifery Order 2001. The matter would not be one for the NMC since she is not registered, but would be a matter for the criminal courts. An offence is committed if a person falsely represents herself as registered or uses a title set out in the Register indicative of different qualifications and different kinds of education or training, to which she is not entitled, or falsely represents herself as possessing qualifications in nursing or midwifery. In October 2003 it was reported that a person who had worked as a GP nurse for 15 years was convicted after pleading guilty to deception at the Crown Court and was given a 9-month suspended sentence. The deception came to light when she used false documents to gain a job as clinical coordinator.[10]

In such a case the Council would be required to provide evidence of the fact that she was not on the Register and not entitled. Of course, if she was on the Register for one purpose, e.g. a general nurse, it would be an offence for her to pretend that she was a midwife. This would then be a matter that could be heard before the Conduct and Competence Committee (CCC) (formerly the Professional Conduct Committee (PCC)) as well as the criminal court, since, as she is already registered, the Committee could decide if she should remain on the Register or if any other action should be taken against her. (A case is considered in chapter 14 where a registered nurse who was training as a midwife was found to be unfit to practise because of her misconduct as a student midwife).[11]

The Statutory Instrument also sets out rules relating to registration, renewal of registration and readmission, lapse of registration and approved qualifications and EEA qualifications. Part IV of the order covers education and training, the appointment of visitors, information to be given by institutions, refusal or withdrawal of approval of courses, qualifications and institutions and post-registration training.

Removal from the Register

Under Article 21 of the Nursing and Midwifery Order 2001, the Council is required to establish and keep under review the standards of conduct, performance and ethics expected of registrants and prospective

registrants and give them such guidance on these matters as it sees fit and to establish and keep under review effective arrangements to protect the public from persons whose fitness to practise is impaired.

The circumstances in which a person can be removed from the Register are:

1 Her fitness to practise is impaired by reason of:
   misconduct
   lack of competence
   a conviction or caution in the UK for a criminal offence, or a conviction elsewhere for an offence which, if committed in England or Wales, would constitute a criminal offence
   her physical or mental health
   a determination by a body in the UK responsible under any enactment for the regulation of a health or social care profession to the effect that her fitness to practise is impaired or a determination by a licensing body elsewhere to the same effect, or
   barring by the Independent Safeguarding Authority (ISA) (now the Disclosure and Barring Service).
2 An entry in the Register relating to her has been fraudulently procured or incorrectly made.

Suspension from the Register

This power was introduced in 1993 and can be exercised where the Health Committee or Conduct and Competence Committee find an allegation well founded and decide not to refer the matter to screeners for mediation or that further action is not appropriate. The suspension must be for a specified period, which shall not exceed one year.

Interim order

An interim order (IO) hearing can be held if the screening team following its risk assessment identify particular risk factors. An interim order can then be made if it is considered necessary to protect the public, is in the public interest or in the registrant's interest (see Box 11.6). The Conduct and Competence Committee, Health Committee or Investigating Committee can also decide to hold an interim orders hearing at any time. From 1 April 2014 when an IO is imposed the NMC will no longer publish on its website the full determination but only the period of the order and the panel outcome. It is conducting research to determine the number of registrants who are placed on an interim order, but eventually have no case to answer, in order to ensure that IO applications are proportionate to the risk presented. The Court of Appeal has held that an interim hearing to determine whether a registrant should be suspended or placed under conditions did not have to hear the substantive evidence of the registrant since fairness would necessitate the complainant being called and the hearing would thus become a trial before a tribunal. It ruled that the NMC guidance on interim hearings was fair and there was no breach of Articles 6 or 8 of the Human Rights Convention.[12]

Removal on grounds of fitness to practise

Practical Dilemma 11.2 Missing ampoule

Janice Lane was a ward sister on a busy surgical ward. One day she was preparing the midday medications on her own and while preparing a morphine injection for a patient dropped the ampoule, which broke. Ashamed of what had happened, she locked up the cupboard and pretended that it had not happened instead of following the correct procedure and writing the loss in the correct book and getting a witness. Subsequently, the loss of the ampoule was noticed by the following shift, and a search and an inquiry commenced which revealed nothing. The police were brought in and eventually Janice confessed.

Screeners and practice committees

Screeners can be appointed under Article 23. At least two screeners (one law person and one registrant selected with regard to the professional field of the person concerned) must consider the allegation and establish whether, in their opinion, power is given under the order to deal with it if it proves to be well founded. If in their opinion there is such power then the screeners can refer the matter together with a report of the result of their consideration to such practice committee as they see fit. If they consider there is no such power then they can close the case, provided, if there are two screeners, the lay person agrees and, if there are more than two screeners, the majority agrees. Screeners can also mediate a case, if requested to do so by a practice committee, with the aim of dealing with the allegation without its being necessary for the case to reach the stage at which the Health Committee or Conduct and Competence Committee would arrange a hearing. If mediation fails, the screener can refer the matter back to the practice committee that had originally referred it.

The constitution of the practice committees is shown in Box 11.4 and the standards for members of practice committees are set out in Box 11.5.

Box 11.4 Constitution of the practice committees

Membership of a practice committee shall comprise:

A chairman and a deputy chairman who shall be members of the Council and:

in the case of the Conduct and Competence Committee, six other members
in the case of the Health Committee, two other members
in the case of the Investigating Committee, three other members.

These members are appointed by Council in accordance with paragraph 18 of Schedule 1 of the order.[13]

The quorum of a practice committee shall be three and shall:

include at least one registrant and one lay member, and
comprise the chairman or deputy chairman and two other members.

Box 11.5 Standards for members of a practice committee

1 A member of a practice committee shall:
- prepare for any meeting of the committee by reading the agenda and any papers issued by the committee of the Council which are relevant to any subject to be considered at that meeting, and
- if he will not be attending a meeting of the committee, take all reasonable steps to give advance warning of his absence to the chairman.

2 A member of a practice committee shall undertake education and training provided or organised by the Council from time to time so that he is properly informed about his responsibilities and in particular shall receive training in:
- the functions of the Council and the role of the committee and its place in the work of the Council –
  - (i) the effective conduct of proceedings by the committee and
  - (ii) the discharge by the committee of its functions under Part V of the Order (Fitness to Practise), including the principles of natural justice, human rights and Community law.

Investigating Committee

Where an allegation is made about a registrant fraudulently procuring an entry in the Register, Council can refer the matter to the Investigating Committee. Where an allegation is made in relation to the other matters set out in Article 21, Council shall refer the matter to screeners or to a practice committee.

The Investigating Committee has the function of investigating any allegation referred to it by Council or by the screeners. After a referral, the Investigating Committee shall:

(a) notify without delay the person concerned of the allegation and invite her to submit written representations within a prescribed period

(b) where it sees fit, notify the person making the allegation of the representations mentioned in sub-paragraph (a) and invite him to deal within a specified period with any points raised by the Committee in respect of those representations

(c) take such other steps as are reasonably practicable to obtain as much information as possible about the case

(d) consider, in the light of the information which it has been able to obtain and any representations or other observations made to it under sub-paragraph (a) or (b), whether in its opinion –

(i) in respect of an allegation of the kind mentioned in Article 22(1)(a), there is a case to answer, and

(ii) in respect of an allegation of the kind mentioned in Article 22(1)(b), whether the entry concerned has been fraudulently procured or incorrectly made.

The Investigating Committee, where it considers that there is a case to answer may:

1 undertake mediation, or

2 refer the case:

to screeners for them to undertake mediation

to the Health Committee

to the Conduct and Competence Committee.

If the allegation relates to an entry on the Register being fraudulently procured or incorrectly made, then the Investigating Committee can, if it is satisfied that the allegation is correct, make an order that the Registrar remove or amend the entry and it must notify the person concerned of her right to appeal under Article 38, but this order can be reviewed if new evidence comes to light (Article 26(7) and (12)).

The Investigating Committee also has the power to make an interim order at the same time or at any time before referring a case to the Health Committee or Conduct and Competence Committee.

If the Investigating Committee concludes that there is no case to answer or that the relevant entry was not fraudulently procured or incorrectly made, it must make a declaration to that effect, with reasons, if so required by the person concerned and can make a declaration with the consent of the person concerned.

Conduct and Competence Committee

It may be that, after scrutiny of the evidence in Janice's case (Practical Dilemma 11.2), the Investigation Committee or screeners decide that the case should be referred to the Conduct and Competence Committee (CCC).

The CCC has the function, after consulting the other practice committees, of advising the Council on:

1 the performance of the Council's functions in relation to standards of conduct, performance and ethics expected of registrants and prospective registrants

2 requirements as to good character and good health to be met by registrants and prospective registrants

3 the protection of the public from people whose fitness to practise is impaired and to consider:

any allegations referred to it by the Council, screeners, the Investigating Committee or the Health Committee, and

any application for restoration referred to it by the Registrar.

Rules to be followed in Fitness to Practise hearings were set out in a Statutory Instrument,[14] which can be downloaded from the NMC or legislation websites.

The Rules cover the following topics in relation to the CCC and the Health Committee:

Action upon referral of an allegation
- Meetings and hearings
  - Notice of hearing
  - Procedure of the CCC and the Health Committee
  - Notice of decision
  - Referral of allegation from CCC to the Health Committee
  - Referral of allegation from the Health Committee to the CCC.

The hearing

The Rules also lay down the procedure which should be followed at a hearing covering preliminary meetings, public and private hearings, representation and entitlement to be heard, absence of the practitioner, witnesses, vulnerable witnesses, and the order of proceedings at the initial hearing, a review or restoration hearing or at an interim orders hearing and the notes and transcript of the proceedings. The details can be seen in the Statutory Instruments which are available from the NMC and legislation websites. In the case of *McDaid* v. *NMC*[15] one of the grounds for the midwife's appeal against being struck off the register was that the panel should not have proceeded with the case in her absence. No satisfactory explanation of her failure to attend was given. The judge found against her on that point but ruled that the panel's decision should be quashed and another CCC should hear the case because she succeeded on one ground (that a letter from the Trust's head of employment stated that it was up to her to write to a complainant which was contrary to the trust's assertion that she had made inappropriate contact with a complainant). Details of the case are discussed by Andrew Symon.[16]

In the case of Becky Read, an independent midwife working with the Albany Group Practice, 63 charges against her were dismissed when the NMC failed to offer evidence to the court[17].

Two nurses were struck off following the Mid Staffordshire Inquiry: Sharon Turner who had said that she didn't give a flying f*** about patients, falsified A&E waiting time records, bullied a colleague and called Asian doctors names; and Tracey White who changed A&E data to make it look as though waiting targets had been met, abused a woman who had had an abortion and called an elderly patient a naughty little monkey.[18] The CCC found that their actions constituted misconduct and their fitness to practice was impaired. Earlier in 2013 the NMC decided that Helen Moss the director of nursing at the hospital between 2006 and 2009 had no case to answer.

In another CCC case a nurse whose job was to accompany sick patients home from abroad was removed from the register after it was found that he wrongly gave patients a clean bill of health to fly and unnecessarily delayed the flights of others by creating false records.[19]

Further information on hearings can be found on the NMC website.

The NMC consulted on whether the criminal standard of proof (beyond reasonable doubt) used in practice committees should be replaced by the civil standard of proof (on a balance of probabilities) (see chapter 1) and concluded in the light of the response that the criminal standard should be kept, but that rules relating to civil procedures should be followed (see NMC website). However, the Health and Social Care Act 2008 Section 112 added a new section 60A to the Health Act 1999:

60A Standard of proof in fitness to practise proceedings

1 The standard of proof applicable to any proceedings to which this subsection applies is that applicable to civil proceedings.

2 Subsection (1) applies to any proceedings before –
- **(a) the Office of the Health Professions Adjudicator, or**
- **(b) a committee of a regulatory body, a regulatory body itself or any officer of a regulatory body, which relate to a person's fitness to practise a profession to which Section 60(2) applies.**

3 In subsection (2) 'regulatory body' means the body (or main body) responsible for the regulation of a profession to which Section 60(2) applies.

This section cannot be amended by an order in council (s. 112(4)).

The civil standard of proof came into force for new proceedings on 3 November 2008.[20] An NMC briefing note for legal assessors in 2008 sets out the House of Lords' judgments in two cases where it was emphasised that the civil standard of proof was a balance of probabilities and did not alter according to the gravity of the allegations.

There are essentially two distinct stages to a hearing: the first is to determine whether the facts which have been alleged are proved and whether these facts mean that the registrant is guilty of misconduct and if her fitness to practise is impaired. The second stage is the determination of what action should be taken by the practice committee. Rule 24 was amended by SI 2007/893 changing the procedure to be followed from the initial hearing.

The outcome

Once there has been a decision that the nurse is guilty of misconduct and her fitness to practise is impaired, the Committee then has to decide what sanction to adopt. There are several choices as outlined in Box 11.6.

Box 11.6 Outcomes available to the Conduct and Competence Committee

1. Refer the matter to screeners for mediation or itself undertake mediation.
2. Take no further action.
3. Strike off the Register.
4. Suspension for a specified period from the Register (not exceeding 1 year): on expiry of this time, she shall be restored to the Register (a suspension order).
5. Impose conditions with which the person must comply for a specified period which shall not exceed 3 years (a conditions of practice order).
6. Caution the practitioner and make an order directing the Registrar to annotate the Register accordingly for a specified period which shall not be for less than 1 year and not more than 5 years (a caution order).
7. Refer to another Committee.
8. Interim orders: Article 31 enables an order to be made to suspend the person's registration or imposing conditions with which the person must comply for a period not exceeding 18 months, if it is necessary for the protection of members of the public or otherwise in the public interest, or is in the interests of the person concerned.

The professional screeners, the president or the Health Committee can refer a case back to the CCC. Under Article 30 any practice committee has power to vary the orders that it has made or refer the matter to another committee.

In all cases the respondent must be notified by recorded delivery of the decision of the CCC.

Criminal misconduct

If the charge relates to criminal misconduct, then slightly different rules apply. Evidence as to a conviction on a criminal charge can be put before the CCC and the respondent can adduce evidence to prove beyond reasonable doubt that she is not the person referred to in the certificate of conviction or that the offence referred to in the certificate of conviction was not that of which she was convicted (this prevents a second trial on the actual charge that was before the criminal courts).

The CCC will determine whether any conviction has been proved and after that the validity of the conviction will not be questioned. Proof of a conviction alone will not in itself be considered to be evidence of impairment of fitness to practise. However, proof of the conviction is evidence of the commission of the offence. It then has to be decided whether that offence constitutes impairment of fitness to practise.

In the case of Balamoody against the UKCC,[21] the court held that the terms of the professional conduct rules covered all criminal convictions regardless of either the seriousness of the offence or whether it was committed in the course of nursing. While a criminal conviction did not of itself constitute misconduct, some offences would almost certainly amount to misconduct and therefore, where a professional had failed to adhere to important statutory requirements while discharging functions of a senior and supervisory nature, resulting in a criminal conviction, the relevant professional body and the court would be forced to regard that person's actions as a cause for serious concern. In Practical Dilemma 11.2, if Janice were convicted of a criminal offence and the CCC were satisfied that the certificate of conviction applied to Janice, they would have to determine if her actions showed that she was unfit to practise and determine the action to be taken. Even if no criminal proceedings were brought, the Investigation Committee of the NMC would initiate proceedings to determine if there was a case to answer following the procedure set out in Rule 4 of the Statutory Instrument (SI).

Practical Dilemma 11.3 Breach of the peace

A district nurse was very angry to discover that a traffic warden was standing by her car as she returned from visiting a patient. She pointed out her nurse's sticker and explained that she was visiting only for a few minutes to give an injection. The traffic warden was unimpressed by her pleading and took no notice of what she was saying. The nurse became very heated and an argument broke out during which the traffic warden said: 'You nurses are all the same. You all think the law does not apply to you.' The nurse lost her temper and pushed the warden. She was subsequently charged with conduct likely to cause a breach of the peace. She was found guilty and fined. She eventually found herself facing CCC proceedings.

A case such as that in Practical Dilemma 11.3 would be conducted under the procedure to be followed where a conviction is alleged. Rule 31 of the SI states that where a registrant has been convicted of a criminal offence a copy of the certificate of conviction shall be conclusive proof of the conviction and the findings of fact upon which the conviction is based shall be admissible as proof of those facts. The only evidence which may be adduced by the registrant in rebuttal of the conviction is evidence that she is not the person referred to in the certificate. If the district nurse in Practical Dilemma 11.3 fails to put forward such evidence, then the CCC would hold that the conviction had been proved, and decide if this was evidence of impairment of fitness to practise. It is then open to the nurse to submit that the charges are not in themselves proof of unfitness to practise.

In the case of *Isaghehi* v. *NMC*[22] where the NMC struck off a psychiatric nurse who had been convicted and imprisoned for dangerous driving, the High Court decided that the striking off was disproportionately high and that a year's suspension from the Register was the appropriate sanction.

In contrast Shackleford, a registered nurse, appealed to the High Court against his being struck off, alleging that the panel had come to the wrong decision about his impairment and the sanction was wrong. He had been given a community order after being convicted of assault on his pregnant partner. The High Court judge stated that this was unacceptable conduct for the profession of nursing. The profession must maintain high standards of personal behaviour. His appeal was dismissed.[23]

Removal on grounds of health

At any time, the Investigating Committee, when investigating a case of alleged unfitness to practise or a complaint against a nurse, can refer the case to the Health Committee of the NMC.

The Health Committee is constituted to determine whether or not:

1 a practitioner will be removed from the Register or part of it
2 a person who has been removed from the Register or part of it may be restored
3 a practitioner's registration shall be suspended
4 the suspension of a person's registration shall be terminated.

The rules relating to membership of a practice committee and a panel are shown in Box 11.7.

Box 11.7 Rules relating to membership of a practice committee and a panel

The members of each practice committee shall include registered professionals and other members, of whom at least one shall be a registered medical practitioner.
The number of registered members on a practice committee may, but need not, exceed the number of other members on the committee and shall not in any case exceed that number by more than one.
The chairman of the committee shall be a Council member.
No one shall be a member of more than one practice committee and shall not be both a screener and a member of a practice committee.
When a panel of a practice committee are selected, there must be at least three members who are chosen with due regard to the former, current or proposed field of the person concerned and the nature of the matters in issue.

The constitution of a panel hearing the matter is:

One member of the panel must be registered in the same part of the Register as the person concerned.
At least one member of the panel must be a lay member and not a registered medical practitioner.
Where health of the person is relevant, there must be a medical practitioner.
Non-Council members may be members of the panel.
The number of registrants on the panel may exceed the number of lay members but not by more than one.
The person chairing the panel may but need not be a member of the Council.
Where there is a tie, the chairman shall have an additional casting vote but in fitness to practise decisions shall exercise his casting vote in favour of the person concerned.
No person who is a member of Council or a committee may take part in proceedings of a practice committee while the subject of any allegations or investigations about her fitness to practise.

Screeners

Allegations may be referred to screeners in accordance with the Nursing and Midwifery Order or rules made under it (Article 23 applies). No person may be a screener if she is:

a member of a practice committee,
a legal, medical or registrant assessor, or
employed by the Council.

Detailed rules relating to the appointment and function of screeners are laid down in Article 24.

Procedure

Information, in writing and received by the Registrar, which raises any question of the practitioner's fitness to practise being seriously impaired by reason of her physical or mental condition shall be submitted to the professional screeners. Anyone wishing to lay information before the Registrar may make a statutory declaration.

1 If the professional screeners decide there is no reasonable evidence to support the allegations, they shall direct the Registrar to inform the complainant and, if they consider it necessary or desirable, the practitioner. The professional screeners may obtain the opinion of a selected medical examiner on the information and evidence that they have received.
2 If they feel that the matter should proceed further, they shall direct the Registrar to write to the practitioner by recorded delivery:
   - notifying her that information has been received that appears to raise a question as to whether her fitness to practise has become seriously impaired by reason of her physical or mental condition and indicating the symptomatic behaviour that gives rise to that question
   - inviting the practitioner to agree within 14 days to submit to examination at the Council's expense by two medical examiners to be chosen by the professional screeners and to agree that such examiners should furnish reports to the Registrar on the practitioner's fitness to practise
   - informing the practitioner that it is open to her to nominate other medical practitioners to examine her at her own expense and to report to the Registrar on the practitioner's fitness to practise
   - inviting the practitioner to submit to the Registrar any observations or other evidence that she may wish to offer as to her own fitness to practise.

If the two medical practitioners are not able to agree, a third can be appointed at the Council's expense. The professional screeners can make their own enquiries before giving any of the above directions.

Action following reports received from the medical examiners

1 If the medical examiners are unanimously agreed that she is not fit to practise, then the Registrar shall refer the information, together with the medical examiners' reports, to the Health Committee. The solicitor may be directed to take all necessary steps for verifying the evidence to be submitted to the Health Committee and for obtaining any necessary documents and the attendance of witnesses.
2 If there is considered to be insufficient evidence of illness, the practitioner and the complainant shall be informed.

Referral of case to professional screeners by Investigating Committee, president or Conduct and Competence Committee

The practitioner is invited:

1 to submit to examination by at least two medical examiners to be chosen by the professional screeners
2 to agree that such examiners should furnish to the Health Committee reports on the practitioner's fitness to practise and
3 the Registrar informs the practitioner that it is also open to her to nominate another medical practitioner at her own expense to examine her and report to the Health Committee.

If she refuses to submit to such an examination or nominate her own medical examiner, the professional screeners shall decide whether or not to refer the information received to the Health Committee, indicating the reason why no medical report is available.

Notice of referral

The procedure relating to the notice of a hearing is set down in Rule 11. The notice must be sent at least 28 days before the date of the hearing.

Health Committee

The Committee sits in private, unless the public interest of any third party outweighs the need to protect the privacy or confidentiality of the registrant. The procedure for the hearing is set down in Part 5 of the Rules.

The Committee can:

1 adjourn for further medical reports
2 find that the fitness to practise is not seriously impaired by reason of the practitioner's physical or mental condition
3 postpone judgment
4 find that the fitness to practise is seriously impaired by the practitioner's physical or mental condition (it can direct the Registrar to remove the practitioner from the Register and can specify a period or not). Following such a finding, the Health Committee can:
   (a) suspend registration for a specified period not to exceed 1 year
   (b) impose conditions of practice for a specified period not to exceed 3 years
   (c) issue a caution for a specified period between 1 and 5 years or
   (d) strike the person off the Register (if they have been continuously suspended or under Conditions of Practice for the previous 2 years).

In the event of a finding under point 2 above, the Committee must refer the matter back to the committee from which the case was referred or to the president (if she referred it) who shall refer it to the Conduct and Competence Committee.

Restoration to the Register

This is governed by Article 33: unless new evidence has come to light that enables a practice committee to review its order under Article 30(7), no application for restoration to the Register may be made:

- before the end of the period of 5 years beginning with the date on which the order for striking off took effect, or
- in any period of 12 months in which an application for restoration to the Register has already been made by the person who had been struck off.

The Registrar shall refer the application for restoration to the committee that made the striking-off order or, where a previous application has been made, to the committee that last gave a decision on an application for restoration.

The Committee shall give the applicant an opportunity to appear before it and to argue her case in accordance with rules made by the Council.

The Committee may not grant an application for restoration unless it is satisfied that the applicant not only satisfies the educational requirements and that she is capable of safe and effective practice as a nurse or midwife but, having regard to the circumstances of the striking-off order, is also a fit and proper person to practise the relevant profession. The Committee can, in granting the application for restoration, make it subject to the applicant satisfying such requirements as to additional education or training and experience as the Council has specified under its rules relating to return to work after an absence (Article 19(3)). When making an order for restoration to the Register, the Committee shall direct the Registrar to register the applicant in the relevant part, subject to payment of the prescribed fee and may also make a condition of practice order with respect to her.

Amendments have been made to the 2001 rules[24] so that Rule 14 which enables a registrant to apply for voluntary removal from the registrar, must now include in the declaration details of any matters which the registrant is aware of which may give rise, or have given rise, to a fitness to practise allegation. The Registrar must seek the advice of a Practice Committee if the application for voluntary removal is received at a time when the registrant is subject to fitness to practise allegations. The Registrar must also obtain comments from the maker of the allegations. The amendments also change Rule 15 to set out the matters which the Registrar must take into account where a registrant's registration has lapsed and the registrant has applied for readmission to the Registrar.

The proceedings of the CCC and the Health Committee are subject to review by the High Court. For example, in *Slater* v. *United Kingdom Central Council for Nursing, Midwifery and Health*

Visitors,[25] the Queen's Bench Division quashed the decision of the PCC in removing Mr Stephen Slater's name from the Register of nurses and remitted the case to a freshly constituted Committee for a rehearing on the grounds that the practitioner's case had not been fully considered by the Committee and an injustice might therefore have been done. In a later case, *Hefferon* v. *Committee of the UKCC*, *Current Law*, May 1988, 221, the High Court quashed the decisions of the Committee on the grounds that there had been a breach of natural justice. With the establishment of the Council for the Regulation of Healthcare Professions, then known as the Council for Healthcare Regulatory Excellence and now known as the Professional Standards Authority for Health and Social Care (see page 291), it is possible for a complainant to apply to the Council if they are aggrieved at a decision made by a health registration body, including the NMC.

Professional standards and codes of practice

The functions of the NMC set out in Box 11.2 include that of establishing and improving standards of training and professional practice and also providing, in such manner as it thinks fit, advice for nurses, midwives and health visitors on standards of professional conduct. In fulfilment of this duty, the NMC has made several revisions to the Code of Professional Conduct and Guidance on different aspects of professional practice. The NMC has established a Library of Standards Project to review the NMC's approach to the development and dissemination of standards for NMC approved programmes of education and training leading to entry on the professional Register. *Standards to Support Learning and Assessment in Practice*[26] was published by the NMC in 2006 and revised in 2008. The standards can all be found on the NMC website.[27]

Education and training

The statutory duty to establish and improve standards of training falls on the NMC. A team of professional officers works with members through specialist committees, including the Educational Policy Advisory Committee, the Midwifery Committee and a committee on research. The NMC published standards of proficiency for pre-registration nursing and midwifery education in March 2004 which were updated in 2010.[28] Revised pre-registration standards for midwifery education were published in February 2009. In January 2010 the NMC published consultation standards for pre-registration nursing education which came into force in 2011.[29] These include standards for education and also standards for competence and replace those published in 2004. The NMC has also provided guidance on the recognition of Accreditation of Prior (Experiential) Learning (AP(E)L) in the approval and monitoring of NMC approved programmes.[30]

Approved education institutions are responsible for ensuring that the quality of their programmes complies with the Standards. Ten Standards of education are set for programme approval and delivery. They are: safeguarding the public; equality and diversity; selection, admission, progression and completion; support for students and educators; structure, design and delivery of programme; practice learning opportunities; outcomes; assessment; resources; and quality assurance. The competency framework comprises four sets of competencies covering the relevant parts of the Register: adult nursing, mental health nursing, learning disabilities nursing and children's nursing. Each set of competencies includes generic competencies required by all nurses and the specific competencies needed for the specific field of nursing. They are set out under four domains: professional values; communication and interpersonal skills; nursing practice and decision-making; and leadership, management and teamworking.

The NMC, the Health Professions Council and the Department of Health work in partnership with the NHS higher education providers and other stakeholders to develop quality assurance arrangements for professional healthcare education. In its second joint statement the NMC and DH outlined the

progress that has been made towards the development of a shared quality assurance framework and the planned outcomes associated with each element of the framework.[31] Five elements were identified as forming a quality assurance framework:

- major review
- ongoing quality monitoring
- approval and re-approval processes
- benchmarks and quality standards
- evidence on which conclusions and judgements are based.

The new quality assurance framework and the appointment of Mott McDonald was announced by the NMC in June 2013.[32] Further information on the NMC Quality Assurance Framework for Nursing, Midwifery and Specialist Community Public Health Nursing is available on the NMC website where reports of the monitoring of individual institutions can be found.

Post-registration education and practice (PREP)

The UKCC set standards for the future of professional practice in 1994 which were known as PREP. These were subsequently revised by the NMC and the following are the current requirements for continuing professional development and practice. There are two separate PREP standards that affect registration:

- The PREP continuing professional development (CPD) standard
- The PREP (practice) standard.

The PREP continuing professional development standard

The PREP CPD standard requires registrants to:

- Undertake at least 35 hours of learning activity relevant to their practice during the three years prior to their renewal of registration.
- Maintain a personal professional profile of this learning activity.
- Comply with any request from the NMC to audit compliance with these requirements.

The PREP (practice) standard

Registrants are required to have worked in some capacity by virtue of his or her nursing or midwifery qualification during the previous three years for a minimum of 450 hours, or have successfully undertaken an approved return to practice course within the past three years.

- Registrants wishing to renew *two* registrations, e.g. nursing *and* midwifery or nursing *and* specialist community public health nursing, must have completed at least 450 hours in each, making a total of 900 hours.
- Registrants wishing to renew all *three* registrations must have completed at least 450 hours in each, making a total of 1,350 hours.

Those registrants who do not meet this standard must undertake an approved return to practice programme before they can renew their registration.

Registrants are required by law to renew their registration every three years by providing a signed 'notification of practice' form in which they declare that they have complied with the PREP standards. They must also pay the annual retention fee. Registration will be renewed only when the signed form and fee payment have been received and processed by the NMC. Since the NMC has moved to the annual payment of fees, registrants are required to pay a retention of registration fee at the end of the first and second years of the registration period.

The NMC has revised its guidance for employers on PREP[33] and a new PREP handbook was published in 2008 and revised in 2011 and is available on the NMC website.

Midwives must also comply with PREP requirements as laid down in the new Midwives' Rules which were brought into force in 2004. In addition, in order to practise, midwives need to give notice of their intention to practise, in accordance with Rule 3 of the *Midwives' Rules and Standards*. This is done by submitting a completed annual 'intention to practise' form every year to their named supervisor of midwives (see chapter 14).

Revalidation from 2015

From 2015 new procedures for revalidation will be introduced building on existing processes and systems. At present registrants renew their registration every three years, declaring that they have practiced for 450 hours over that time, that they have undertaken continual professional development and that they are of good health and character. They must also declare any police charges, cautions or convictions. From 2014 they must declare that they hold an appropriate level of professional indemnity insurance. From 2015 they will need to confirm that they have sought and received third party feedback and third party confirmation. The NMC is consulting on the source of confirmation.[34] The NMC code is being revised to ensure that it will support revalidation and a draft has been circulated for consultation. Revisions take into account recommendations from the Francis Report;[35] and Compassion in Practice.[36] The NMC is consulting on the revalidation process in early 2014 and following its implementation in 2015 will evaluate its effectiveness. The NMC is to issue guidance on the following subjects in order to underpin the Code: revalidation; social networking; professional indemnity insurance; candour; raising concerns; medicines management and good health and good character.

A registrant has a duty to co-operate with internal and external investigations in accordance with the Code of Practice. Complaints had been made to Harford about a nurse in a general practice. Harford refused to provide a list of complainants and was subsequently found to have her fitness to practice impaired by reason of misconduct. She appealed against this decision and lost. The High Court held that the panel was entitled to make that decision. The panel considered that H had limited insight into the potential harm her actions had for undermining the trust and confidence of the public in the nursing profession. It said it was not confident that H truly understood the relationship and potential between confidentiality on the one hand and the protection of patients on the other.[37]

Fitness to Practise Annual Report 2012–13

During 2012–2013, 4,106 referrals against nurses and midwives were made to the NMC. This equates to 0.6% of the 673,567 registered nurses and midwives. A total of 864 interim orders were imposed to restrict or suspend a nurse or midwife's practice for a period pending the outcome of the case or an appeal. The Investigating Committee adjudicated on 2,165 cases, of which 2,015 went to the Conduct and Competence Committee and the remainder to the Health Committee. Of the 1,377 cases which were concluded during the year, in 222 cases fitness to practise was found not to be impaired. Of the remaining 1,155 cases 589 nurses or midwives were struck off the Register; 243 suspended; 160 had conditions imposed on how they can practise and 163 received a caution order. The referrals were made by employers (41%); members of the public (25%); others (7%); and self-referral (6%). In 2012–13 changes were implemented to ensure cases were dealt with more speedily. These changes included improved case management, voluntary removal from the Register and consensual panel determination. The latter enables a shorter hearing where the registrant agrees that his or her fitness to practise is impaired.

The type of allegations made in the new referrals was: misconduct (63%); lack of competence (17%); criminal (16%); health (3%).

The NMC stated that it would continue to drive through change to improve the efficiency of its fitness to practise process and needed to reduce further adjudication times by December 2014 to meet

targets. It also needed to look at the way it worked and shared information with other regulators and public organisations. Addressing the recommendations made by the Francis Inquiry (see chapter 5) would remain a priority. The full Annual Report and the reports relating to the business plan, statistics and financial report can be downloaded from the NMC website. The NMC has provided guidance for employers on the role of the NMC and when and how to make referrals to the NMC in relation to fitness to practise of a nurse or midwife.[38]

A fitness to practise case

An example of a case heard by the CCC was that of Jane Hirst. A conditions of practice order had been imposed on her registration on 3 April 2013. This was reviewed in April 2014 in her absence since she failed to attend in spite of having notice of the hearing. The charges which were found proved in April 2013 were:

1 she had slept on duty
2 allowed a healthcare assistant to sleep on duty and/or failed to adequately supervise her
3 failed to ensure that the care needs of the residents were met by failing to ensure that some residents had been turned every two hours from 20.00 to prevent pressure sores from developing and failed to adequately care for some residents' continence needs.

The panel accepted that this type of misconduct was remediable but her failure to attend meant that the panel was unable to explore with her any steps she might have taken to remedy her behaviour or to explore any insight she may have into her failures. She had shown no remorse, insight or remediation. The panel considered all the options available to it (allowing the order to lapse; a caution order; a further conditions of practice order; a period of suspension and striking off). It concluded that a 4-month suspension with immediate effect was the most appropriate action to take to protect the public, to address the issue of public interest and to uphold the standards of the profession. The 4-month time limit would give the registrant sufficient time to re-engage with the NMC proceedings.

In another fitness to practise case a nurse who forgot to give a blood transfusion to a patient overnight was suspended for 9 months.[39]

The Court of Appeal held that the time lime of 28 days (set in Article 29(10) of the 2001 Order) to appeal against an order for removal from the Register was absolute and the appellants had left it too late.[40]

Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence (CHRE))

The Council for the Regulation of Health Care Professionals (CRHCP)[41] was set up under the NHS Reform and Healthcare Professions Act 2002 in the wake of the Kennedy Report into children's heart surgery at Bristol Royal Infirmary.[42] Its remit covered nine regulatory bodies, including the NMC. A White Paper was published in February 2007 on the future of health professional regulation,[43] which envisaged major changes for the CHRE, including a smaller and more board-like Council with all members being appointed and the national regulators no longer nominating their presidents to the Council. These changes were effected by the Health and Social Care Act 2008 and the Council's name was changed to the Council for Healthcare Regulatory Excellence. In 2010 a review of arm's-length bodies[44] recommended that the CHRE should cease to be an executive non-departmental public body and instead should be self-funded with fees paid by the regulatory bodies. In addition, its remit should be extended to set standards and to quality assure other voluntary registers and professional bodies.

These changes were made in 2013.[45] The name of the CHRE was changed to the Professional Standards Authority for Health and Social Care with the remit of protecting users of healthcare, users of social care in England and users of social work services in England.[46] The NHS Reform and Health

Care Professions Act 2002 was amended to include the power of the Secretary of State to request the Authority for advice on any matter connected with the social work profession, or social care workers in England. The Authority can provide advice and auditing services to a regulatory body. The PSA is accountable to Parliament and provides an annual report which is available on its website.[47] It describes its functions as regulating the statutory bodies and 'we assess their performance, conduct audits, scrutinize their decisions and report to Parliament. We also set standards for organizations holding voluntary registers for health and social care occupations and accredit those that meet them.' It has the power to refer to the High Court cases which have been heard by the regulatory body including those cases where there has been an acquittal.[48]

In 2008 the CHRE published a report on the NMC[49] pointing out serious weaknesses in the NMC's governance and culture, in the conduct of its Council and in its ability to protect the interests of the public through the operation of fitness to practise processes. The NMC took appropriate action. In 2013 the House of Commons Select Committee on Health reported on an accountability hearing with the Nursing and Midwifery Council and published the latter's response as an appendix.[50] The NMC accepted the recommendations for change and improvement and noted that significant changes had already taken place. It concluded that, 'We are determined to continue to improve delivery of our core functions and build confidence in our work and look forward to providing confirmation of further progress at our next hearing.'

In June 2014 the Professional Standards Authority (in its annual review for 2013–14) reported that the NMC had achieved improvements across each of its regulatory functions.

Public involvement

One of the main features of the new registration system was that public involvement should increase. Under Article 3(5) of the 2001 Order[51] as amended in 2008[52] in carrying out its functions the NMC has a duty to cooperate, in so far as is appropriate and reasonably practicable, with public bodies or other persons concerned with –

(i) the employment (whether or not under a contract of service) of registrants,
(ii) the education or training of nurses, midwives or other healthcare professionals,
(iii) the regulation of, or the coordination of the regulation of, other health or social care professionals,
(iv) the regulation of health services, and
(v) the provision, supervision or management of health services.
(5A) In carrying out its duty to cooperate under paragraph (5)(b), the Council shall have regard to any differing considerations relating to practising as a nurse or midwife which apply in England, Scotland, Wales or Northern Ireland.

The NMC predecessor, the UKCC, issued in October 2000 a strategy for public involvement[53] which identified the current public involvement in the work of the UKCC. The NMC has continued to ensure good communications with the general public and its website is accessible not only to registered practitioners and health service employers, but also to the general public. As charity trustees the NMC is required to give evidence that the public benefit is part of its decision-making processes and considered this issue at its meeting in May 2009. It has also published a leaflet, 'Care and respect every time', informing the public of the standards they can expect in relation to people, process and place.

NHS Improving Quality (formerly NHS Institute for Innovation and Improvement)

As a result of the NHS Plan published in July 2000[54] the NHS University was set up which in December 2003 became a special health authority publishing a draft strategic plan for 2004–2008.[55] The NHS

University was dissolved on 31 July 2005 and its responsibilities for learning and skill development in the NHS taken over by the NHS Institute for Innovation and Improvement using host organisations across the country to deliver the NHS University's programmes and services. For example 'Skills for Health' was concerned with the development and use of integrated competency frameworks across healthcare. One of the initiatives developed by the NHS Institute, known as QIPP (Quality, Information, Productivity and Prevention), was given greater prominence as a result of the White Paper published in 2010 *Equity and excellence* which outlined the government's commitment to ensuring that QIPP supported the NHS to make efficiency savings, which can be reinvested back into the service to continually improve quality of care.

NHS Improving Quality (NHS IQ) was established on 1 April 2013 to improve health outcomes for people by providing improvement and change expertise. It is hosted by NHS England and works to the five domains of the NHS Outcomes Framework:

1 living longer lives
2 enhancing the quality of life for people with long term disabilities
3 helping people to recover from episodes of ill health or following injury
4 ensuring that people have a positive experience of care
5 treating and caring for people in a safe environment and protecting them from avoidable harm.

Further information including its strategic plans can be found on the website.[56]

Framework for assessing national competence standards

Standards for those involved in specific specialities were being prepared to ensure that the workforce had the skills necessary in a particular care area. The first toolkit designed to assist staff was published in November 2003, when new guidelines were issued for coronary heart disease.[57] The NMC published a framework for assessing national competency standards for registered nurses, enrolled nurses and midwives in October 2013 which are available on its website. Five key principles are to be applied when assessing national competency standards:

1 principles of accountability
2 principle of performance-based assessment
3 principle of evidence-based assessment
4 principle of validity and reliability in assessment
5 principle of participation and collaboration.

Health and Care Professions Council

The Health Professions Council was renamed the Health and Care Professions Council in April 2012[58] when it became the registration body for social workers as well as the other health professions already in its remit. The constitution of the Council was reduced from 20 to 12 and its quorum from 11 to 7.[59] Further information can be obtained from its website.[60]

Conclusions

There is no doubt that the Professional Standards Authority for Health and Social Care (replacing the Council for Healthcare Regulatory Excellence) in its new and focused remit and constitution should exercise a significant role in regulatory standards, not only through its powers to refer individual decisions

to the High Court but also through its overall review of the performance of the different regulatory bodies. The critical report of the CHRE in 2008 of the NMC has led to significant changes. The CHRE identified the need to reduce the backlog of conduct and competence cases and the NMC planned to reduce the waiting time to six months by 2010. Legislation implementing fundamental changes to the registration provisions of all healthcare professionals following the White Paper *Trust, Assurance and Safety*[61] was enacted in the Health and Social Care Act 2008 and subsequently in the Health and Social Care Act 2012.

In January 2014 the NMC initiated a consultation on the revalidation process and on a draft revised Code of Conduct. It ended in March 2014 and the NMC have confirmed the consultation is now closed and they hope that a new revalidation model will be launched by October 2015. The importance of professional regulation of health professions and also of the unregistered health care assistants was emphasised in the recommendations of the Francis Report on Stafford Hospital which is considered in chapter 5. The HCPC responded to a BBC *Panorama* programme which revealed cruelty and malpractice in a nursing home by emphasising the need to regulate and hold to account the healthcare assistants.

The Law Commission in 2014 recommended a single clear and consistent legal framework for all health and social care professionals in a new UK-wide single statute. New powers and duties would be set with the main objective of protecting the public. The report includes a draft bill which would enact the reforms.[62]

Reflection questions

1 How would you define fitness to practise by a nurse? Would any of the following count as evidence of unfitness to practise by your definition?
   - **(a)** a nurse has an illegitimate child
   - **(b)** a nurse is convicted of shoplifting
   - **(c)** a nurse is found guilty of a breach of the peace after being involved in an argument with a traffic warden
   - **(d)** a nurse is fined for speeding
   - **(e)** a nurse borrows money from a junior member of staff on her ward
   - **(f)** a nurse is discovered to be drunk when off duty, but still in her uniform.

2 Since the decision as to whether there is misconduct or not and therefore whether there is impairment of fitness to practise depends on the detailed circumstances, what additional information would you need to answer question 1 and how would that information affect your answer?

Further exercises

1 The CCC sits in different parts of the country and is open to the public and members of the profession. Next time it meets in your vicinity, try to attend and write up the hearing from the point of view of the formality, the procedure followed, justice to the nurse defendant and justice to the general public.

2 In what ways does a hearing before the CCC differ from a hearing before a civil court? To what extent do you consider that the hearing and its procedure comply with Article 6 of the European Convention on Human Rights? (See the website of this book.)

3 What do you consider should be the time limit before a nurse who has been struck off can apply to be restored to the Register?

4 To what extent do you consider that the Professional Standards Authority for Health and Social Care influences and affects the professional status of the nurse or midwifery practitioner?

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Chapter 12

Health and safety and the nurse

This chapter discusses

- Statutory provisions
- Corporate manslaughter and corporate homicide
- Common law duties: employer's duty
- Remedies available to an injured employee
- Special areas
- The future

Introduction

This chapter covers the basic principles of law relating to health and safety at work, taking examples from nursing practice. It covers both the statutes (Acts of Parliament and Statutory Instruments) and the common law (i.e. decided cases or judge-made law) that set out the legal requirements on health and safety. Statute law and common law work in parallel and cover similar duties (although statute law is more specific).

Statutory provisions

Health and Safety at Work Act 1974 (HASWA)

General principles

The Health and Safety at Work Act 1974 is enforced through the criminal courts by the Health and Safety Inspectorate, on behalf of the Health and Safety Executive, which has the power to prosecute for offences under the Act and under the regulations, also powers of inspection, and which can issue enforcement or prohibition notices. (The Health and Safety Executive and the Health and Safety Commission were merged on 1 April 2008).

The employer has two parallel duties – one under the civil law and enforced through the civil courts (see page 318), the other under the criminal law and enforced through the criminal courts. The Health and Safety at Work Act is an Act that is enforceable through the criminal courts and places on both employer and employee considerable duties in relation to health and safety. Originally some regulations made under the Health and Safety at Work Act 1974 (such as the manual handling regulations) could also be used as the basis for a claim for compensation in the civil courts. However, under section 69 of the Enterprise and Regulatory Reform Act 2013 breach of the Health and Safety regulations is not actionable in the civil courts except to the extent that the regulations specify. It follows that negligence by the employer and not a simple breach of the regulations must be proved by the employee to obtain compensation in the civil courts. Statute Box 12.1 sets out the general duties under section 2 of the Act. Statute Box 12.2 sets out the duties of the individual employee. A glance will show how comprehensive they are.

It was reported following a Freedom of Information request that Essex County Council had paid out claims of £1.05 million between 2011 and 2013 – the largest was £230,000 paid to a school teacher who was injured after slipping on a discarded ketchup sachet.[1]

Statute 12.1 Section 2 of the Health and Safety at Work Act 1974: Duty of employer

General duties of employers to their employees

1 It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.
2 Without prejudice to the generality of an employer's duty under the preceding subsection, the matters to which that duty extends include in particular:
   (a) the provision and maintenance of plant and systems of work that are, so far as is reasonably practicable, safe and without risks to health;
   (b) arrangements for ensuring, so far as is reasonably practicable, safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances;
   (c) the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees;
   (d) so far as is reasonably practicable as regards any place of work under the employer's control, the maintenance of it in a condition that is safe and without risks to health and the provision and maintenance of means of access to and egress from it that are safe and without such risks;
   (e) the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.
3 Except in such cases as may be prescribed, it shall be the duty of every employer to prepare and as often as may be appropriate revise a written statement of his general policy with respect to the health and safety at work of his employees and the organisation and arrangements for the time being in force for carrying out that policy, and to bring the statement and any revision of it to the notice of all of his employees.

4 Regulations made by the Secretary of State may provide for the appointment in prescribed cases by recognised trade unions (within the meaning of the regulations) of safety representatives from among the employees, and those representatives shall represent the employees in consultations with the employers under subsection (6) below and shall have such other functions as may be prescribed.
5 (Repealed.)
6 It shall be the duty of every employer to consult any such representatives with a view to the making and maintenance of arrangements which will enable him and his employees to co-operate effectively in promoting and developing measures to ensure the health and safety at work of the employees, and in checking the effectiveness of such measures.
7 In such cases as may be prescribed it shall be the duty of every employer, if requested to do so by the safety representatives mentioned in subsections (4) and (5) above, to establish, in accordance with regulations made by the Secretary of State, a safety committee having the function of keeping under review the measures taken to ensure the health and safety at work of his employees and such other functions as may be prescribed.

Statute 12.2 Section 7 of the Health and Safety at Work Act 1974: Duty of employee

(a) to take reasonable care for the health and safety of himself and of others who may be affected by his acts or omissions at work.
(b) as regards any duty or requirement imposed on his employer or other person by or under any of the relevant statutory provisions to co-operate with him in so far as is necessary to enable that duty or requirement to be performed or complied with.

The duties set by the Health and Safety at Work Act 1974 are enforced through the criminal courts.

Abolition of Crown immunity

Health authorities used to enjoy protection from the enforcement provisions of much legislation on the grounds that, as Crown bodies, they were immune from prosecution. However, this immunity was removed by the National Health Service (Amendment) Act 1986 sections 1 and 2 in respect of the food legislation and Health and Safety at Work Act 1974. Some immunities were, however, retained under Schedule 8 of the Act, including Employer's Liability (Compulsory Insurance) Act 1969 (see page 319). Basildon and Thurrock University Hospital Trust was found guilty of health and safety offences after a patient died when his head became trapped in the bars of his bed.[2]

Powers of the health and safety inspector and Care Quality Commission

Health and safety inspectors employed by the Health and Safety Executive have extensive powers to ensure that health and safety duties are implemented. These powers are set out in section 20 of HASWA (see page 301). The inspector is able to issue improvement or prohibition notices that order the recipient to make equipment or premises safe or to cease a particular activity until the danger is removed. He also has the power to prosecute the authority in the magistrates' or Crown Court for a breach of the duties or regulations or failure to comply with the notice. In October 2007 in a prosecution brought by the Health and Safety Executive, a headmaster was fined £12,500 with legal costs of £7,500 following the death of a 3-year-old pupil who fell down unguarded steps. It was held there was inadequate supervision for the children at playtime.[3] However, his appeal to the Court of Appeal succeeded and his conviction was quashed.[4] The Court of Appeal held that the risk which the prosecution had to prove was a real risk as opposed to a fanciful or hypothetical risk. The fact that risk was a part of everyday

life went to the issue of whether the injured person was exposed to that risk by the conduct of the operation in question. The evidence suggested that there was no real risk of the kind statutorily contemplated. Unless it could be said that the child was exposed to a real risk by the conduct of the school, no question as to the reasonably practicable measures taken to meet risk arose. In another case,[5] a headmistress and four school staff were suspended after a boy died following an asthma attack in school (see chapter 23).

The Care Quality Commission (CQC) (formerly the Healthcare Commission) also has powers under the Health and Social Care (Community Health and Standards) Act 2003 section 53A (as added by the Health Act 2006 section 16) to issue improvement notices in respect of hygiene failings against with the standards set by the Secretary of State and the Code of Practice on hygiene (see chapter 26).

The House of Lords has held that in criminal prosecutions against an employer following an accident at work, it was sufficient for the prosecution to prove merely a risk of injury arising from a state of affairs at work, without identifying and proving specific breaches of duty by the employer. Once that was done, a *prima facie* case of breach was established. The onus then passed to the employer to make good the defence of reasonable practicability.[6]

Could an individual nurse be prosecuted?

Yes, under the Health and Safety at Work Act 1974 Section 7 (see Statute Box 12.2), which places a duty on all employees in respect of health and safety. First, a nurse who, for example, failed to follow the correct practice in disposing of pressurised cans as a result of which an incinerator blew up, injuring a porter, could be prosecuted for breach of her duty under section 7 of the Act. Second, the nurse as manager will have responsibilities in advising on and implementing the NHS trust's duties under the Act and if she neglects these she could also be prosecuted personally. In Practical Dilemma 12.1 the ward sister and others responsible for failing to undertake a risk assessment and basic precautions could be prosecuted under Section 7 of the 1974 Act and the employer could be prosecuted for breach of its duties under Section 2 of the 1974 Act (see Statute Box 12.1).

Practical Dilemma 12.1 Ward boiler

A ward kitchen has a water heater that is not fixed according to the regulations. The boiler is moved to a more convenient location. A lead from the boiler runs to a point a few feet away. A domestic trips over the lead, the boiler falls on her and she is severely scalded. The Health and Safety Inspectorate investigates and considers prosecuting the ward sister and others responsible.

It is also a criminal offence for any person to interfere with health and safety measures (see Statute Box 12.4).

General health and safety duty of employer to non-employees

Under section 3 of the 1974 Act, the employer has a general duty of care to persons not in his employment. The employer has a duty to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not exposed to risks to their health and safety. This duty would therefore cover patients, visitors and the general public. The Court of Appeal refused to allow an appeal against conviction of offences under sections 3(1) and 33(1)(a) of HASWA when a boy of 7 went with his father and younger brother to an indoor pool operated by the defendants. There was a notice saying that children under 8 should be accompanied by an adult. The boy could not swim and was not wearing armbands. He went to part of the pool near the deep end and was seen under water and rescued by a member of the public. He survived

but sustained severe brain damage. The pool owner argued that the accident had resulted from inadequate supervision by the boy's father: it was not the conduct of his undertaking which had exposed the boy to risk. However, the Court of Appeal held that the absence of parental supervision did not exonerate the defendant from responsibility. Absolute safety could not be guaranteed but what was required of the defendant was that the running of the swimming pool should be carried out in a way that ensured the safety, as far as was reasonably practicable, of all those who used it.[7] The implications of this case for paediatric wards and areas where children come with parents are obvious.

Statute 12.3 Section 20 of the Health and Safety at Work Act 1974

An inspector may, for the purpose of carrying into effect any of the relevant statutory provisions within the field of responsibility of the enforcing authority which appointed him, exercise the powers set out in subsection (2) below.

(i) The powers of an inspector referred to in the preceding subsection are the following, namely:

- **(a)** at any reasonable time (or, in a situation which in his opinion is or may be dangerous, at any time) to enter any premises which he has reason to believe it is necessary for him to enter for the purpose mentioned in subsection (1) above;
- **(b)** to take with him a constable if he has reasonable cause to apprehend any serious obstruction in the execution of his duty;
- **(c)** without prejudice to the preceding paragraph, on entering any premises by virtue of paragraph (a) above to take with him:
  - **(i)** any other person duly authorised by his (the inspector's) enforcing authority; and
  - **(ii)** any equipment or materials required for any purpose for which the power of entry is being exercised;
- **(d)** to make such examination and investigation as may in any circumstances be necessary for the purpose mentioned in subsection (1) above;
- **(e)** as regards any premises which he has power to enter to direct that those premises or any part of them, or anything therein, shall be left undisturbed (whether generally or in particular respects) for so long as is reasonably necessary for the purpose of any examination or investigation under paragraph (d) above;
- **(f)** to take such measurements and photographs and make such recordings as he considers necessary for the purpose of any examination or investigation under paragraph (d) above;
- **(g)** to take samples of any articles or substances found in any premises which he has power to enter, and of the atmosphere in or in the vicinity of any such premises;
- **(h)** in the case of any article or substance found in any premises which he has power to enter, being an article or substance which appears to him to have caused or to be likely to cause danger to health or safety, to cause it to be dismantled or subjected to any process or test (but not so as to damage or destroy it unless this is in the circumstances necessary for the purpose mentioned in subsection (1) above);
- **(i)** in the case of any such article or substance as is mentioned in the preceding paragraph, to take possession of it and detain it for so long as is necessary for all or any of the following purposes, namely:
  - **(i)** to examine it and do to it anything which he has power to do under that paragraph;
  - **(ii)** to ensure that it is not tampered with before his examination of it is completed;
  - **(iii)** to ensure that it is available for use as evidence in any proceedings for an offence under any of the relevant statutory provisions or any proceedings relating to a notice under section 21 or 22;
- **(j)** if he is conducting an examination or investigation under (d) to require any person . . . to answer any questions as the inspector thinks fit and to sign a declaration of the truth of his answers . . .
- **(k)** to require production of, inspect and take copies of any entry in any books or documents . . .
- **(l)** to require any person to afford himself such facilities and assistance within that person's control or responsibilities as are necessary for him to exercise his powers;
- **(m)** any other power which is necessary for the purpose of exercising any of the above powers.

Statute 12.4 Section 8 of the Health and Safety at Work Act 1974

No person shall intentionally or recklessly interfere with or misuse anything provided in the interest of health, safety or welfare in pursuance of any relevant statutory provisions.

The Court of Appeal has held[8] that, provided the employer has taken all reasonable care in laying down safe systems of work and ensuring that the employees had the necessary skill and instruction and were subject to proper supervision, with safe premises, plant and equipment, the employer was not guilty of an offence under section 3 of the 1974 Act if the employee were negligent and caused harm to others.

Safety Representatives and Safety Committees Regulations 1977 (SRSC)

These regulations brought into force the requirement in HASWA 1974 that employers should permit the safety representative appointed by the recognised trade union to inspect the workplace, get information held by the employer relating to health, safety or welfare and have paid time off for training and carrying out their functions. Each employer is required to set up a Health and Safety Committee to consider matters relating to health and safety. The Health and Safety Executive (HSE)[9] has published guidance for the Trade Union Congress known as the 'Brown Book' for training purposes.

Health and Safety (Consultation with Employees) Regulations 1996

These apply to those workplaces that are not covered by SRSC and require employers to consult with workers or their representatives on all matters relating to employees' health and safety. Guidance from the HSE is available on its worker involvement website.

Health and safety at work regulations

Regulations came into force on 1 January 1993 as a result of European Directives. These are shown in Box 12.1.

Box 12.1 Health and safety regulations that came into force on 1 January 1993

1 Management of Health and Safety at Work Regulations 1992 (updated 1999) (see page 303).
2 Provision and Use of Work Equipment Regulations 1992 (updated 1998).
3 Manual Handling Operations Regulations 1992 (as amended 2002) (see pages 329–34).
4 Workplace (Health, Safety and Welfare Regulations) 1992 (updated 1999).
5 Personal Protective Equipment at Work Regulations 1992 (updated 1999).
6 Health and Safety (Display Screen Equipment) Regulations 1992 (updated 1999).

The regulations shown in Box 12.1 are enforceable against all employers and employees (whether NHS or not). Many of these have now been updated and reissued. Codes of practice have been issued by the Health and Safety Commission. Failure to comply with the code is not in itself an offence, but can be used in evidence in criminal proceedings.

(For protection of the employee against dismissal in health and safety cases, see chapter 10.)

The Environmental Protection Act 1990 creates duties in relation to waste management.[10] Failure to comply with the waste management regulations could lead to prosecution, sanctions from the Care Quality Commission and professional conduct proceedings by the NMC. (See also the regulations relating to the disposal of sharps on page 313.)

Management of Health and Safety at Work Regulations 1999

These regulations require each employer to undertake a suitable and sufficient assessment of the risks to the health and safety of his employees. A code of practice has been approved in conjunction with these regulations.[11] This code does not have legal force, but has special legal status.

If an employer is prosecuted for a breach of health or safety law and it is proved that he did not follow the relevant provisions of the code, he will need to show that he has complied with the law in some other way or a court will find him at fault.

The guidance

The guidance emphasises that risk assessment must be a systematic general examination of work activity with a recording of significant findings rather than a *de facto* activity.

The definition of risk includes both the likelihood that harm will occur and its severity. The aim of risk assessment is to guide the judgement of the employer or self-employed person, as to the measures they ought to take to fulfil their statutory obligations laid down under the Health and Safety at Work Act 1974 and its regulations.

Suitable and sufficient is defined in the guidance as:

- able to identify the significant risks arising from or in connection with work
- able to identify appropriate sources of information and examples of good practice
- appropriate to the nature of the work and should identify the period of time for which it is likely to remain valid.

Recording

The 'record should represent an effective statement of hazards and risks which then leads management to take the relevant actions to protect health and safety'. It should be in writing, unless in computerised form, and easily retrievable. It should include:

1. a record of the preventive and protective measures in place to control risks
2. further action required to reduce risk sufficiently
3. proof that a suitable and sufficient assessment has been made.

Principles that apply in risk assessment

The following principles apply in risk assessment:

1. If possible avoid the risk altogether.
2. Evaluate risks that cannot be avoided by carrying out a risk assessment.
3. Combat risks at source rather than by palliative measures.
4. Adapt work to the requirements of the individual.
5. Take advantage of technological and technical progress.
6. Implement risk prevention measures to form part of a coherent policy and approach. This will progressively reduce those risks that cannot be prevented or avoided altogether and will take account of the way work is organised, the working conditions, the environment and any relevant social factors.
7. Give priority to those measures that protect the whole workplace and all those who work there, and so give the greatest benefit.
8. Ensure that workers, whether employees or self-employed, need to understand what they must do.

9 The existence of a positive health and safety culture should exist within an organisation. This means that avoidance, prevention and reduction of risk at work must be accepted as part of the organisation's approach and attitude to all its activities. It should be recognised at all levels of the organisation, from junior to senior management.

The Court of Appeal[12] held that the duty of the employer to provide a suitable and sufficient risk assessment under Regulation 3 of the Management of Health and Safety at Work Regulations 1999[13] and training for its employees under Regulation 9 of the Provisions and Use of Work Equipment Regulations 1998[14] imposed a higher standard than the common law duty which incorporated reasonable foreseeability. The claimant worked for London Underground first as a guard and then as a driver and developed tenosynovitis in her shoulder owing to the strain from the prolonged use of the traction brake controller, known as the dead man's handle. The employer had a duty to provide adequate training, which included a duty to investigate the risks inherent in its operations, taking professional advice where necessary. The right approach to deciding whether the training was adequate for health and safety purposes was to examine whether the risk assessment was suitable and sufficient.

In a case on the Provisions and Use of Work Equipment Regulations 1998 Regulation 4 and 5, the court had to decide if the council was responsible for a ramp.

Case 12.1 *Smith (Jean) v. Northamptonshire County Council* (2008)

Unsafe ramp[15]

The Court of Appeal held that an employer was not liable for a slip on another's ramp. Mrs Smith was employed by the council as carer/driver and collected a client in a wheelchair from her home. When pushing the chair down the ramp, which had been installed by the NHS, she stepped on the edge and it gave way.

The trial judge had held that Regulation 5 imposed strict liability on the council for maintaining the ramp as work equipment for use at work and found in favour of Mrs Smith. The Court of Appeal, however, allowed the Council's appeal and held that strict liability should only be imposed by clear language. For someone to have an obligation to maintain something it would normally have to be within his power to do so without obtaining someone else's consent. Strict liability should not flow out of a position in which there was no right and no responsibility to do that thing or insist on doing that thing for which strict liability was being imposed.

The claimant appealed to the House of Lords but lost her appeal.[16] The House of Lords, in a majority judgment, held that the test to be applied was whether the work equipment was incorporated into and adopted as part of the employer's undertaking. It could not be said that the ramp was either incorporated into or adopted as part of the council's undertaking or under their control. They did not provide it or own it or possess it. They did not have any responsibility or indeed any right without more to repair it.

The House of Lords[17] held that a door-closing device could be work equipment for the purposes of Regulation 2 of the Provision and Use of Work Equipment Regulations,[18] so that a mechanic who was injured while repairing such a device could bring proceedings against his employer.

The Court of Appeal has held that earlier good industrial practice is no defence and whether a workplace was in fact made and kept safe was to be judged objectively without reference to what might earlier have been thought to be good practice.[19] The claimants held that they had suffered hearing loss in a knitwear factory.

The Workplace (Health, Safety and Welfare) Regulations (SI 1992 No. 3004) were breached by an employer when an accident occurred when a school caretaker pushing a trolley hit a protruding paving slab. The council was held liable in damages since it was in breach of the regulations. The council could not plead as a defence that it was a freak accident.[20]

Risk management and the nurse

For the most part, the nurse would share common health and safety hazards with other hospital, community or social services employees and thus models of risk assessment and management that applied to other health professionals would also apply to nursing. Thus hazards relating to the safety of equipment, cross-infection risks, safe working practices or to violence at work would all apply to nurses who should be involved in the system of the assessment of risk.

Each nurse should therefore be able to carry out a risk assessment of health and safety hazards in relation to colleagues, clients, carers and the general public. (Manual handling and risk assessment is considered on pages 329–34.)

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), updated in 2012 and replaced in 2013

The regulations govern the reporting of injuries, diseases and dangerous occurrences. The 1985 regulations were replaced by new regulations that came into force on 1 April 1996.[21] There is now one set of regulations in place of the four sets under the 1985 regulations. The list of reportable diseases has been updated, as has the list of dangerous occurrences. It is legally possible for reports to be made by telephone to the Incident Contact Centre.[22] The 2013 lists specific injuries to workers which must be reported, replacing the major injury list of the 1995 regulations.[23]

Schedule 1 to the 2013 regulations lists the reporting and recording procedures Schedule 2 lists the dangerous occurrences that are reportable, Schedule 3 sets out the diseases reportable offshore.

Regulation 12 of RIDDOR 2013 lays down the requirements in relation to record keeping of reportable events or diseases. These records must be kept for at least three years from the date on which they were made. The records must contain the details set out in Schedule 1 (see Box 12.2).

Box 12.2 Contents of records kept under RIDDOR Schedule 1 Part 2

1. Date and time of the accident or dangerous occurrence.
2. Where accident suffered by a person at work: full name, occupation and nature of injury.
3. Where accident suffered by a person not at work: full name of person, status, nature of injury, unless these are not known and it is not reasonably practicable to ascertain them.
4. Place where the accident or dangerous occurrence happened.
5. Brief description of the circumstances in which the accident or dangerous occurrence happened.
6. Date on which the accident or dangerous occurrence was first notified or reported to the relevant enforcement authority.
7. Method by which the accident or dangerous occurrence was first notified or reported.

Schedule 1 part 2 also sets out the records required in the event of a reportable disease.

A record must be kept of any accident causing an injury which results in the worker being away from work or incapacitated for more than 3 days, but the incident does not have to be reported unless the incapacitation period exceeds 7 days.[24] Further guidance on RIDDOR 2013 is available on the HSE website.

National Patient Safety Agency (NPSA)

The National Patient Safety Agency (NPSA) was established in 2001 following a report, *An Organisation with a Memory*,[25,26] written by an expert group chaired by Professor Liam Donaldson, Chief Medical Officer, which had recommended setting up a national reporting system. The Expert Committee was

established in February 1999 with the brief to 'examine the extent to which the National Health Service and its constituent organisations have the capability to learn from untoward incidents and service failures so that similar occurrences are avoided in the future. To draw conclusions and make recommendations.' The aim of the new NHS mandatory reporting system was to log all failures, mistakes, errors and near misses in healthcare and to be in place before 2001. Since May 2006 all reporting organisations have been able to access their incident data and compare their profile with similar NHS organisations.

An alert issued by NPSA in March 2007 was concerned with safe practice with epidural injections and infusions.[27] The remit of the NPSA was extended in 2005 to include safety aspects of hospital design, cleanliness and food. It was also given the task of ensuring research was carried out safely through its responsibility for the National Research Ethics Service (NRES) (formerly the Central Office for Research Ethics Committees (COREC)). It was also responsible for the National Clinical Assessment Service (NCAS)[28] which is concerned with the performance of individual doctors and dentists and took over from NICE (see chapter 5) responsibility for the three confidential enquiries: into maternal death and child health; patient outcome and death; and suicide and homicide by persons with mental illness. Since April 2013 NCAS has been an operating division of the NHS Litigation Authority.[29]

An open culture within the NHS

The NPSA had as one of its objectives to promote an open and fair culture in the NHS, encouraging all healthcare staff to report incidents without undue fear of personal reprimand. In furtherance of this aim it issued in September 2005 a safer practice notice advising NHS organisations to put in place local policies to improve communication with patients who are unintentionally harmed by their treatment.[30] The NPSA has also enabled patients to report incidents directly to it via its website through its NRLS. NPSA has set up direct web links with complaints organisations in England, Scotland and Wales for patients wishing to make a complaint or get advice. A patient safety incident is defined as 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care'. The NPSA revised its guidance on being open in 2009.[31] Ten principles of being open are identified: acknowledgement; truthfulness, timeliness and clarity of communication; apology; recognising patient and carer expectations; professional support; risk management and systems improvement; multidisciplinary responsibility; clinical governance confidentiality; and continuity of care.

In August 2010 the Action against Medical Accidents reported on figures obtained from Freedom of Information requests that more than 1,200 NPSA patient safety alerts were still outstanding and that hospitals were putting patients' lives at risk by failing to comply with safety alerts on medicines, equipment, surgery and the risk of overdoses.[32]

The review of arm's-length bodies[33] in 2010 recommended that the NPSA should be abolished. Some functions would transfer to the NHS Board; the work of the Patient Safety Division should move to the NHS Commissioning Board; the National Clinical Assessment Service would continue initially but eventually become a self-financing body; the National Research Ethics Service should eventually become part of a single research regulatory body. The three confidential enquiries commissioned by the NPSA would become part of the National Clinical Audit Patient Outcome Programme managed on behalf of the Department of Health by the Healthcare Quality Improvement Partnership.

The Health and Social Care Act 2012 provided for the abolition of the NPSA, the transfer of its key functions and expertise for patient safety to the NHS Commissioning Board Special Health Authority (NHS England). Regulations implemented this change.[34] The transfer took place on 1 June 2012. Information relating to patient safety alerts and safety information on specific topics can be accessed on www.nrls.npsa.nhs.uk. The NHS Commissioning Board (now known as NHS England) uses the National Reporting and Learning System (NRLS) database for patient safety information.

On 31 January 2014 NHS England launched a new alerting system, the National Patient Safety Alerting System (NPSAS) to ensure that warnings of potential risks to the safety of patients can be developed much more quickly and be rapidly disseminated across the NHS. The new system replaces the patient safety alerts and the rapid response reports. There are 3 stages: A stage 1 warning alert; a

stage 2 resource alert if the stage 1 warning requires further action and a stage 3 directive alert requiring organisations to confirm that they have undertaken specific actions and introduced specific processes to mitigate the risk.

The Health and Social Care Information Centre publishes an NHS Safety Thermometer providing figures on patient harms and harm free care. It concentrates on pressure ulcers, falls, urinary tract infections and venous thromboembolisms. The report is available from the HSCIC website.[35]

Protection of employees who report health and safety hazards

Additional protection for staff who report health and safety hazards has been given by the Trade Union Reform and Employment Rights Act 1993 against dismissal in health and safety cases and was consolidated in the Employment Rights Act 1996 (see chapter 10). The Public Interest Disclosure Act 1998 was intended to strengthen protection given to employees who report health and safety hazards. (This is considered in chapter 4 under whistleblowing.)

Occupiers' Liability Acts 1957 and 1984

General principles

If a nurse is injured as a result of the state of the premises, she may be able to bring an action against the occupier who has a duty under the Occupiers' Liability Act 1957 to ensure that the premises are safe. The statutory duty is set out below. The occupier's duty to trespassers comes under the Occupiers' Liability Act 1984, which is considered below.

Statute 12.5 Sections 2(1) and (2) of the Occupiers' Liability Act 1957

Section 2(1) An occupier of premises owes the same duty, the 'common duty of care', to all his visitors, except in so far as he is free to and does extend, restrict, modify or exclude his duty to any visitor or visitors by agreement or otherwise.

Section 2(2) The common duty of care is a duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there.

The duty under the Occupiers' Liability Act is owed to the visitor. This term 'visitor' includes the person who has express permission to be on the premises as well as the person who has implied permission to be there. Thus in the hospital context, the term 'visitors' will include employees, patients, friends and relatives visiting patients, contractors and suppliers and others who have a genuine interest in being there. If any of these persons were to be injured, for example, when plaster fell off the wall, they could claim compensation from the occupier.

Who is the occupier?

The occupier is the person who has control over the premises. This will usually be the owner of the premises, but not necessarily. There could be several occupiers, each having control over the premises and responsibilities for the safety of the building. For example, contractors might be working on hospital premises and both the NHS trust and the contractor could be regarded as occupiers for the purpose of the Act. A private house visited by a community nurse may be owner-occupied, in which case that person will be the occupier for the purposes of the Act. Alternatively, it could be under a

tenancy agreement, in which case the landlord and the tenant will have different duties under this agreement regarding the upkeep and maintenance of the premises and could therefore be regarded as occupiers under the statutory provisions. Which occupier is liable for harm to a visitor will therefore depend on the cause of the injury.

Case 12.2 *Slade v. Battersea HMC* (1955)

Slippery floor[36]

A visitor slipped on polish that had been put on the floor but not wiped off, which left the floor excessively slippery.

The visitor succeeded in obtaining compensation for the harm. The occupier had failed to take reasonable care for the safety of the visitor. (This was a case decided before the 1957 Act, but the result would be the same after 1957.) In a more recent case,[37] a woman sustained personal injuries when, late at night, she fell down a flight of stairs leading to a public lavatory for which the local authority (LA) was responsible. The premises were locked and the stairway was unlit. She admitted that she had drunk a relatively small amount of alcohol. She sued the LA on the grounds that they were occupiers of the premises and owed a duty of care to her. She lost the case on the grounds that she had voluntarily accepted the risk of injury by using the stairs in the darkness (*volenti non fit injuria* – see chapter 6, pages 145–6) and without taking proper care for her own safety. Further, the evidence from the A&E department showed that she had consumed a greater amount of alcohol than she had admitted in evidence. Even if the court were wrong on the voluntary assumption of risk, she would be contributorily negligent to a high degree.

Statute 12.6 Section 2(4)(a) of the Occupiers' Liability Act 1957

Section 2(4)(a) In determining whether the occupier of premises has discharged the common duty of care to a visitor, regard is to be had to all these circumstances, so that (for example): where damage is caused to a visitor by a danger of which he had been warned by the occupier, the warning is not to be treated without more as absolving the occupier from liability, unless in all the circumstances it was enough to enable the visitor to be reasonably safe.

What is the effect of a warning notice?

Section 2(4)(a) of the Occupiers' Liability Act 1957 is set out in Statute Box 12.6. The warning is not conclusive: if compliance with it is sufficient to prevent any harm to the visitor, then it will be effective as a defence in an action under the 1957 Act.

Practical Dilemma 12.2 Warning

An NHS trust is undertaking major renovation work to a corridor and puts up a warning notice saying 'Danger'. As a nurse walks along, she is struck by a piece of plaster falling from the ceiling.

If there were other precautions that the NHS trust could reasonably have taken, e.g. a safety net cordoning off the work area, then the NHS trust would probably be seen to have been in breach of its duty of care to the visitor subject to the possibility of contributory negligence by her. If, contrariwise, the notice said, 'Corridor closed – diversion' and indicated a different route that was practicable, then the occupier would have satisfied the duty under the Act. If, of course, the nurse ignored the notice, continued along the dangerous corridor and was injured, then it is probable that there would be no breach of duty by the NHS trust, since the notice was in all the circumstances enough to enable the nurse to be reasonably safe.

Independent contractors

Where independent contractors are brought on to site, the usual occupier or owner of the premises will not normally be liable for their safety (see Statute Box 12.7).

Privatisation of cleaning and catering services

What is the effect of the privatisation of services on the occupier's liability? Privatisation may lead to some complications, since where services are contracted out, there is likely to be dual occupation of premises, i.e. by the NHS trust and by the private company. Thus in the case of a contract for cleaning services, if an injury is caused to a visitor by the conditions of the premises, e.g. an uneven surface or falling plaster and the NHS trust has retained responsibility for such conditions, then the NHS trust would be responsible for the visitor's injuries. If, by way of contrast, the injuries were caused by the carelessness of any of the contractor's employees, then the contractor would be responsible for compensating the person injured as a result of the negligence under the principles of vicarious liability previously discussed in chapter 4. If, therefore, the employee of the cleaning firm has left the floor in a dangerous state and there are no warning notices and a nurse is injured as a consequence, she would sue the cleaning company because its employee had been negligent in the course of employment and had caused her foreseeable harm.

Statute 12.7 Section 2(4)(b) of the Occupiers' Liability Act 1957

Section 2(4)(b) When damage is caused to a visitor due to the faulty execution of any work of construction, maintenance or repair by an independent contractor employed by the occupier, the occupier is not to be treated without more as answerable for the danger, if in all the circumstances he had acted reasonably in entrusting the work to an independent contractor and had taken such steps (if any) as he reasonably ought in order to satisfy himself that the contractor was competent and that the work had been properly done.

Liability for children under the Occupiers' Liability Act 1957

It is expressly provided that all the circumstances must be taken into account in deciding whether the occupier is in breach of his duty of care under the Act (see Statute Box 12.8). The occupier can expect a lower standard of care from children and therefore additional precautions have to be taken where the presence of children can be foreseen.

Statute 12.8 Section 2(3) of the Occupiers' Liability Act 1957

Section 2(3) The circumstances relevant for the present purpose include the degree of care, and of want of care, which would ordinarily be looked for in such a visitor, so that (for example) in proper cases: an occupier must be prepared for children to be less careful than adults.

Case 12.3 *Jolley v. Sutton LBC* (2000)

Playing about on a boat[38]

Sutton Borough Council were the owners and occupiers of the common parts of a block of council flats. A boat with trailer was brought on to the land and abandoned on a grass area where children played. The boat became derelict and rotten. The council put a notice on the boat that said: 'Do not touch this vehicle unless you are the owner.' Some boys planned to repair it in the hope that they could take it to Cornwall. They swivelled it round and lifted the bows on to the trailer so as to be able to get under the boat to repair the hull. They jacked the bows of the boat up. The boat fell on to the claimant, a boy of 14, as he lay underneath it attempting to repair and paint it. He sustained serious spinal injuries and became paraplegic.

The High Court judge awarded the claimant £633,770, taking into account contributory negligence of 25 per cent for the injuries he sustained. However, the Court of Appeal found in favour of the defendant since, although it was reasonably foreseeable that injuries could have occurred from playing on the boat, the injuries sustained were not reasonably foreseeable and therefore the defendants were not liable for them. The Council had not disputed that it was negligent, but argued that it was not liable because the accident was of a different kind from anything that it could have reasonably foreseen. The claimant appealed to the House of Lords, which upheld the appeal. The House of Lords held that ingenuity of children in finding unexpected ways of doing mischief to themselves and others should not be underestimated. Reasonable foreseeability was not a fixed point on the scale of probability. The Council was liable under the Occupiers' Liability Act 1957 and under section 2(3) had to take into account the fact that children would be less careful than adults. The Council had admitted that it should have removed the boat and the risk that it should have taken into account was that children would meddle with the boat and injuries would thereby occur.

Clearly, following this judgment, liability depends on how the risk is framed.

Trespassers and Occupiers' Liability Act 1984

The Occupiers' Liability Act 1957 does not cover any duty towards trespassers. The courts recognised a limited duty of the occupier towards trespassers, particularly children, but subsequently statutory provision was made in the Occupiers' Liability Act 1984. Whether or not a duty is owed by the occupier to trespassers, in relation to risks on the premises, depends on the following factors (s. 1(3)):

- if the occupier is aware of the danger or has reasonable grounds to believe that it exists
- if the occupier knows or has reasonable grounds to believe that the other is in the vicinity of the danger concerned or that he may come into the vicinity of the danger (in either case, whether the other has lawful authority for being in that vicinity or not)
- the risk is one against which, in all the circumstances of the case, he may reasonably be expected to offer the other some protection.

In applying these factors to decide if a duty is owed to a trespasser, it would be rare for a duty to be owed to an adult. There is, however, more likely to be a duty owed to a child trespasser. For example, on hospital premises, if a child is expressly told that he may not go through a particular door or into another section of the hospital and he disobeys those instructions, then he becomes a trespasser for the purposes of the Occupiers' Liability Acts. It is likely that a duty would then arise under the 1984 Act.

Nature of the duty owed to trespassers

Once it is held that a duty of care is owed to a trespasser, section 1(4) of the 1984 Act defines the duty as shown in Statute Box 12.9.

Statute 12.9 Duty of care to a trespasser under section 1(4) 1984 Act

'The duty is to take such care as is reasonable in all the circumstances of the case to see that he does not suffer injury on the premises by reason of the danger concerned.'

The duty can be discharged by giving warnings, but in the case of children, these may have limited effect and depend on the age of the child.

The occupier has the right to request a person to leave the premises and if that person fails to leave he or she then becomes a trespasser and the occupier can use reasonable force in removing the trespasser. This rule does not apply to a motor vehicle.[39]

The nurse and premises in the community

Where a nurse is visiting private homes, the occupier may be the owner of the house who is also in occupation or the occupier may be a tenant. If the nurse is injured on the premises, it will depend on how the injury occurred as to who would be liable: thus, if she is injured as the result of a frayed rug, the person in occupation, whether tenant or owner, would be liable; if she were injured as a result of a structural defect, then the owner or landlord would be liable depending on the nature of the tenancy agreement.

The occupier has the right to ask any visitor to leave the premises. Should the visitor fail to leave, then she becomes a trespasser and the occupier can use reasonable force to evict the trespasser. If, therefore, the nurse should be asked by a client or carer to leave, she should go. Should she be concerned for the well-being of the client, she should ensure that social services are notified so that appropriate action can be taken under the Care Act 2014 or the Mental Health Act 1983. Where there is a clash between carer and client and the former asks her to leave and the latter for her to stay, the nurse has to decide on the basis of the specific circumstances: the rights of the client to occupation as compared with those of the carer and the specific needs of the client. Where she considers it prudent to leave the premises, she must discuss with her manager how best the client's needs can be met.

Consumer Protection Act 1987

Product liability

The Consumer Protection Act 1987 enables a claim to be brought where harm has occurred as a result of a defect in a product. It is a form of strict liability in that negligence by the defendant does not have to be proved. The Consumer Protection Act 1987 (Part 1), which came into force on 1 March 1988, gives a right of compensation against the producers and suppliers of products if a defect in the product has caused personal injury, death, loss or damage to property, without the requirement of showing that the defendant was at fault. This was introduced into this country following a European Directive dated 25 July 1985 (No. 85/3741/EEC). The Act applies to the Crown. The NHS trust itself could be a defendant in a product liability action since it is a producer of many products; it could also be liable as a supplier.

A product is defined as meaning any goods or electricity and includes a product that is comprised in another product, whether by virtue of being a component part or raw material or otherwise.

Defect

The definition of defect is shown in Statute Box 12.10. The defendant can rely on the fact that the state of scientific knowledge at the time was such that the defect could not have been discovered (i.e. 'the state of the art' defence or that the state of scientific and technical knowledge at the time the goods were supplied was not such that the producer of products of that kind might be expected to have discovered the defect).

Statute 12.10 Sections 3 and 4 of the Consumer Protection Act 1987

3 (1) Subject to the following provisions of this section, there is a defect in a product for the purposes of this part if the safety of the product is not such as persons generally are entitled to expect; and for those purposes 'safety', in relation to a product, shall include safety with respect to products comprised in that product and safety in the context of risks of damage to property, as well as in the context of risks of death or personal injury.

(2) In determining for the purposes of subsection (1) above what persons generally are entitled to expect in relation to a product all the circumstances shall be taken into account, including:

(a) the manner in which, and purposes for which, the product has been marketed, its get-up, the use of any mark in relation to the product and any instructions for, or warnings with respect to, doing or refraining from doing anything with or in relation to the product;

(b) what might reasonably be expected to be done with or in relation to the product; and

(c) the time when the product was supplied by its producer to another; and nothing in this section shall require a defect to be inferred from the fact alone that the safety of a product which is supplied after that time is greater than the safety of the product in question.

4 (1) In any civil proceedings by virtue of this part against any person ('the person proceeded against') in respect of a defect in a product it shall be a defence for him to show:

(a) that the defect is attributable to compliance with any requirement imposed by or under any enactment or with any Community obligation; or

(b) that the person proceeded against did not at any time supply the product to another; or

(c) that the following conditions are satisfied, that is to say:

(i) that the only supply of the product to another by the person proceeded against was otherwise than in the course of a business of that person's; and

(ii) that Section 2(2) above does not apply to that person or applies to him by virtue only of things done otherwise than with a view to profit; or

(d) that the defect did not exist in the product at the relevant time; or

(e) that the state of scientific and technical knowledge at the relevant time was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his products while they were under his control; or

(f) that the defect

(i) constituted a defect in a product ('the subsequent product') in which the product in question has been comprised; and

(ii) was wholly attributable to the design of the subsequent product or to compliance by the producer of the product in question with instructions given by the producer of the subsequent product.

How does product liability affect the nurse?

Practical Dilemma 12.3 Needle injury

A nurse is giving an injection to a patient when the needle snaps and she is injured.

Under the Consumer Protection Act 1987, the nurse would need to discover from the supplier of the needle in the NHS trust (probably the CSSD) the producer of that particular needle. The supplier has a duty under section 2(3) to inform her of the name of the producer who will then be strictly liable to the nurse for causing her harm. If the CSSD is unable to provide her with that information, the CSSD could itself be liable to her. The nurse herself would have to show that there was a defect in the needle, i.e. that the safety was not such as persons generally are entitled to expect. This is defined in section 3(2) as including the manner in which and purpose for which the product has been marketed, the instructions and warnings accompanying

it and what might reasonably be expected to be done with or in relation to it at the time it was supplied. In addition, the nurse has a remedy under the Employer's Liability (Defective Equipment) Act 1969 (see page 320). The nurse should also ensure that an adverse notice about the needles is made to the Medicines and Healthcare Products Regulatory Agency (see page 315). An EU Directive[40] led to the introduction of regulations relating to sharp instruments in healthcare which came into force on 11 May 2013.[41] These require healthcare employers and contractors to follow rules relating to the use and disposal of medical sharps including the duty to ensure that the use of medical sharps at work is avoided so far as is reasonably practicable. The regulations also cover information and training, arrangements in the event of an injury,

In a Scottish case a driver was awarded £3,500 following a needle stick injury sustained during waste collection. The employers were found to be in breach of the Personal Protective Equipment at work Regulations 1992.[42]

Consumer protection

New legislation to give consumer greater rights has been criticised on the grounds that inconsistencies within the draft Consumer Rights Bill will prevent it from simplifying and modernising consumer law.[43] A report by the National Consumer Council[44] in November 1995 recommended that consumers should be assisted in using their rights under the Consumer Protection Act 1987 and the Consumer Rights Bill should support, when enacted, consumers further.

Timing

There is a 10-year time limit from the date of the supply of the product. The individual plaintiff must bring the action within three years of suffering the harm or having knowledge of the relevant circumstances. The Supreme Court refused to allow the substitution of the parent company more than 10 years after the product was circulated in a case where it was argued that a defect in the vaccine had caused brain damage.[45]

Naming the producer

What if the NHS trust department that supplied the goods cannot name the producer? The person who suffered the harm must ask the supplier to identify the producer or importer of the product in the EU and must make that request within a reasonable period after the damage has occurred and at a time when it is not reasonably practicable for the person making the request to identify those persons. If the health department supplying the goods fails to comply within a reasonable period after receiving the request, then the claimant is entitled to recover damages from the supplying department. All departments in an NHS trust that supply products to persons who suffer damage from them could thus become liable: the supplies department, pharmacy, cleaning, catering, CSSD, office equipment, works and buildings.

The implications of this are that department records must be sufficiently comprehensive and clear to provide the appropriate information to the person injured by the defect, in order that the claim can be made against the actual producer of the product rather than the supplier.

The nurse as supplier

Could the nurse ever be a supplier? In the course of her duty, a nurse certainly supplies many products to patients, other staff, visitors and contractors: drugs, food/drink, equipment, syringes, etc. Could she be a supplier for the purposes of this Act?

Practical Dilemma 12.4 Supplying defective products

The nurse gives a patient a high-protein food to take home with him, which is defective, e.g. it has glass in it, and the patient is injured.

In most similar circumstances, it will be clear to the person suffering harm who the producers or trademark user are and it will therefore be reasonably practicable for the person suffering harm to identify the potential defendant. In other cases, the nurse will have obtained the goods from another department in the hospital, which would become the supplier for the purposes of the Act.

Product liability (Consumer Protection Act 1987) and the Employer's Liability (Defective Equipment) Act 1969

The right of the employee to claim from the employer under the 1969 Act (see page 320) is unaffected by the provisions of the 1987 Act. Clearly, any person who has been injured by a defective product can use whichever remedy is likely to be most successful and in fact can bring an action using several different causes of action. The relationship between these two Acts is as follows:

1 The injured employee can obtain compensation from the employer under the 1969 Act only if there has been negligence by a third party.
2 The injured employee can obtain compensation from the employer as supplier only if he has not identified the producer under the 1987 Act.
3 The 1987 Act covers all persons suffering damage, i.e. patients, employees, visitors, etc. The 1969 Act relates only to employees.
4 The 1987 Act covers damages in the form of personal injury, death, loss or damage to property; the 1969 Act covers only loss of life, impairment of a person's physical or mental condition and any disease, not loss or damage to property.
5 Fault need not be established under the 1987 Act – only a defect in the product. However, the defence of what is known at the time is available.

Defences

Certain defences are available under section 4, which are shown in Statute Box 12.10 on page 312.

What damage must the claimant establish?

Compensation is payable for death, personal injury or any loss of or damage to any property (including land) (s. 5(1)). The loss or damage shall be regarded as having occurred at the earliest time at which a person with an interest in the property had knowledge of the material facts about the loss or damage (s. 5(5)). Knowledge is further defined in section 5(6) and (7).

There have been few examples of actions being brought under the Consumer Protection Act 1987 in healthcare cases and only a handful of cases brought under it have been reported. One reported in March 1993[46] led to Simon Garratt being awarded £1,400 against the manufacturers of a pair of surgical scissors that broke during an operation on his knee, with the blade being left embedded. A second operation was required to remove it. Had he relied on the law of negligence to obtain compensation, he would have had to show that the manufacturers were in breach of the duty of care that they owed to him. Under the Consumer Protection Act 1987, he had to show the harm, the defect and the fact that it was produced by the defendant.

In a case in 2001,[47] it was held that a claim brought under the Consumer Protection Act 1987 in respect of the infection by patients with hepatitis C contracted from blood and blood products used in blood transfusions could succeed. This decision may well lead to greater use of the Consumer Protection Act 1987 if personal injuries are caused, since negligence does not have to be established under the Act, only that there was a defect in the product that has caused the harm.

The General Product Safety Regulations 1994 require producers and distributors to take steps to ensure that the products they supply are safe, that they provide consumers with relevant information and warnings, and that they keep themselves informed about risks. The Consumer Protection (Distance Selling) Regulations 2000 provide protection for the consumer where contracts are made on the internet, through digital TV, by mail order, by phone or fax.

Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA was established in April 2003 as an executive agency of the Department of Health and took over the functions formerly carried out by the Medical Devices Agency (MDA) and the Medicines Control Agency. It can be accessed via its website.[48] This section looks at its role in medical devices. (Consideration of its role in medicines can be seen in chapter 28.)

Medical devices

The MDA (now superseded by the MHRA) was established to promote the safe and effective use of devices. In particular its role was to ensure that whenever a medical device is used, it is:

1 suitable for its intended purpose
2 properly understood by the professional user
3 maintained in a safe and reliable condition.

What is a medical device? Annex B to Safety Notice 9801 gives examples of medical devices.[49] It covers the following.

1 Equipment used in the diagnosis or treatment of disease, and the monitoring of patients, e.g. syringes and needles, dressings, catheters, beds, mattresses and covers, physiotherapy equipment.
2 Equipment used in life support, e.g. ventilators, defibrillators.
3 *In vitro* diagnostic medical devices and their accessories, e.g. blood gas analysers. (Regulations came into force in 2000 on *in vitro* diagnostic devices.)
4 Equipment used in the care of disabled people, e.g. orthotic and prosthetic appliances, wheelchairs and special support seating, patient hoists, walking aids, pressure care prevention equipment.
5 Aids to daily living, e.g. commodes, hearing aids, urine drainage systems, domiciliary oxygen therapy systems, incontinence pads, prescribable footwear.
6 Equipment used by ambulance services (but not the vehicles themselves), e.g. stretchers and trolleys, resuscitators.
7 Other examples of medical devices, including: condoms, contact lenses and care products, intrauterine devices.

Regulations[50] require that from 14 June 1998 medical devices placed on the market (made available for use or distribution even if no charge is made) must conform to 'the essential requirements', including safety required by law and bear a CE marking as a sign of that conformity. Although most of the obligations contained in the Regulations fall on manufacturers, purchasers who are positioned further down the supply chain may also be liable – for example, for supplying equipment which does not bear a CE marking or which carries a marking liable to mislead people.[51]

The CE marking is the requirement of the EC Directive on medical devices.[52] The manufacturer that can demonstrate conformity with the regulations is entitled to apply the CE marking to a medical device.

The essential requirements include the general principle that:

> **A device must not harm patients or users, and any risks must be outweighed by benefits. Design and construction must be inherently safe, and if there are residual risks, users must be informed about them. Devices must perform as claimed, and not fail due to the stresses of normal use. Transport and storage must not have adverse effects. Essential requirements also include prerequisites in relation to the design and construction, infection and microbial contamination, mechanical construction, measuring devices, exposure to radiation, built-in computer systems, electrical and electronic design, mechanical design, devices which deliver fluids to a patient, function of controls and indicators.**

The Medical Devices Directives of the EU were consolidated in regulations in 2002[53] and amended in 2007.[54] Part II of the 2002 regulations sets out the requirements for general medical devices; Part III

covers active implantable medical devices and Part IV covers *in vitro* diagnostic medical devices. The regulations were amended in 2003 to cover the reclassification of breast implants,[55] in 2007 to cover the reclassification of total hip, knee and shoulder joints[56] in 2008[57] and in 2012.[58] The regulations are available on the UK legislation website.[59]

Exceptions to the regulations include:

1 Devices made especially for the individual patient ('custom made'). (Guidance note No. 9 of the MHRA covers this.)
2 Devices made by the organisation ('legal entity') using them. (Bulletin 18 of the MHRA gives guidance on such items.)

Non-CE-marked medical devices undergoing clinical investigation are now covered by the 2002 regulations and require approval from the MHRA and guidance is provided on its website.

The MHRA (formerly the MDA) has powers under the Consumer Protection Act 1987 to issue warnings or remove devices from the market.

Devices are divided into three classes according to possible hazards, Class 2 being further sub-divided. Thus Class 1 has a low risk, e.g. a bandage; Class 2a has a medium risk, e.g. simple breast pump; Class 2b has a medium risk, e.g. ventilator; Class 3 has a high risk, e.g. intra-aortic balloon.

Any warning about equipment issued by the MHRA should be acted on immediately. Notices from the Agency are sent to regional general managers, chief executives of HAs and NHS trusts, directors of social services, managers of independent healthcare units and rehabilitation service managers. Failure to ensure that these notices are obtained and acted on could be used as evidence of failure to provide a reasonable standard of care. Guidance on the management of medical devices for use by hospitals and community-based organisations (including social services) was issued in 2006.[60] The topics covered include: monitoring/audit; reporting adverse incidents; acquiring the most appropriate device; acceptance procedures for newly delivered devices; maintenance and repair; training; adequacy of manufacturer instructions disposal and legal liability. In February 2004 the MHRA issued a warning about equipment misuse. Doctors and nurses had carried out procedures with improvised equipment which had resulted in cases where two infants had died after a wooden tongue depressor was used as a splint, and led to an infection. In another case the wrong kind of cot sides were fitted to a bed, leading to the death of an elderly patient from asphyxiation.[61]

Adverse incident reporting procedures

The Device Bulletin issued in 2006 covers adverse incident reporting procedures. Minor faults or discrepancies should also be reported to the MHRA. The website home page of the MHRA gives advice on reporting methods which can be online, or by email, post, fax or telephone.[62]

In 2014 the MHRA and NHS England worked together to simplify adverse incident reporting. Further information on patient safety alert on improving medical device incident reporting and learning can be found on the website.[63] The intitiative also covers alerts about medication errors (see chapter 28).

Liaison officer

The MHRA recommends that each healthcare organisation should appoint a medical devices management group which should include the MHRA medical device liaison officer to ensure that adverse incident reporting and MHRA information and advice are implemented. Specialist subgroups may be needed to make recommendations to this group. The liaison officer should have the necessary authority to:

1 ensure that procedures are in place for the reporting of adverse incidents involving medical devices to the MHRA
2 act as the point of receipt for MHRA publications
3 ensure dissemination within their own organisation of MHRA publications
4 act as the contact point between the MHRA and their organisation.

Single-use items

Where a supplier has labelled its product 'single use', then the official advice is that it should not be reprocessed and reused unless the reprocessor is able to ensure the integrity and safety in use of each reprocessed item and there is clear evidence of the effectiveness of the reprocessing operation.[64]

A pushchair company, Maclaren, paid compensation to more than 40 British children who suffered injuries in their buggies, with payments of between £25,000 and £10,000 depending on the severity of the injury. Maclaren stated that the agreement to pay out compensation was not an admission of liability but that it took children's safety very seriously.[65]

Control of Substances Hazardous to Health 2002

The Control of Substances Hazardous to Health (COSHH) Regulations 1988 came into effect in 1989 and were replaced by amended regulations in 1996. New regulations came into force in November 2002,[66] replacing the 1999 regulations in order to comply with the EC Chemical Agents Directive, which set more detailed rules of compliance. The HSE has set up a COSHH website to provide guidance for employers[67] and has provided a brief guide to the regulations.[68] This guide sets out the eight stages of a COSHH assessment, which are shown in Box 12.3.

The regulations aim to control activities where exposure to substances could lead to disease or ill health, i.e. substances that are toxic, harmful, corrosive or irritant; the regulations also cover those that have delayed effects or are hazardous in conjunction with other substances. The employer must assess the risks and take appropriate action, e.g. providing protective clothing, information and training of staff. All health workers have responsibilities under the regulations relating to the Control of Substances Hazardous to Health. The nurse who uses different substances in her work should be specifically alert to the need to ensure that the regulations are implemented. New maximum exposure limits have been introduced. Further details of the regulations and guidance can be obtained from the Health and Safety Executive or from the COSHH website.

There must be clarity over who has the responsibility of carrying out the assessment. The guidance emphasises the importance of involving all employees in the assessment.

All potentially hazardous substances must be identified: these will include domestic materials such as bleach, toilet cleaner, window cleaner and polishes; office materials such as correction fluids as well as the medicinal products in the treatment room and materials and substances used in nursing.

Box 12.3 Stages in COSHH assessment

1. Work out what hazardous substances are used in your workplace and find out the risks from using these substances to people's health.
2. Decide what precautions are needed before starting work with hazardous substances.
3. Prevent people being exposed to hazardous substances, but where this is not reasonably practicable, control the exposure.
4. Make sure control measures are used and maintained properly and that safety procedures are followed.
5. If required, monitor exposure of employees to hazardous substances.
6. Carry out health surveillance where your assessment has shown that this is necessary or where COSHH makes specific requirements.
7. If required, prepare plans and procedures to deal with accidents, incidents and emergencies.
8. Make sure employees are properly informed, trained and supervised.

An assessment has to be made as to whether each substance could be inhaled, swallowed, absorbed or introduced through the skin or injected into the body (such as by needle).

The effects of each route of entry or contact and the potential harm must then be identified.

There must then be an identification of the persons who could be exposed and how.

Once this assessment is complete, decisions must be made on the necessary measures to be taken to comply with the regulations and who should undertake the different tasks. In certain cases, health surveillance is required if there is a reasonable likelihood that the disease or ill effect associated with exposure will occur in the workplace concerned. Nurses should be particularly vigilant about any substances used in their activities, including cleaning fluids, and ensure that a risk assessment is undertaken and its results implemented.

Managers should ensure that the employees are given information, instruction and training.

Records should show the results of the assessment, what action has been taken and by whom, and regular monitoring and review of the situation.

Corporate manslaughter and corporate homicide

As a consequence of the Corporate Manslaughter and Corporate Homicide Act 2007 it is possible for an organisation to which the Act applies to be prosecuted in the case of a death under both Health and Safety legislation and the 2007 Act. The jury can be instructed to find the accused organisation guilty of both offences. An organisation can be found guilty of an offence under the 2007 Act only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach of duty of care owed by the organisation. Senior management means the persons who play significant roles in (i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or (ii) the actual managing or organising of the whole or a substantial part of those activities (see chapter 2, pages 34–5).

Common law duties: employer's duty

Direct duty of care for safety of the employee

Duty of the employer as an implied term of the contract of employment

As was seen in chapter 10, some of the terms in the contract of employment are implied by the law. These include the obligation of the employer to safeguard the health and safety of the employee by employing competent staff, setting up a safe system of work and maintaining safe premises, equipment and plant. The employee must obey the reasonable instructions of the employer and take reasonable care in carrying out the work. Thus the employee may have a claim for breach of contract by the employer if she has been injured as a result of failures on the employer's part in not providing the appropriate training or equipment. The employer's duty at common law is set out in Box 12.4.

Box 12.4 Employer's direct duty of care

At common law, the employer has an implied term in the contract of employment to look after the safety of the employee:

1 to ensure the premises, plant and equipment are safe
2 to provide competent staff
3 to establish a safe system of work.

The employer's duty at common law to take reasonable care to safeguard the employees against the reasonably foreseeable possibility of harm arising from work-related disorders is paralleled by the duties laid down in the Health and Safety at Work Act 1974 and under the regulations relating to Manual Handling, the Management of Health and Safety at Work, Display Screen Equipment and the other regulations discussed above. Where several employers are involved in causing harm to an employee the House of Lords ruled, in a case where employees alleged that asbestos had caused mesothelioma, that liability was several only, i.e. each defendant employer was only responsible for its own contribution to the claimant's injuries.[69] This led to the Compensation Act 2006 which states that liability in such circumstances is joint and several and the Act has retrospective effect.

Effect of failures by the employer

Failure by the employer to take reasonable care of the health, safety or welfare of the employee could result in the following actions by the employee.

1. Action for breach of contract of employment.
2. Action for negligence, where the employee has suffered harm.
3. Application in the employment tribunal for constructive dismissal, if it can be shown that the employer is in fundamental breach of the contract of employment.

It was reported in July 2014 that a care assistant had been murdered by a patient at Wotton Lawn Hospital in Gloucester, an acute mental health unit. An inquiry should eventually establish to what extent, if any, the employer is to blame.[70]

Examples of cases brought in relation to the employer's duty of care at common law are given in Cases 12.5 and 12.6, relating to stress and manual handling, respectively.

There is an overlap between the direct duty of care of the employer for the safety of the employee and the duty of the employer as occupier under the Occupiers' Liability Act 1957. Thus in a case where a nurse is injured as a result of defects in the NHS trust's premises, she may have a cause of action under the Occupiers' Liability Act and also because of breach of the employer's common law duty to care for the employee.

Statute 12.11 Employer's Liability (Compulsory Insurance) Act 1969

Every employer carrying on any business in Great Britain shall insure against liability for bodily injury or disease sustained by his employees and arising out of and in the course of their employment.

'Business' includes a trade or profession and includes any activity carried out by a body of persons, whether corporate or unincorporate. There is a penalty for failure to insure.

Insurance by the employer

The Employer's Liability (Compulsory Insurance) Act 1969 obliges all non-Crown employers to be covered by an approved policy of insurance against liability for bodily injury or disease sustained by an employee and arising out of and in the course of employment. By section 60 of the NHS and Community Care Act 1990, health authorities ceased to enjoy Crown immunity. However, Schedule 8 of the Act preserves immunity from this Act for health authorities and NHS trusts. The employers of a nurse working in the private sector or a practice nurse working for general practitioners are, however, bound by the Act.

Defective equipment

If an employee has been injured as the result of defective equipment, an additional remedy may be available under the Employer's Liability (Defective Equipment) Act 1969. This is set out in Statute Box 12.12. The Act is binding on the Crown and enables the employee to obtain compensation from the employer if the injury has been caused by defective equipment supplied by the employer where a third party is to blame. Instead of the employee having the cost and hassle of obtaining compensation from the third party, that burden falls on the employer, from whom the employee can obtain direct compensation. Now that civil liability for breach of the health and safety regulations has been abolished (see s. 69 Enterprise and Regulatory Reform Act 2013), the Employer's Liability (Defective Equipment) Act is likely to become more significant for the injured employee who has been injured by defective equipment.

Statute 12.12 Employer's Liability (Defective Equipment) Act 1969

Factors which must be present

1 Personal injury by employee in the course of employment.
2 As a consequence of a defect in equipment.
3 Equipment provided by his employer for purposes of his business.
4 Defect attributable wholly or partly to the fault of a third party (whether identified or not).

Action

1 Recover compensation from employer.
2 Contributory negligence by employee may be raised as a defence (either full or partial).
3 Employer can recover contribution from third party (in contract or negligence).

Applies to the Crown.

Practical Dilemma 12.5 Faulty bed

A nurse is injured when a recently supplied bed, which she is raising by the foot pedal, breaks and falls on to her leg. It is discovered that there was a defect in the bed mounting that should have been spotted by the manufacturers before it left the factory.

The nurse could claim compensation from the NHS trust under the provisions of the Employer's Liability (Defective Equipment) Act 1969. The costs, problems and time associated with suing the manufacturers would then fall on the shoulders of the NHS trust. She also has an additional remedy under the Consumer Protection Act 1987 (see page 314 where the two Acts are compared).

Remedies available to an injured employee

The laws relating to health and safety are significant to nursing practice. The nurse herself may suffer from injuries at work and also she has a significant responsibility to protect the health and safety of others, including colleagues, patients and visitors. Back injuries are seen almost as an occupational hazard for nurses and midwives; publicity has recently been given to the number of staff who are injured by violence at work, including work in the community; the hazards that a nurse faces in administering carcinogenic substances such as cytotoxic drugs are only now being appreciated and precautions (such

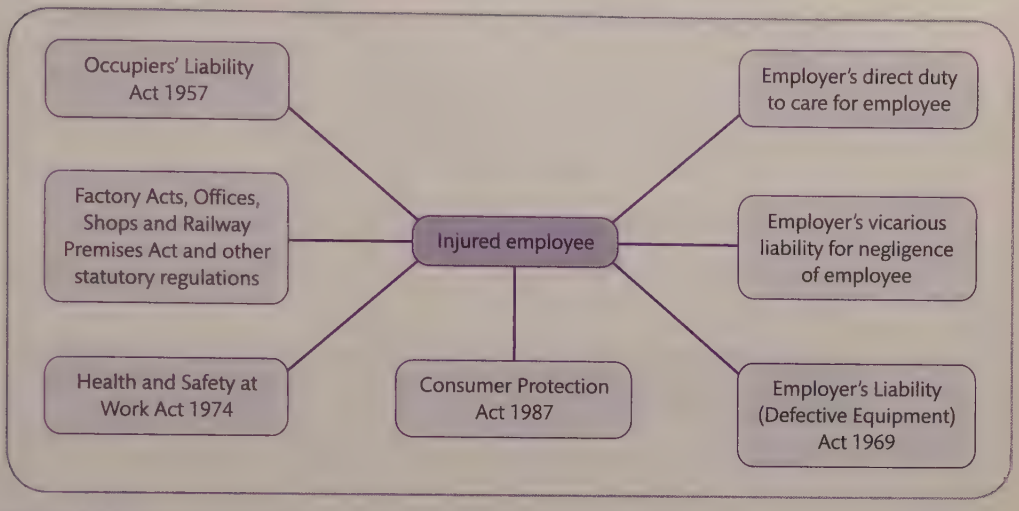


Figure 12.1 Remedies available to an injured employee

as protective clothing and masks) are being laid down. The nurse has always faced the problem of contamination from infectious diseases, and the particular problems relating to AIDS and infectious diseases and the role of the Health Protection Agency are considered in chapter 26. In this section, the remedies available to the nurse for injuries at work will be considered. The remedies can be seen in Figure 12.1. She may be able to sue several different defendants.

Injuries caused by another employee

Where a nurse has been injured as a result of the negligence of another employee, she can either sue the employee for compensation or she could bring an action against the NHS trust under the principles of vicarious liability.

Practical Dilemma 12.6 Wheelchair chaos

Two nurses, Mary and Jean, are working together in a ward for elderly mentally infirm patients. They are moving a patient from a chair into a wheelchair. As they do so, the wheelchair moves and Mary, in her endeavour to save the patient, takes the full weight and falls to the floor. She suffers a severe injury to her back and shoulder. An investigation reveals that Jean was responsible for ensuring that the wheelchair brake was safely on and her carelessness was responsible for Mary's injuries.

Mary can take one of the following paths:

1 She could sue Jean personally, since Jean is probably in breach of the duty of care she owes to Mary to ensure that reasonable steps are taken to prevent foreseeable harm to Mary. However, such an action is likely to be pointless unless Jean is insured for such liability or has sufficient funds to pay compensation to Mary.
2 She could sue the NHS trust for its vicarious liability for harm caused by the negligence of an employee. Jean is an employee, has been negligent and is acting in the course of employment. Mary would still have to establish that Jean was personally negligent, but this action has the advantage over suing Jean personally since the NHS trust should have the funds to pay compensation.

3 In addition, Mary could sue the NHS trust for breach of its duty of care to look after her safety as an employee. In this action, Mary would have to establish that the NHS trust itself was at fault, e.g. if it had failed to provide Jean with adequate training in carrying out such a manoeuvre.

In all three actions it will, of course, be a defence, complete or partial, that Mary was herself contributorily negligent (see chapter 6).

Liability of the employer for work outside the premises

In the following case, a health authority was held liable for failing to give adequate instruction to a young resident support worker.

Case 12.4 *Fraser* v. *Winchester HA* (1999)

Employer's liability for failing to give adequate instructions[71]

A resident support worker at a home for mentally and physically disabled residents was sent on a week's camping holiday with a patient without supervision or assistance. She had no training or instruction in the use of camping equipment. She suffered burns to her face and hands when, needing to cook an evening meal for the patient, she changed a cylinder on a gas cooker at the entrance to the tent and near to a lit candle. There was an explosion and the tent caught fire. The Court of Appeal agreed with the High Court finding that she should have been given instruction and better equipment, but held her one-third to blame because she realised the risk in what she did.

Special areas

Violence

Violence in the NHS against health service employees not just from strangers in the streets, but also from carers and clients, is an increasing phenomenon. Figures produced by the Department of Health in 2003[72] show that there was an estimated 116,000 violent incidents in the NHS (excluding general medical services), with 16 incidents per 1,000 ambulance staff per month. The terms of service of general practitioners were changed to enable them to arrange for the removal from their list of any patient who threatened them with violence. Several assaults on staff have led to criminal prosecutions and inquiries. For example, in 1983,[73] a voluntary patient at a mental hospital was charged with assault occasioning actual bodily harm to an occupational therapist employed at the hospital. An occupational therapist was killed by a mentally ill patient in the Edith Morgan Unit at Torbay and an inquiry was set up.[74] A healthcare assistant was attacked in the grounds of a Bristol hospital,[75] in spite of the fact that there were security guards and improved lighting and closed circuit television as a result of a review four and a half years before. A young mental health worker, Ashleigh Ewing, was stabbed to death by a patient who had been discharged from psychiatric hospital. The patient was found guilty of manslaughter on the ground of diminished responsibility and ordered to be detained indefinitely in a secure unit. An Inquiry was set up by the North East Strategic Health Authority.[76] The charity Mental Health Matters was fined £30,000 for failing to protect Ashleigh Ewing, the support worker who had visited the patient unaccompanied. Of all hospital staff working for NHS trusts, midwives experience more harassment than any other professional group, including doctors, nurses and healthcare assistants.[77]

The Court of Appeal held in 2006 that the NHS trust had failed in its duty of care to six nursing staff who were assaulted by a patient in Rampton Hospital. The hospital had failed to carry out a risk assessment in accordance with the recommendations of the Tilt Report into Security in High Security Hospitals and as a consequence the staff were injured.[78]

Zero tolerance

In October 2000, the Department of Health announced new guidelines to tackle violence against NHS staff who are most at risk.[79] The guidelines cover risk assessment, crime prevention, protection of NHS staff in the community, techniques for dealing with abusive and potentially violent situations, training, reporting of incidents, the criminal justice system and support for victims.

The HSE has declared a zero tolerance policy on violence and assaults on staff in the NHS and set up a website[80] to provide information and advice. Guidance has been issued for managers in reducing violence to NHS staff. The RCN and NHS Executive have also published guidance on reducing the risks from violence and aggression in the community.[81] The Crime and Disorder Act 1998 established local crime and disorder reduction partnerships (CDRPs), led jointly by police and local authorities. They have a statutory responsibility to develop and implement a strategy to tackle crime and disorder in their area in consultation with health, education and the voluntary and private sectors. The 1998 Act was amended by the Police Reform Act 2002 to extend responsibility for implementing the strategy to the fire and police authorities and included PCTs in the partnerships. In spite of the efforts, the National Audit Office[82] reported in March 2003 that reports of violence against NHS staff had risen by 13 per cent over two years, with many incidents not being reported. The Secretary of State for Health therefore announced[83] the establishment of a new legal protection unit within the Department of Health to support private legal action against the attackers.

The NHS Security Management Service was established in April 2003 to take responsibility for all security management issues in the NHS, including violence to staff. It published a strategy placing violence against staff as a top priority and established mandatory reporting of incidents of violence. It is now incorporated into the NHS Counter Fraud and Security Management Service Division of the NHS Business Services Authority and has developed a programme of work from the Zero Tolerance Campaign.[84] In Wales the Welsh Assembly government has launched the All Wales NHS Violence and Aggression Training Passport and Information Scheme, and in Scotland the Scottish Executive is co-ordinating a Zero Tolerance Campaign. In September 2007 funding of £97 million was announced for further protection of NHS staff from violence: £29 million of this sum was to be used for safety alarms for lone workers and the remainder for training, additional local security management specialists, more prosecutions and a centralised reporting system to the NHS Security Management Service.[85] The Security Incident Reporting System allows NHS health bodies to report security incidents to NHS Protect. Its remit is to identify and tackle crime across the health service. The collected data assists NHS organisations to work to prevent further occurrences[86]. NHS Protect also hosts a safe and secure health facilities website to provide an information service on security.[87] Reference can also be made to a practical guide on dealing with violence in the NHS by Paul Linsley.[88]

Remedies following violence

If a nurse has suffered harm as a consequence of violence, the remedies shown in Box 12.5 are available to her.

Box 12.5 Remedies following violence

1. Sue the aggressor personally for trespass to the person. (There is little point if they have no assets or income to pay the damages awarded.)
2. Sue the employer if she can establish that there has been a breach of the employer's duty of care to her.
3. Obtain compensation from the criminal courts following a successful prosecution of the assailant.
4. Claim compensation from the Criminal Injuries Compensation Authority (see chapter 2, pages 40–2).
5. Could receive, if eligible, statutory sick pay, Whitley Council sickness pay and DSS benefits.

Practical Dilemma 12.7 Injuries in the A&E department

A patient with lacerations to the face and severe bruising is brought into the department by two friends. All three have been drinking heavily. Two nurses take the injured man into the treatment room and ask the others to stay in the waiting room or leave the hospital. They insist on following the patient and in the ensuing fracas a nurse is injured.

Suing the patient

Could the nurse sue the patient if she has been injured by an assault? Yes, the nurse would have a right of action against anyone who assaults her, but there are difficulties where the defendant is mentally disordered. The magistrates' courts have thrown out such cases as being inappropriate. If the defendant is prosecuted, then the magistrate or judge can make an order for compensation to be paid by the defendant to the injured person. If the nurse decides to bring civil proceedings for trespass to the person, the defendant may not have the resources to pay any compensation awarded by the civil courts. Alternatively (and probably preferably), the nurse could seek compensation from the Criminal Injuries Compensation Authority (see chapter 2, pages 40–2).

Suing the NHS trust or employer

The employer's duty extends to protecting the employee against reasonably foreseeable attacks from violent patients or even from violent visitors and trespassers. If the employer has failed in this duty, then the injured employee could sue the employer.

Practical Dilemma 12.8 Mixed ward

A psychiatric nurse is on an acute mixed ward. Complaints have been made that, although this is a mixed ward, there are insufficient numbers of male nurses and thus the female nurses are often dealing with male patients on their own. A known aggressive male patient, without any warning or provocation, suddenly produces a razor and cuts a nurse badly on the face.

To obtain compensation from the NHS trust, the nurse must establish that another employee has been negligent in the course of employment and therefore the NHS trust is vicariously liable or that the NHS trust was itself directly at fault. To establish this, she would need to show that inadequate precautions were taken for her safety; that the risk of harm was reasonably foreseeable; that there were reasonable precautions that the authority could have taken and failed to take, e.g. male staffing, training in the handling of violent patients, special facilities for dealing with known aggressive patients, a special wing, an alarm system, a safe system for control of dangerous items. The injured nurse would also have to show a causal connection between the injuries she suffered and these failures on the authority's part, i.e. if she would still have been injured even had these precautions been taken, then the NHS trust would not be liable. In its defence, the NHS trust would have to establish either that such reasonable precautions had been provided – a dispute on the facts – or that even if such precautions had been taken, the injury would still have occurred. In addition, it might be able to show that the nurse failed to take reasonable care of her own safety, i.e. she was contributorily negligent. Some employers have argued that being injured by aggressive mentally disturbed patients is an occupational hazard for the nurse working with the mentally ill or handicapped and that there is a voluntary assumption of the risk

of injury by the staff concerned (see chapter 6). However, it is not thought that this would provide a successful defence for an employer who was clearly at fault in respect of reasonable precautions in protecting the nurse from harm.

Criminal prosecution

Any aggression should be reported to the police and the Crown Prosecution Service will decide whether a public prosecution should commence. If the defendant is convicted, the magistrates or judge could make an order that criminal compensation is paid to the victim. There is evidence that public prosecutions for assault on NHS staff are increasing. In its response to the Healthcare Commission's NHS staff survey on violence and abuse against NHS staff by patients and relatives, the NHS Security Management Service stated that there had been a 1,600 per cent increase in the number of prosecutions brought against those who assaulted NHS staff. If the assault has been notified to the police, the victim would be able to obtain compensation from the Criminal Injuries Compensation Authority, which is considered in chapter 2.

Self-defence

Can the nurse defend herself if attacked by a patient, visitor, trespasser or employee? Every citizen has the right of self-defence. In the above example, therefore, the nurse could use reasonable means to defend herself against an aggressor. What is meant by reasonable?

Practical Dilemma 12.9 Reasonable means

A nurse is faced by a patient who is approaching her with a knife. He is 6 feet tall, a stockily built man of 35 years. There are no other staff or competent patients in the room and there is no call system available. As he comes forward, she picks up a chair and hits him over the head with it. He is severely concussed and requires stitches. Could she successfully defend an action for assault brought by the patient? Has she acted reasonably in defending herself?

Reasonableness means, first, that the force used should be no more than is necessary to accomplish the object for which it is allowed (so retaliation, revenge and punishment are not permitted) and, second, the reaction must be in proportion to the harm that is threatened. Thus, all the circumstances must be taken into account: the contrast between the strength, size and expertise of the assailant and the defendant, and the type of harm with which the person is being threatened. Obviously, the greater the severity of the threatened danger, the more reasonable it is to take tougher measures. In assessing the reasonableness of the defence, account is taken of the fact that the defendant may have only a brief period to make up his mind what to do. Turning back to Practical Dilemma 12.9, if the nurse in question is tiny with no training in self-defence, the odds do seem to be stacked against her and may justify her use of the chair. All the circumstances must be taken into account, including the possibility of her retreating from the assault. Should the nurse be prosecuted and a trial take place in the Crown Court, it is for the jury to decide if the measures used in self-defence were reasonable in all the circumstances. The issue of violence and the community health worker is discussed in chapter 23.

Risk assessment

Monitoring of potentially violent situations is essential and the nurse should play her full part to bring any concerns to the attention of the management and ensure that action is taken. The employer has a

duty to take reasonable care of the nurse in relation to reasonably foreseeable violence. A risk assessment could include the following questions.

1 *Is it possible to remove the risk altogether?* If the answer to this is 'yes' but, for example, only by stopping all home visits by nurses, this would not be reasonably practicable.
2 *What preventive action or protective measures can be taken?* The answer to this might include the provision of two-way radios, personal alarms or, in very dangerous areas or on visits to clients who present a threat, nurses going in pairs or accompanied by another person. In the institutional setting, protective measures may include more staffing, higher levels of supervision of difficult-to-manage patients and special security measures.
3 *Has the nature of the risk changed?* (e.g. is the district more violent than it was formerly assessed to be? Has the nature and condition of patients in a hospital ward deteriorated?) Assess the extent of the success of the measures taken to prevent harm to nurses. Are any further measures necessary?

This type of analysis will not only relate to the nurses, but also to a wider assessment of all health professionals into which the nurse could have an input.

Practical Dilemma 12.10 Fear of violence

A nurse visited a patient in his home following a stroke. She felt threatened by his attitude, but found difficulty in defining exactly the reason for her fears. Should she record her concerns?

This is a situation with which many nurses could identify. There is almost an intuitive feeling of fear. However, the nurse would have a duty to ensure that her colleagues were warned of potential dangers and she might therefore record in her notes that it might be advisable for a second person to accompany the nurse for the next house call. The duty of confidentiality owed to the patient (see chapter 8) would be subject to an exception in the public interest where a nurse needed to warn colleagues about a fear of violence from a particular patient. Reference should be made to the guidance prepared by the Health and Safety Commission.[89] This gives practical advice for reducing the risk of violence in a variety of settings and emphasises the importance of commitment from the highest levels of management.

Domestic violence

It may sometimes come to the attention of nurses and particularly midwives that patients are possibly being subjected to violence at home. Clearly, if this involves a child, it is essential to ensure that child protection procedures are initiated and these are considered in chapter 13. Where it is an adult who is the victim, the tendency in the past has been to respect the confidentiality of the victim and leave it to that person to report it to the police. However, attitudes are changing and domestic violence is no longer seen as a private matter between individuals but a criminal act where society has responsibilities.[90] In June 2003 the Home Office issued a consultation paper[91] on ways to prevent and follow up domestic violence. The paper looked at three elements: prevention, protection and justice and support for victims. The Domestic Violence, Crime and Victims Act 2004 followed and was aimed at facilitating prosecutions and convictions. It made breach of a non-molestation order a criminal offence, created a new offence of causing or allowing the death of a child or vulnerable adult (extended in 2012 to causing or allowing serious physical harm (equivalent to grievous bodily harm) to a child or vulnerable adult).[92] The 2004 Act also defined a common assault as an arrestable offence for the purposes of the Police and Criminal Evidence Act 1984, thereby increasing the powers of the police and citizens in relation to such an offence. Provisions under Part 3 of the Act relating to victims required a Victim's Code of Practice to be issued by the Secretary of State to cover the services to be provided to a victim of criminal conduct. Failure to comply with the Code, although not an offence in itself, could be used in evidence in

civil and criminal proceedings.[93] A revised code of practice for victims of violence came into operation on 10 December 2013.[94] It can be accessed online.[95]

In January 2011 the European Commission on Domestic Violence funded a two-year project called the Iceberg Project, which together with other projects known as Daphne, sought to contribute to the protection of children, young people and women from all forms of violence. The role of Coventry University in this project and its literature review is described by Susan Lees and colleagues.[96]

The Domestic Violence Disclosure Scheme is to be implemented following regional trials. Dubbed Clare's law (after Clare Wood was murdered by her boyfriend) her father campaigned for women to be able to ask the police if a man has a history of abuse. The scheme gives a 'Right to ask' to the family and a 'Right to know' to the police to give information. Critics of the scheme suggest that the money would be better spent on improving the basic police response to victims of domestic violence.[97]

A report by the HM Inspectorate of Constabulary commissioned by the Home Secretary stated that thousands of people are at risk of harm or even murder because of widespread police failure in England and Wales to tackle domestic abuse. Only 8 out of 43 forces were responding well to domestic abuse. The Home Secretary responded by saying that she expected the forces to implement the recommendations and she was establishing a new national oversight group which she would chair.[98]

(See chapter 19 for a discussion on elder abuse.)

Stress

Concern with stress at work is now recognised as part of the employer's duty in taking reasonable care of the health and safety of the employee. One of the first cases to recognise stress as a ground for compensation is shown in Case 12.5.

Case 12.5 *Walker* v. *Northumberland County Council* (1994)

Stress at work[99]

A social worker obtained compensation when his employer failed to provide the necessary support in a stressful work situation when he returned to work following an earlier absence due to stress. The employer was not liable for the initial absence, but that put the employer on notice that the employee was vulnerable and its failure to provide the assistance he needed was a breach of its duty to provide reasonable care for his health and safety as required to do under the contract of employment.

In order to establish grounds for compensation for stress induced by work, an employee would have to show:

1. that she was under an unacceptable level of stress at work
2. that the employer was aware of this situation
3. that there was reasonable action that the employer could have taken to relieve this pressure
4. that the employer failed to take that action
5. that as a result the employee has suffered a serious mental condition.

The Court of Appeal has clarified the law relating to compensation for stress at work in four appeals which were heard together.[100] In each one the employer appealed against a finding of liability for an employee's psychiatric illness caused by stress at work. Two of the claimants were teachers in public sector comprehensive schools, the third an administrative assistant at a local authority training centre and the fourth a raw material operative in a factory.

In determining whether the employer was liable or not, the Court of Appeal held that the ordinary principles of employer's liability applied to an allegation of psychiatric illness caused by stress at work.

The threshold question was whether the particular kind of harm – an injury to health (as distinct to occupational health) that was attributable to stress at work (as distinct from other factors) – to the employee was reasonably foreseeable. Foreseeability depended on what the employer knew or ought reasonably to have known about the individual employee. Because of the nature of mental disorder, it was harder to foresee than physical injury, but might be easier to foresee in a known individual than in the population at large. An employer was usually entitled to assume that the employee could withstand the normal pressures of his job unless he knew of some particular problem or vulnerability. The test was the same whatever the employment: there were no occupations that should be regarded as intrinsically dangerous to mental health.

The relevant factors identified by the Court of Appeal in determining the reasonable foreseeability of stress were:

- nature and extent of the work done by the employee
- signs from the employee of impending harm to his health.

The employer was entitled to take at face value what he was told by an employee; he did not have to make searching enquiries of the employee or seek to make further enquiries of the employee's medical advisers. If there were indications of impending harm to health arising from stress at work and these indications were plain enough for any reasonable employer to realise that he should do something about it, the duty of the employer to take steps would be triggered. The employer could only be in breach of duty if he failed to take the steps which were reasonable in the circumstances, bearing in mind the magnitude of the risk of harm occurring, the gravity of the harm which might occur, the costs and practicability of preventing it and the justifications for running the risk. The factors to be taken into account in determining what was reasonable action by the employer included:

- size and scope of the employer's operation, its resources, and the demands it faced
- interests of other employees
- need to treat other employees fairly (for example, in any redistribution of duties).

An employer could be reasonably expected to take steps which were likely to do some good, and the court was likely to need expert evidence on that. An employer who offered a confidential advice service, with referral to appropriate counselling or treatment services, was unlikely to be found in breach of duty. If the only reasonable and effective step would have been to dismiss or demote the employee, the employer would not be in breach of duty in allowing a willing employee to continue in the job. In all cases, therefore, it was necessary to identify the steps that the employer both could and should have taken before finding him in breach of his duty of care. The claimant had to show that the breach of duty had caused or materially contributed to the harm suffered. It was not enough to show that the occupational stress had caused the harm. Where the harm suffered had more than one cause, the employer should only pay for that proportion of the harm suffered that was attributable to his wrongdoing, unless the harm was truly indivisible. It was for the defendant to raise the question of apportionment. The assessment of damages would take account of any pre-existing disorder or vulnerability and of the chance that the claimant would have succumbed to a stress-related disorder in any event.

On the actual facts of the appeals before it, the Court of Appeal allowed the appeals by the employers in three cases and dismissed the appeal in the case of *Jones* v. *Sandwell Metropolitan Borough Council*.

Subsequently, the House of Lords (in a majority decision) allowed an appeal from one of the employees,[101] holding on the facts of the case that the school's senior management team should have taken the initiative in making sympathetic enquiries about Mr Barber, head of the maths department, when he returned to work in June 1996 and in making some reduction in his workload to ease his return. In addition, his condition should have been monitored and, had it not improved, some more drastic action would have had to be taken.

In a subsequent case it was held that the mere fact that the employers had provided counselling services did not relieve them of the duty to take reasonable care of an employee who was being

subjected to considerable stress because of overwork and a lack of clear management controls. The Court of Appeal dismissed the employer's appeal against the finding of a breach of the duty of care and the award of £134,000.[102]

A university head of department, who claimed that he was subject to deliberate harassment by the university and that his psychiatric illness was stress-induced, failed in his claim because the judge held that the evidence did not support the contention that he was the victim of organised and deliberate harassment and that the risk of injury was not foreseeable until May 1997, when his symptoms became evident and the university had not failed to take reasonable steps to address the situation. He lost his appeal to the Court of Appeal.[103]

A Court of Appeal decision[104] dismissed an employer's appeal against a finding that it had breached its duty of care to the employee. The Court of Appeal held that the judge had been right to find that the Post Office owed a duty of care to Young, given its knowledge that Young's psychiatric problems were work-related. The Post Office's failure to fully implement the agreed measures for Young's return to work were sufficiently serious to amount to a breach of that duty. Young was known to the Post Office to be both vulnerable, which meant that extra care should have been taken of him, and conscientious, which meant that he was likely to try to carry out his work without complaint. No finding of contributory negligence was therefore appropriate.

Nicola Adedeji, a mother of two, who miscarried while under stress after her employer refused her flexitime working, won her case against the City of London Corporation, owner of the Barbican Centre. Her compensation, which has not been reported, is likely to have exceeded £100,000 for sex discrimination and unfair dismissal.[105]

The Health and Safety Inspectorate issued its first enforcement notice for failure to protect staff from stress in August 2003 against the West Dorset Hospitals NHS Trust.[106] Failure to observe the enforcement notice would lead to prosecution. The trust was given six months to assess stress levels among its 1,100 staff and introduce a new programme.

Stress reduction is one of eight key targets set by the HSE, which has set up a stress website[107] covering the reasons why stress must be tackled, management standards and good practice. It has also provided a guide on improving efficiency which shows how tackling stress at work can improve an organisation's efficiency and gives examples in case studies, many from the NHS where stress levels have been reduced. Guidance is also provided on managing stress by the RCN for employees[108] and employers[109] and for its shop stewards.[110] The latter guidance takes RCN representatives through the HSE's management standards and the process of conducting a stress risk assessment and details how RCN safety representatives can get involved in each stage of the risk assessment process. It includes a number of case studies highlighting how representatives have implemented the HSE standards in their own workplaces. It also provides guidance for assisting staff who have returned to work after stress-related absence.

NICE published guidelines on workplace well-being in 2009.[111] The guidelines were endorsed by MIND, encouraging employers to follow the guidelines and reduce workplace stress. The guidance of NICE aimed to help reduce the estimated 13.7 million working days lost each year due to work-related mental health conditions, including stress, depression and anxiety which were currently estimated to cost UK employers around £28.3 billion per year at current pay levels.

Manual handling

Where a nurse has injured her back at work, she may have a claim against her employer for breach of the duty of care owed to her at common law or failure to implement the Manual Handling Regulations. In addition, the employer may be vicariously liable for harm caused by another employee. Alternatively, if her back has been injured as a result of a defect in a product (e.g. a hoist or bed), she may be able to bring a case against the supplier under the Consumer Protection Act 1987. This section will first consider the regulations relating to manual handling, the decided cases and then consider specific situations that cause concern to the nurse.

Case 12.6 *Boag* v. *Hounslow* (1994)

Back injury[112]

On 24 July 1994 a nurse was awarded £205,000 for a back injury. The circumstances were that in November 1988, she and a colleague were trying to lift an elderly woman from a commode to a chair, when the patient's legs gave way. Owing to the lack of space, Mrs Boag was forced to twist her back to place the woman in the chair. The health authority, which admitted liability, agreed the out-of-court settlement shortly before the case was due to be heard. She was forced to give up her job and is regularly confined to bed. She attended a pain relief clinic and will probably never work again. Her husband had had to take time off work to help with the two children.

Manual handling regulations

Regulations were introduced in 1992 as a result of an EC Directive and were amended in 2002.[113] The RCN and the National Back Pain Association, in their 'Guide to the Handling of Patients',[114] point out that there are discrepancies between the EC Framework Directive[115] and the UK regulations and that the former imposes a higher duty on employers closer to that of 'practicality' rather than 'reasonable practicability'. The regulations were amended in 2002 to add another paragraph on determining the appropriate steps to reduce the risk of injury.[116] The risk assessment must take into account that a worker may be at risk if he or she: is physically unsuited to carry out the task; is wearing unsuitable clothing, footwear or other personal effects; or does not have adequate or appropriate knowledge or training. Guidance on manual handling is given by the HSE.[117] The guidelines are not themselves the law and the booklet advises that the guidelines set out in Appendix 1 'should not be regarded as precise recommendations. They should be applied with caution. Where doubt remains a more detailed assessment should be made.' A short guide is provided by the HSE which can be downloaded from its website.[118]

The HSE has developed a manual handling assessment chart tool which can be downloaded from its website.[119] The HSE has also published case studies on how simple action can be taken to prevent back injuries. For example, the provision of bed rails enabled the best use of a patient's arm strength when being washed in bed.[120] It has also published in 2012 a brief guide for smaller organisations on manual handling at work. The RCN has also published guidance on manual handling in a variety of settings.[121]

Summary of manual handling regulations

The duty placed on the employer under the regulations can be summed up as follows.

1 If reasonably practicable, avoid the hazardous manual handling.
2 Make a suitable and sufficient assessment of any hazardous manual handling that cannot be reasonably avoided.
3 Reduce the risk of injury from this handling so far as is reasonably practicable.
4 Give general indications of risk and precise information on the weight of each load and the heaviest side of any load, where the centre of gravity is not positioned centrally.
5 Review the assessment if there are any changes in the circumstances.

It is in the interests of all nurses to ensure that the employer is reminded when a review becomes necessary under the above provisions.

The duty that is owed by the employer is owed not only to employees, but also to temporary staff such as agency or bank staff who are called in to assist. All such employees are entitled to be included in the risk assessment process, since, as has been seen, the assessment must take into account the individual

characteristics of each employee. Nurses who are unusually small in height or not so strong as the average might require special provisions in relation to manual handling.

Provision and Use of Work Equipment Regulations 1998 (PUWER)

PUWER (as amended by 2002 regulations) replaces the earlier Provision and Use of Work Equipment Regulations 1992 and applies to all equipment, including lifting equipment, used at work. There is a new requirement to inspect work equipment where significant risk could result from incorrect installation or relocation, deterioration or as a result of exceptional circumstances and to record the results of those inspections (Reg. 6). PUWER places requirements on duty holders to provide suitable work equipment for the task (Reg. 4), information and instructions (Reg. 8), and training to people who use it (Reg. 9). It also requires measures to be taken concerning dangerous parts of machinery (Reg. 11), controls and control systems (Regs 14–18), stability (Reg. 20) and mobility (Regs 25–9). The House of Lords held that there had been a breach of Regs 4(1) and 20 of the 1998 PUWER Regulations when a ladder to a bunk in a production platform was not fixed and had not been replaced properly so that a worker fell when descending from the top bunk. The incident was a foreseeable situation.[122]

Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)

These regulations came into force on 5 December 1998 and apply in all premises and work situations subject to the Health and Safety at Work Act 1974 and build on the requirements of the Provision and Use of Work Equipment Regulations 1998.

In its guidance on the application of the LOLER regulations, the Health and Safety Commission note that (paragraph 47):

> **As hoists are used to lift patients, e.g. from beds and baths, in hospitals and residential homes, are provided for use at work and are lifting equipment to which LOLER applies, the duty holder, e.g. the NHS trust running the hospital or the owner of the residential home, must satisfy their duties under LOLER.**

Enforcement of regulations on manual handling

What action can be taken if the employer ignores these regulations? The regulations are part of the health and safety provisions that form part of the criminal law. Infringement of the regulations can lead to prosecution by the Health and Safety Inspectorate. The Inspectorate has the power to issue enforcement or prohibition notices against any corporate body or individual.

Court decisions on manual handling

Carrying a microwave The Court of Appeal found in favour of an employee who had injured his back while carrying a microwave weighing between 15 and 20 kg.[123] The Court of Appeal found that:

- the employers had failed to assess the specific risk in relation to the particular task to be performed by the employee and was therefore in breach of the Manual Handling Regulations (Reg. 4(1)(b)(ii))
- the employers had failed to take appropriate steps to reduce the risk by failing to give the training recognised as being necessary to increase awareness of the risk and reduce instinctive responses
- it was reasonably foreseeable that an employee would twist while supporting a lead
- failure to provide the appropriate training was therefore, on the balance of probabilities, a cause of the accident.

Carrying by ambulance crew The microwave case contrasts with another decision of the Court of Appeal in another manual handling case[124] where the Court held that the employers were not in breach of the directive or regulations on manual handling. King, an ambulance technician, suffered serious

injuries carrying an elderly patient down the stairway of his home. He and his colleague had taken the patient down the stairway, which was narrow and steep, in a carry chair. He had been injured when forced for a brief moment to bear the full weight of the chair. The judge found in favour of the ambulance technician, holding that the employers were in breach of EC Directive 90/269 (Article 3(2)) and the Manual Handling Regulations and that the employers had acted negligently by discouraging employees in circumstances such as those in this particular case from calling the fire service to take patients from their homes.

Sussex Ambulance NHS Trust appealed against the finding. The Court of Appeal held that the NHS trust was not liable either under the Directive or under the Manual Handling Regulations. There was nothing to suggest that calling the fire service would have been appropriate in the case. The evidence showed that such an option was rarely used because it had to be carefully planned, took a long time and caused distress to the patient. There might be cases where calling the fire service would be appropriate, but that would depend on the seriousness of the problem, the urgency of the case and the actual or likely response of the patient or his/her carers and the fire service. King had failed to show that, given that possibility, more emphasis in training would have avoided his injuries. The ambulance service owed the same duty of care to its employees as did any other employer. However, the question of what was reasonable for it to do might have to be judged in the light of its duties to the public and the resources available to it when performing those duties. While the risks to King had not been negligible, the task that he had been carrying out was of considerable social utility.

Furthermore, Sussex Ambulance NHS Trust had limited resources so far as equipment was concerned. There was no evidence of any steps that the trust could have taken to prevent the risk and the only suggestion made was that it should have called on a third party to perform the task for it. Since calling the fire service was not appropriate or reasonably practicable for the purpose of the directive and the regulations, the Sussex Ambulance NHS Trust had not shown a lack of reasonable care. Accordingly, it had not acted negligently.

Newham General Hospital In contrast to the ambulance case, a nurse aged 36 years was awarded £420,000 in damages by the High Court for a crippling back injury caused by her lifting a patient at Newham General Hospital, East London.[125]

East Sussex case and human rights and manual handling In February 2003 the High Court gave judgment on a case, where the claimants raised the issue of their human rights not to be hoisted.[126] A and B were sisters born in 1976 and 1980 who suffered from profound physical and learning disabilities. They lived in the family home which had been specially adapted and equipped for them and were looked after on a full-time basis by their mother X and their stepfather Y. A dispute arose between the claimants and East Sussex County Council (ESCC), which provided community care services, over the extent to which moving and lifting should be done manually. ESCC's policy on manual handling did not permit care staff to lift A or B manually. The claimants, supported by the Disability Rights Commission, argued that ESCC's manual handling policies, as applied to A and B, were unlawful and unjustifiable, on the basis that they improperly failed to take into account the needs of the disabled people involved. Its policy was subsequently amended to make it clear that ESCC did not operate a blanket no lifting policy. The claimants argued that the application of the policy to the specific circumstances of A and B's care and the draft protocols prepared by the independent handling adviser were unlawful.

The judge considered the effect of sections 2 and 3 of the Health and Safety at Work Act 1974, the Manual Handling Operations Regulations 1992 and the Management of Health and Safety at Work Regulations 1999; decided cases on manual handling and the implications of the European Convention on Human Rights and the Charter of Fundamental Rights of the European Union. He emphasised that one must guard against jumping too readily to the conclusion that manual handling is necessarily more dignified than the use of equipment. Hoisting is not inherently undignified, let alone inherently inhuman or degrading. He identified the principles that applied and stated that, ultimately, the employer must balance the impact of the assessment on both carer and the disabled person.

This balancing exercise is to be resolved in the context of Article 8 by enquiring of each claimant whether the interference with his right to be respected is such as to be 'necessary in a democratic society'. Once the balance has been struck, if it comes down in favour of manual handling, then the employer must make the appropriate assessment and take all appropriate steps to minimise the risks that exist. The assessment must be properly documented and lead to clear protocols which cover all situations, including foreseeable emergencies and, in the case of patients such as A and B, events such as episodes of spasm and distress that might arise. The judge accepted that protocols developed by the employer cannot be too prescriptive. He emphasised that it was for ESCC to formulate its manual handling policy and to make the appropriate assessment in relation to A and B. Neither of those is a matter for the court. The making and drafting of the kind of assessments called for in a case such as this is outside the competence and expertise of the court. What the court can and should do is to assist ESCC by identifying the relevant legal principles.

The outcome of the case was that ESCC was required to complete with the assistance of the independent manual handling adviser the appropriate assessments and protocols. If these were not acceptable to the claimants, they could challenge them by way of judicial review.

Wolstenholme case In a case in Milton Keynes where Lorraine Wolstenholme, a disabled woman of 50, had slept in a wheelchair for 17 months after nurses stopped lifting her in case they were injured, a High Court judge ordered that arrangements for moving her had to be made by a specific date (19 December 2003).[127]

What remedies exist for compensation?

Section 47 of the Health and Safety at Work Act 1974 prevents breach of a duty under sections 2–8 of the Act being used as the basis for a claim in the civil courts. Breach of the regulations can no longer be the basis of a civil claim for compensation, as a consequence of section 69 of the Enterprise and Regulatory Reform Act 2013 unless the Regulations provide to the contrary. Regulations provide an exception for new or expectant mothers in respect of their rights under the Pregnant Workers Directive.[128] A nurse who suffered harm as a result of the failure of the employer to take reasonable steps to safeguard her health and safety could sue in the civil courts on the basis of the employer's duty at common law (see page 318) i.e. negligence by the employer would have to be shown, which is likely to be more difficult to prove than a breach of the regulations. The statutory duty to ensure the Act is implemented is paralleled by a duty at common law placed on the employer to take reasonable steps to ensure the employee's health and safety. Contracts of employment should state clearly the duty on the employer to take reasonable care of the employee's safety and also the employee's duty to cooperate with the employer in carrying out health and safety duties under the Act and at common law. It is, of course, in the long-term interest of the employer to prevent back injuries, thereby avoiding payment of substantial compensation to his injured employees and also reducing the incidence of sickness and absenteeism.

Training in risk management and manual handling

This is essential to ensure that staff have the understanding to carry out the assessments and to advise on lifting and the appropriate equipment. Regular monitoring should take place to ensure that the training is effective and the policies for review are in place. There is also a duty on the employer to ensure that staff who are not expected to be regularly involved in manual handling are aware of the risks of so doing. This was the decision in the case of *Colclough* v. *Staffordshire County Council*,[129] where a social worker obtained compensation following a back injury caused by moving a client to safety. The council was liable because it failed to provide any training on risk awareness of the dangers of that situation. The implication of this decision is that even staff who are not expected to be involved in manual handling as part of their work, must be trained in risk awareness to protect them, should they ever be in the situation where they could be endangered through manual handling.

Lifting and instructing others

Nurses may be asked to instruct others such as carers, clients or other health or social service employees in the carrying out of the regulations on manual handling. Before they instruct others, they should be sure that they receive the necessary additional training to undertake the task of instruction, since failure to instruct competently could in itself give rise to an action in negligence, should harm occur as a result of negligent instructions.

Failures to instruct by agencies

Sometimes nurses become aware that agency staff have not been instructed in manual handling techniques. It would be reasonable practice in this situation for the nurses to ensure that senior management or the agency were informed so that steps could be taken to provide formal training for agency staff.

Therapeutic handling

It is sometimes argued that therapeutic lifting, e.g. in orthopaedic wards, to facilitate early mobilisation does not come under the manual handling regulations. There are, however, no grounds for this assertion. The definition of manual handling is:

> **[A]ny transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or by bodily force.**

This would, therefore, include therapeutic situations.

No lifting policy and therapeutic handling

The first requirement of any manual handling policy is to avoid any manual handling that could reasonably practically be avoided. Clearly, if this were to be implemented in the therapeutic regime, patients would never get mobilised following strokes and orthopaedic and other trauma. The nurse should ensure that a risk assessment is carried out that takes into account both the needs of the patient to become mobile and also dangers that staff face in promoting this mobilisation.

Lifting extremely heavy persons

This is of considerable concern to nurses. The National Institute for Health and Clinical Excellence defined morbid obesity as having a body mass index of more than 40 kg/m^2 or between 35 and 40 kg/m^2 with comorbidities.[130] An article on support for bariatric employees includes the case study of a nurse who weighed 27 stone but was assessed as medically fit for practise by the occupational health consultant.[131] The legal issues arising are considerable. Staff cannot cease to provide services for such persons, but the consequences in terms of costs and effort in minimising the risk of harm are considerable. (See the case of the ambulance officer, pages 331–2.)

Sexual and other harassment and bullying

It is essential that nurses are sensitive to the dangers of sexual harassment and make every effort to avoid potentially difficult situations. On the one hand, they must be aware of the sex discrimination laws (see chapter 10) and must ensure that they do not discriminate either directly or indirectly. On the other hand, they must ensure that they are chaperoned in any situation that could lead to accusations of harassment by the nurse or where the nurse is herself (or himself) at risk.

Protection from Harassment Act 1997

The Protection from Harassment Act 1997 can also provide some protection in the workplace, if an individual considers that they are subject to unreasonable unwanted attention.

The Act creates:

1. *a criminal offence of harassment* (section 1), which is defined as a person pursuing a course of conduct that amounts to harassment of another and that he knows or ought to know what amounts to harassment of the other (the reasonable person test is applied)
2. *a civil wrong*, whereby a person who fears an actual or future breach of section 1, may claim compensation including damages for anxiety and financial loss
3. the right to claim an injunction to restrain the defendant from pursuing any conduct that amounts to harassment
4. the right to apply for a warrant for the arrest of the defendant, if the injunction has not been obeyed
5. *an offence of putting people in fear of violence*, where a person causes by his conduct another person to fear on at least two occasions that violence will be used against him
6. *restraining orders* can be made by the court for the purpose of protecting the victim of the offence or any other person from further conduct amounting to harassment or to fear of violence.

Certain defences are permitted in the Act, including that an individual is preventing or detecting crime. Judy Veakins won her appeal after the County Court had dismissed her claim against her employers for damages for harassment under the Protection from Harassment Act 1997. She claimed that she was harassed at work by her supervisor for whose acts the company was vicariously liable. The company did not dispute vicarious liability if harassment was established. The Court of Appeal held that there was no reason why the Protection from Harassment Act could not be used for workplace harassment but the usual remedy for high-handed or discriminatory misconduct by or on behalf of an employer would be more fitting in the employment tribunal.[132] In another case the House of Lords held that the Act was not restricted to protection against stalking but had a wider application[133] and an employer could be vicariously liable for harassment caused by an employee. Those suffering from harassment as a result of discrimination may also have a cause of action under the Equality Act 2010 (see chapter 10).

Bullying at work

Research into bullying in an NHS community trust found that, of the 70 per cent of staff who responded to a questionnaire on bullying, 38 per cent reported being bullied in the previous year and 42 per cent reported witnessing the bullying of others. It was concluded that bullying was a serious problem.[134] There was a suggestion at the public inquiry into the deaths at Staffordshire Hospital, that bullying was a significant issue.

In a case in 1998, £100,000 was accepted in an out-of-court settlement by a teacher who alleged that he had been bullied by the head teacher and other staff, when he was teaching in a school in Pembrokeshire.[135] Dyfed County Council denied negligence. He suffered a minor breakdown in October 1996 and was returned to the same school, although he had asked for a transfer. He claimed that he was isolated, ignored and subjected to a series of practical jokes. He then suffered a second nervous breakdown. It was claimed that a support plan worked out for him by the council was not properly implemented. Another teacher was awarded £86,000 after being bullied, harassed and being subjected to unacceptable professional conduct.[136] The Barber decision (see page 328) was followed in a case where a police officer sued the Chief Constable for his vicarious liability for the actions of policemen who bullied and victimised the claimant. Since it was foreseeable that he could suffer psychological injury from their actions, he was awarded £18,000 general damages for the physical and mental injury he suffered.[137] Failure by an employer to take adequate steps to control bullying by a group of women of another female employee which led to a foreseeable risk of psychiatric injury led to a finding that he was vicariously liable for his employees' actions under the Protection from Harassment Act 1997 and also at common law. The employee was awarded £60,000 plus past and future loss and expenses.[138] A former police officer succeeded in a claim for personal injuries caused by the bullying by officers

employed by the Chief Constable who was held vicariously liable. The injuries were foreseeable as a consequence of the treatment he received.[139]

The lessons for managers from these cases are obvious. Advice is given by Claire Walker on how to deal with bullying[140] and Jacqueline Grove gives some practical advice on how to recognise the signs of stress from bullying and provides a survival guide.[141] In August 2000 a teacher was paid £15,000 compensation for unfair dismissal after an education authority had ignored medical reports that the teacher was being bullied into a breakdown, and then dismissed him while on long-term sick leave. The teacher stated that he planned to seek civil compensation for personal injuries.[142] An RCN guide on harassment and bullying at work[143] emphasises that nurses should not tolerate harassment, but challenge it by reporting it and keeping records. A review on the literature on bullying at work from the Health and Safety Laboratory is available from the HSE website.[144] The aim of the project is to enable the HSE to develop guidance for organisations on primary interventions in relation to bullying. The Chartered Management Institute published a report on bullying at work in 2008[145] which showed that 70 per cent of those managers polled by the CMI had witnessed bullying in the past three years and 42 per cent had been bullied themselves. Root causes appeared to be lack of management skills, personality clashes and authoritarian management styles. ACAS has published leaflets on bullying for use by: (1) managers and employers; (2) employees; and (3) building a culture of respect.[146]

Repetitive strain injury (RSI)

This condition is also known as occupational overuse syndrome (OOS). Nurses should be aware, both for themselves and their patients, of the legal implications of RSI.

Even though, in an early case, a judge was quoted out of context as declaring that RSI has no place in medical books,[147] RSI has been recognised for the purpose of compensation in health and safety cases. A House of Lords' decision, however, may make it more difficult to obtain compensation for RSI.

On 25 June 1998 the House of Lords[148] rejected claims that a secretary, who was sacked after she developed a form of RSI, should be able to sue her employers. It overruled the Court of Appeal decision that Ann Pickford should be allowed to make a claim against Imperial Chemical Industries. The Court of Appeal had found that ICI was negligent in failing to warn her of the need to take breaks during her work using a word processor and gave her the right to take her case back to the High Court for an assessment of damages, which she estimated at £175,000. In a majority judgment (4 to 1), the House of Lords decided that ICI did not need to warn her about the dangers of RSI because typing took up only a maximum 75 per cent of her workload. To impose a warning that might cause more harm than good would be undesirable, since it might be counterproductive. The House of Lords questioned whether she had proved that the pain was organic in origin. She had been sacked in 1990 after taking long periods off work because of pain in both hands. She claimed that the injury had been caused by the very large amount of typing at speed for long periods without breaks or rest periods. The House of Lords said that it could reasonably have been expected that a person of her intelligence and experience would take rest pauses without being told.

It also held that RSI as a medical term was unhelpful. It covered so many conditions that it was of no diagnostic value as a disease. PDA4 (Prescribed Disease A4) had, however, a recognised place in the Department of Health and Social Security's list for the purposes of industrial injury, meaning a cramp of the hand or forearm due to repetitive movements such as those used in any occupation involving prolonged periods of handwriting or typing. The House of Lords held that the Court of Appeal should not have overruled the findings of the High Court judge, since he had ample evidence before him to justify his decision that in the plaintiff's case the giving of warnings was unnecessary, even though typists in another department had been given warnings. The Health and Safety Executive published guidance on RSI in March 2009, on upper limb disorders and on musculoskeletal low back pain in October 2010 which are available on its website.[149]

Smoking

The dangers of smoking both to the smoker and to those passive smokers in the vicinity have led to an increase in the number of workplaces and public areas where smoking is prohibited.

From July 2007 smoking has been banned in public places, which include hospitals.

In April 2002, NICE published guidance on the effectiveness of aids to smoking cessation.

Recently the sale of e-cigarettes has escalated, with controversy as to whether they should be banned on the grounds that in a non-smoking area it is difficult to distinguish an e-cigarette from a conventional cigarette. Those promoting e-cigarettes stress that they are far less dangerous to health.

Anti-smoking legislation

The Tobaccos Advertising and Promotion Act 2002, banning press and billboard advertising of tobacco products in the UK, came into force on 14 February 2003 and provisions prohibiting sponsorship of sporting and other events by tobacco companies were being brought into force between July 2003 and July 2005. On 30 September 2003 new, more forceful, warnings in black and white have been compulsory on cigarette packets covering at least 30 per cent of the front of the packet and at least 40 per cent of the back. The warnings also include the NHS Helpline number (0800 169 0169).[150] Evidence that a ban on smoking in public places can improve health is seen from evidence of its effects in the US town of Helena.[151] Smoking in public places was banned for six months and researchers showed that, in comparison with earlier figures, the ban led to a 60 per cent reduction in heart attacks. The ban was lifted after a legal challenge. From July 2007 smoking in public places throughout the United Kingdom has been illegal. A consultation was launched in February 2007 to obtain views on raising the minimum legal age to purchase tobacco, and this was increased to 18 years in October 2007. The Chief Medical Officer has produced a series of video podcasts on smoking during pregnancy – these are available on the Department of Health website.[152] The EU on 30 November 2009 called on member states to adopt anti-smoking laws in public places, work places and public transport within three years. Patients at Rampton secure hospital failed in their argument that to ban smoking in a secure hospital was contrary to their human rights. The High Court held on 20 May 2008 that the ban on smoking was justified on health and safety grounds. The Court of Appeal in a majority judgment dismissed their appeal. The patients argued that the policy of prohibiting smoking in the premises of an NHS trust was a violation of their human rights as set out under Articles 8 and 14. The Court of Appeal held that although Rampton was the claimants' home, it was not a private home but a public institution operated as a hospital under section 4 of the 2006 Health Act which required all premises used by the public to be smoke-free by 1 July 2007.[153] Article 8 did not protect the right to smoke at Rampton. The dissenting judge Lord Keene held that the concept of personal autonomy which the Strasbourg court had adopted in *Pretty* v. *United Kingdom*[154] was wide enough to incorporate a right to choose to smoke.

In contrast, in Scotland Charles McCann, a detained patient, won his case that a ban on smoking was contrary to his human rights. He was not, however, awarded the £3,000 compensation he sought since it was held that he had saved more than £8,000 in not being allowed to smoke.[155]

In September 2013 it was reported that the government was contemplating banning smoking in prisons.[156] A pilot scheme is to be introduced in the spring of 2014 with a ban likely in 2015.

European Union and patient safety

In 2009 the Council of the European Union made recommendations on patient safety which included the recommendation that patients should be informed and empowered by involving them in the patient safety process.[157] Other recommendations relate to education and training of healthcare workers, and national strategies and long-term priorities for the control and prevention of healthcare-associated infections (see chapter 26).

The future

The Coalition government indicated its intention to review health and safety regulations and their surrounding bureaucracy, and appointed Lord Young to carry out the review.[158] He reported in October 2010[159] and the report is available online.[160] The aim was to end the culture of extreme health and safety correctness which had led to bureaucracy and red tape and endangered lives. (It was reported in July 2009 that a man died of a heart attack as a paramedic on the 999 call stood outside the house for 16 minutes making a risk assessment.[161] The patient had been told to leave the door open, but the paramedic feared that there were burglars. In a similar incident a coroner criticised paramedics who refused to jump into a drainage ditch to save a farmer when his Land Rover crashed.[162])

Ambulance crews were banned from taking a patient from her home to a weekly hospital appointment because there were three doorsteps. Instead her nephew paid for a private ambulance to take her at £250 a time.[163]

The main recommendations of the report cover the following.

- *Compensation culture*: introduce a simplified claims procedure for personal injury claims similar to that for road traffic accidents under £10,000 on a fixed costs basis and which may extend to low value medical negligence claims. Implement Lord Jackson's recommendations on civil litigation costs (see chapter 6). Control advertising for personal injury cases. Clarify liability in relation to 'Good Samaritan' acts. (The Social Action, Responsibility and Heroism Bill 2014 if passed and enacted will protect volunteers, teachers and organisations from legal action if they act in an emergency or take reasonable steps in organising school trips.)
- *Low-hazard workplaces*: simplify the risk assessment procedure for low-hazard workplaces such as offices, classrooms and shops using checklists which could also be used by voluntary organisations.
- *Standards*: raise standards by requiring all health and safety consultants to have a professional qualification accredited by professional bodies and listed in a web-based directory of accredited health and safety consultants.
- *Insurance*: insurance companies should cease to require businesses operating in low-hazard environments to employ health and safety consultants to carry out full health and safety risk assessments. Only qualified health and safety consultants on the web directory should be employed to carry out full health and safety risk assessments. Insurance companies should draw up a code of practice on health and safety for businesses and the voluntary sector.
- *Education*: simplify the process that schools and similar organisations undertake before taking children on trips with a single consent form covering all activities a child may undertake during his or her time at a school with a simplified risk assessment for classrooms. Shift from a system of risk assessment to a system of risk–benefit assessment.
- *Local authorities*: reasons should be given for a ban on events on health and safety grounds which can be challenged by citizens. Unfair decisions can be referred on a fast-track system to the Ombudsman who could award damages if the event cannot be reinstated.
- *Health and safety legislation*: the HSE should produce clear separate guidance under the Code of Practice focused on small and medium businesses engaged in lower risk activities. Health and safety regulations should be consolidated into a single set of accessible regulations.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 to be amended, with returns sent to a centralised body. The period before an injury or accident needs to be reported to be increased to 7 days and the system to be reviewed by the HSE.
- Combine food safety and health and safety inspections.
- Police officers and firefighters should not be at risk of investigation or prosecution under health and safety legislation when engaged in the course of their duties if they have put themselves at risk as a result of committing a heroic act.
- Abolish the Adventure Activities Licensing Authority and replace licensing with a code of practice.

An update on the initiative to reduce the number of unnecessary health and safety rules and regulations was published in April 2013 and identified the actions being taken:

- Setting up an Occupational Safety and Health Consultants Register
- Concentrating health and safety enforcement on higher risk areas
- Simplifying health and safety law and guidance (see review by Professor Lofstedt[164]).

The Health Foundation, an independent charity, has launched Closing the Gap in Patient Safety which, at a cost of £4 million, aims to support 10 project teams to implement and evaluate tested, evidence-based patient safety interventions.[165]

Francis Inquiry

How the NHS can create a learning culture which will raise standards and make it safer is an issue at the heart of the Francis Inquiry into failings at Stafford Hospital which is discussed in chapter 5. Professor Berwick (President Obama's former healthcare adviser), who was invited to report on patient safety following the Francis Report has argued that more laws and regulations will lead to a bureaucratic nightmare. His key findings are that:

1 The quality of patient care, especially patient safety, should be paramount.
2 Patients and carers must be empowered, engaged and heard.
3 Staff should be supported to develop themselves and improve what they do.
4 There should be complete transparency of data to improve care.

He makes 10 recommendations including that there should be criminal charges for organisations or staff who wilfully and recklessly cause harm.[166]

Concern is raised about the use of foreign doctors who carry out cosmetic surgery in this country without professional indemnity cover.[167]

Following these recommendations the Secretary of State announced in 2014 that there would be a 'Sign up to Safety' campaign for trusts to identify serious mistakes and take action to halve the incidence. In addition a duty of candour upon organisations is being introduced, which he described as 'potentially the biggest advance in patients' rights and patient safety since the creation of the NHS'. The power to draw up regulations to introduce a duty of candour are contained in section 81 of the Care Act 2014. In June 2014 a new section of the NHS Choices website called 'How safe is my hospital?' was launched which enables patients to compare patient safety across a range of indicators. It is available on the NHS website[168] and the Secretary of State hopes that the focus on patient safety will lead to improved standards and potentially over 6,000 lives will be saved over the next three years.

Conclusions

A risk management strategy is at the heart of any policy relating to health and safety, not just for employees, but also for the clients and general public. Regular monitoring of the implementation of a risk management policy should ensure that harm is avoided and that a quality service is maintained for the public. This should be accompanied by clear, comprehensive documentation. The Health and Safety Executive has continued to implement its strategy for workplace health and safety in Great Britain to 2010 and beyond. However, there is still much room for improvement within the NHS. It is clear that there is no room for complacency and there is a strong imperative for the NHS to improve the health and safety of the working environment as well as the health, safety and welfare of the workforce. The effect of Lord Young's recommendations on the NHS and the 'compensation culture' and the implications of the Francis Inquiry on the culture of the NHS in relation to safety remain to be seen.

Also unknown are the implications of the change in law so that breach of the Health and Safety regulations ceases to be the basis for a civil action for compensation. (Infection control is considered in chapter 26.)

Reflection questions

1 The Health and Safety at Work Act 1974 is enforced through the criminal courts. The employer's duty to care for the safety of his employees exists at common law. What is meant by these two statements and what is the difference in the enforcement provisions of each?

2 Who is the occupier of premises owned by the NHS trust and used by general practitioners?

3 All the circumstances must be taken into account in deciding whether the occupier is in breach of his common duty of care. What does this mean? Explain the statement in relation to an accident caused to an infant patient who slipped on a pool of water on the floor in the ward.

4 A nurse is injured while lifting a patient because the nurse assisting her suddenly let go and the injured nurse was left supporting the whole weight. What remedies, if any, does the injured nurse have and how could she claim compensation?

5 If a nurse is injured as the result of defective equipment, in what ways could she obtain compensation and what action should be taken?

6 What records should be kept in relation to any health and safety incident or in connection with claims under Part 1 of the Consumer Protection Act 1987?

Further exercises

1 Ask to see (if you have not already received one) a copy of your NHS trust's or employer's health and safety policy. How is this policy reflected in your working conditions?

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Part II

Specialist areas





Chapter 13

Children and young persons

This chapter discusses

- Consent to treatment
- Child protection
- Parental care and the nurse
- Disciplining a child
- Education of children in hospital
- Children's trusts
- National Service Frameworks (NSFs)
- Adolescents
- Teenage sexuality
- Court proceedings and the child or young person

Introduction

In addition to the basic principles of law discussed in the first part of this book, those who nurse children and young persons must also be aware of several special legal provisions that apply to those under 18 years. (In some hospitals, children over 16 years are cared for in adult wards, in others there are special adolescent units.) The Human Rights Act 1998 gives rights to the child (see the website of this book), as does the United Nations Convention on the Rights of the Child (1989).[1] While the UN Convention is not directly enforceable in the UK (unlike the European Convention on Human Rights), the extent to which the UK complies with the Convention is monitored on a biannual basis. The Children Act 1989 has provided a framework for the provision of services for children in need and sets out the basic principles to be followed in determining the welfare of the child. There have been significant

developments in the protection of children following the inquiries into the deaths of Victoria Climbié (which led to the Children Act 2004) and of Baby P (the Laming recommendations followed). The Department of Health has provided guidance on the welfare of children and young people in hospital[2] and the Audit Commission investigated the care of children in hospitals in 1993.[3] The RCN has published the results of a study into children's nursing and acute healthcare service provision that found a high level of non-adherence to national recommendations.[4] It followed this with a report in July 2001[5] and also guidance for nurses of children on a philosophy of care[6] and a position statement on children and young people.[7] Subsequently it published a toolkit for practice nurses in caring for children[8] and guidance on clinical practice and competencies across a range of conditions.

In 2014 the RCN published updated guidance on child abuse.[9] The British Medical Association has provided guidance on consent and the child.[10] A National Service Framework (NSF) was published for children's services in 2004 to ensure good standards of care across the NHS. The Royal College of Paediatrics and Child Health (RCPCH) has published guidance on many aspects of child protection, including *Child Protection Companion Guidance for Clinicians on how to recognise and manage child abuse and neglect* (2006); *Safeguarding Children and Young People: roles and competencies for Healthcare Staff. An Intercollegiate document outlining the competencies required for healthcare staff to safeguard children and young people* (2006); *Child Protection Confidentiality: responsibilities of doctors in child protection cases with regard to confidentiality* (February 2004); an updated version of its *Fabricated and Induced Illness by Carers* (2009); *Involving Children and Young People in Health Services* (2011) and guidelines and standards for clinical practice on a range of topics. All these publications are available from the RCPCH website.[11]

In September 2013 the President of the Royal College of Paediatrics and Childhealth stated that children in Britain were more likely to die from diseases or infections such as asthma, pneumonia and meningitis than elsewhere in Western Europe and 2,000 children die needlessly every year due to poor NHS care.[12] A letter was sent by the RCPCH and the chief executive of Public Health England to every Council in the country urging local authorities to take action to tackle the unacceptable variation in the quality of care for children and young people and reduce health inequalities.

Consent to treatment

At age 18 and over, adults, if mentally competent, are able to make all decisions in relation to their medical care. They can also consent to being participants in research programmes and this applies whether the research is seen as being in their therapeutic interests or not. Prior to 18 years, several different provisions apply.

The 16- and 17-year-old

Treatment

Under section 8 of the Family Law Reform Act 1969, the child of 16 or 17 can give a valid consent to treatment. The provisions of this section are set out in statute 13.1 below. These two subsections cover most eventualities as far as consent to treatment is concerned for the 16- and 17-year-old. Treatment is defined widely and would cover all nursing care. There is a presumption that, like the adult, the young person of 16 or 17 is capable of giving consent. This presumption is now contained in the Mental Capacity Act 2005 (which applies to those over 16 years) section 1(2), which states that a person must be assumed to have capacity unless it is established that he lacks capacity. Under section 2(4) of the MCA any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

Consent to research

It should be noted, however, that the Family Law Reform Act does not cover consent to take part in research unless it can genuinely be considered to be part of the treatment. Thus a 16-year-old suffering from a

disorder where there is no clearly proven successful method of treatment might well be asked to consent to a new, untried form of treatment as part of a research project. If the presumption that the individual has the mental capacity to give consent stands and it is clearly in the patient's therapeutic interests and if there are no undue risks, then such a proposal would be covered by the words of the section. If, however, there was at hand a proven successful method of treatment, but the child was approached to see if he would agree to take part in a research programme where there were considerable risks that may or may not be of benefit to him, it is likely that such a treatment would not be covered by the Family Reform Act (though it may be covered by the Mental Capacity Act 2005 and its provisions relating to research and mental incapacity (see chapter 18)). Similarly, where a child or a young person of 16 and 17 is asked to participate in research which is of no benefit to him, consent cannot be given under the provisions of the Family Law Reform Act 1969, but could be given under the Mental Capacity Act 2005, if the young person lacked the requisite mental capacity and was over 16 years. In February 2014 NICE stated that children should be taking part in clinical trials since it is an important factor that has contributed to improved survival rates of childhood cancers. NICE published new guidance on 27 February 2014 (see chapter 28).

Statute 13.1 Sections 8(1) and (2) of the Family Law Reform Act 1969

Section 8(1) The consent of a minor who has attained the age of 16 years to any surgical, medical, or dental treatment, which in the absence of consent would constitute a trespass to his person will be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment, it shall not be necessary to obtain any consent for it from his parent or guardian.

Treatment is defined very widely (Section 8(2)). In this section, 'surgical, medical, or dental treatment' includes any procedure undertaken for the purposes of diagnosis and this section applies to any procedure (including in particular the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

Refusal to have treatment

Case 13.1 *Re W*

Anorexia nervosa and the 16-year-old[13]

A 16-year-old girl under local authority care suffered from anorexia nervosa. She refused to move to a specialist hospital. The Court of Appeal held that the Family Law Reform Act 1969 section 8 did not prevent consent being given by parents or the court. While she had a right to give consent under the Act, she could not refuse treatment that was necessary to save her life.

In a more recent case Mr Justice Hayden made a 16-year-old girl a ward of court and temporarily ordered that she should have no contact with her mother. The girl 'A' weighed 5½ stones and had been in hospital for a year, vomiting up to 30 times a day. Her mother objected to plans to tube feed her. The judge was told that her condition was critical and her body had started shutting down. The judge authorised reasonable force and sedation to be used in inserting the tube in her nostril. The mother, however, felt that the doctors must have missed some other reason for her condition.[14]

In another case[15] (*An NHS Foundation Trust* v. *P*) the hospital was granted a declaration of lawfulness to enable it to treat a 17-year-old against her wishes following an overdose of paracetamol even though a psychiatrist declared her mentally competent to give consent to treatment. Her parents gave consent

to treatment but she refused. The court found that the girl had capacity to make decisions as to medical treatment but that in balancing the competing factors there could be no hesitation in concluding that the balance fell firmly in favour of overriding her wishes. Her Article 8 rights had to be taken into account but here they were outweighed by her rights under Article 2. The court was under a positive duty to protect a person whose life was at risk.

Emergencies

The Act does not prevent any emergency action being taken to save the life of a child who is unconscious or unable to give consent. Thus a 16-year-old who is wheeled into the A&E department in an unconscious state can be given emergency treatment in the same way that a patient of any age would be treated. The professional providing this emergency treatment would be protected against any allegation of trespass to the person by the defence that he or she was acting in an emergency in the person's best interests under the Mental Capacity Act 2005. For a younger person the health professional could rely on the Children Act 1989 Section 3(5) (see page 352).

Parallel consent

Section 8 of the Family Law Reform Act can also be interpreted as giving power to parents to give a valid consent on behalf of their child of 16 or 17. This is because a third subsection of this section states:

> **Section 8(3): Nothing in this section shall be construed as making ineffective any consent which would have been effective if the section had not been enacted.**

One interpretation of this is that the fact that the child of 16 or 17 can now give a valid consent to treatment does not mean that consent by the parents on behalf of the child ceases to be effective. Prior to the 1969 Act, a parent could give a valid consent on behalf of his child up to adulthood and this right is not affected by the Act. Thus there exists a parallel right to consent: both the parents and the child of 16 or 17 could give consent. This is unlikely to cause difficulties except in those rare occasions where there is a dispute between the child and the parent. Whose views does the doctor or nurse take?

Practical Dilemma 13.1 Clash between parent and child

A girl of 17 who had recently become a Jehovah's Witness was involved in a car crash. She was just conscious as she was wheeled into the A&E department and made it clear that she did not wish to be given a blood transfusion. Her parents were notified of the crash and told of her statement. However, not sharing her religious views, they said they would give their consent if blood was necessary to save her life. The consultant wishes to know the legal situation.

The fact that section 8(3) preserves the right of the parent to give consent means that, legally, the doctor could rely on that consent as a defence against any action for trespass to the person subsequently brought by the girl. Prior to section 8 of the Family Law Reform Act being passed, parents had the right to give consent and this right continues. However, to go against the wishes of the young girl is a serious situation and ideally the dispute should be brought to court. What if the doctor took notice of the girl's refusal, did not give blood and as a consequence the girl died? Could the parents then sue the doctor for negligence? The answer is that such a case would probably be unsuccessful, but much would depend on the circumstances – for example, the mental competence of the daughter in refusing blood; whether she understood the full implications; her general and specific capacity to give a valid consent.

Where there is a clash, the doctor has the choice of following the wishes of the child or the parents: if the position were reversed and the parents were Jehovah's Witnesses and the daughter consented to

having blood, there would be no difficulties; he could rely on her consent under section 8(1) and if the girl were unconscious he could act in an emergency to save her life, whatever the views of the parents. However, where it is the child of 16 or 17 who is withholding consent and the parents wish to give it, many would argue that it is the doctor's duty to save life and he should rely on the parents' consent under section 8(3). The point was considered by the courts in *Re W*[16] where the court overruled the child's refusal (see Case 13.1). Were such a dispute to arise and where time permits, the best procedure to follow would be a reference to the court under the Children Act 1989. If time did not permit a court application, the ruling in the case of *An NHS Foundation Trust* v. *P* discussed above[17] could be followed and her Article 2 right to life be seen to take precedence over her Article 8 rights.

A significant amendment to the law on the detention of young persons of 16 and 17 in psychiatric hospitals by the Mental Health Act 2007 (section 43 amending section 131 of the 1983 Act) meant that from October 2008 parents are no longer able to give consent to the admission of young persons of 16 and 17 who refuse to or are incapable of giving consent to admission. The Mental Capacity Act 2005 which came into force between April and October 2007 covers those over 16 years who lack the mental capacity to make decisions because of an impairment or a disturbance in the functioning of the mind or brain. It requires those who make decisions on behalf of those who lack mental capacity to act in the best interests of that person. Young persons of 16 or 17 who have the requisite mental capacity would not come within the provisions of the Act and disputes over their care would be heard by the Family Court. The Court of Protection can make orders and directions in relation to those who lack mental capacity in relation to both property and financial matters as well as personal welfare. Where a person under 16 years is unlikely to have the requisite mental capacity after 16 years, then an order can be made in respect of such a person. For example, if a boy of 14 received compensation following a road accident which caused serious brain damage, the Court of Protection could give directions for the use of that compensation. There are provisions in the Mental Capacity Act 2005 to facilitate the transfer of cases between the Family Division of the High Court and the Court of Protection to ensure that cases are heard in the most appropriate forum.

Children under 16 years

The Children Act 1989 requires the court to have regard to 'the ascertainable wishes and feelings of the child concerned considered in the light of their age and understanding' (section 1(3)(a)) in deciding whether to make specific orders under the Act. Certain sections require, if the child has sufficient understanding, the child's consent to be given, before the child can be asked to submit to a medical or physical examination.

Case 13.2 *Re E*

Refusal of blood by 15-year-old[18]

A youth aged 15 years 9 months was suffering from leukaemia and required a blood transfusion as part of his treatment. Both he and his parents were devout Jehovah's Witnesses and refused to give consent. The health authority applied for him to be made a ward of court and for a declaration that the treatment could proceed. The judge held that the lad was intelligent enough to take decisions about his own well-being, but that he did not have a full understanding of what the blood transfusions would involve. The welfare of the child was the first and paramount consideration. Although the court should be very slow to interfere in a decision the child had taken, the welfare of the child led to only one conclusion: that the hospital should be at liberty to treat him with blood transfusions. The judge therefore gave leave to the hospital authority to give treatment, including blood transfusion, and the consent of the patient and his parents was dispensed with.

In a case similar to *Re E*, a girl of 15 years suffered from thalassaemia and had been kept alive by monthly blood transfusions and injections. She and her mother began to attend meetings of Jehovah's Witnesses and subsequently refused to accept blood transfusions. The judge decided that the treatment could be authorised on the grounds that it was in her best interests and the court had the power to overrule a competent child's refusal of treatment. He did, however, find that the girl was not Gillick-competent (see page 353) because she lacked emotional maturity.[19] The High Court applied the Gillick principle to a case where parents were not informed that an abortion was to be carried out on a competent girl under 16 years[20] (see chapter 15). The European Court of Human Rights has stated that taking blood samples and intimate photographs of a girl of 9 without her parents' consent was a breach of Article 8 (see page 367).[21]

The principle that the courts must act in the best interests of the child can be seen in those cases where parents disagreed over whether their children should receive the MMR vaccination which are considered in chapter 26.

A trust applied for a declaration that a general anaesthetic could be used to insert a gastrojejunal tube and investigate why the stomach was not functioning normally. The child was 7 years with cerebral palsy and related medical and developmental complications. The parents agreed to the procedures but did not wish J the paediatric surgeon to operate. The Family Court granted the application and refused to dictate to the hospital who should carry out the procedures.[22]

Non-parents

The Children Act 1989 section 3(5) provides that a person who (a) does not have parental responsibility for a particular child, but (b) has care of the child, may (subject to the provision of this Act) do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare. It is suggested that this would include giving consent to necessary emergency treatment in the absence of the parents. In addition, professional staff would have a duty of care to take action to save life in such circumstances.

Case 13.3 *Re R (A minor: wardship: consent to medical treatment)* [1991] 4 All ER 177 CA

Compulsory treatment for mental disorder

The court gave permission for psychiatric medication to be given to a girl aged 15 against her will. Her mental health had deteriorated and she was placed in an adolescent psychiatric unit. Her condition fluctuated between periods of lucidity. The Court of Appeal held that she was not mentally competent owing to the fluctuating nature of her mental illness.

Kennedy and Grubb[23] have suggested in discussing the reasoning of the Court of Appeal that: 'It is more respectful of patients' autonomy to interpret incompetence so as to include the manic depressive and the anorexic (where appropriate) rather than regard them as apparently competent and then do wholesale violence to the law's commitment to the rights of decision-making of the competent.'

Children's rights: can children give consent themselves?

If the child is mature and capable of understanding the situation and it is not possible to contact the parents, the child can give a valid consent and this principle is emphasised in the Children Act 1989. This issue was considered in the Gillick case on the narrow issue of advice and treatment for family planning. However, the principles established by the House of Lords cover a much wider area.

Case 13.4 *Gillick v. West Norfolk and Wisbech AHA and the DHSS* (1985)

The Gillick case[24]

Mrs Gillick questioned the lawfulness of a DHSS circular, HN(80)46, which was a revised version of part of a comprehensive *Memorandum of Guidance* on family planning services issued to health authorities in May 1974 under cover of circular HSC(IS)32. The circular stated that in certain circumstances a doctor could lawfully prescribe contraception for a girl under 16 without the consent of the parents. Mrs Gillick wrote to the acting administrator formally forbidding any medical staff employed by the Norfolk AHA to give 'any contraceptive or abortion advice or treatment whatever to my . . . daughters whilst they are under 16 years without my consent'. The administrator replied that the treatment prescribed by a doctor is a matter for the doctor's clinical judgement, taking into account all the factors of the case. Mrs Gillick, who had five daughters, then brought an action against the AHA and the DHSS seeking a declaration that the notice gave advice that was unlawful and wrong and that did or might adversely affect the welfare of her children, her right as a parent and her ability properly to discharge her duties as a parent. She sought a declaration that no doctor or other professional person employed by the health authority might give any contraceptive or abortion advice or treatment to any of her children below the age of 16 without her prior knowledge and consent.

She failed before the High Court judge, succeeded in her appeal before the Court of Appeal, and the DHSS and health authority then appealed to the House of Lords. The Lords decided by a majority of three to two against Mrs Gillick. The majority held that in exceptional circumstances a doctor could provide contraceptive advice and treatment to a girl under 16 without the parents' consent. The circular was therefore upheld.

Lord Fraser stated the exceptional circumstances, which are set out in Box 13.1. Mrs Gillick has subsequently requested that the phrase 'Gillick-competent child' should be replaced by 'a child competent according to Lord Fraser Guidelines'. Many questions still remain uncertain. Can it be assumed that a mature child under 16 can give a valid consent to any form of treatment and research? What efforts must be made to obtain the parents' consent? For what can a child give consent: a few stitches; an anaesthetic; an abortion? Clearly the competence of the child must match the nature of the decision to be made: a young child may be able to agree to having stitches in his leg, but not to brain surgery. It is an overwhelming requirement that decisions must be made in the best interests of the child. The paramount consideration is the welfare of the child.

Box 13.1 Exceptional circumstances set out in the Gillick case

1. The girl would, although under 16, understand the doctor's advice.
2. He could not persuade her to inform her parents or allow him to inform the parents that she was seeking contraceptive advice.
3. She was very likely to have sexual intercourse with or without contraceptive treatment.
4. Unless she received contraceptive advice or treatment her physical or mental health or both were likely to suffer.
5. Her best interests required him to give her contraceptive advice, treatment or both without parental consent.

What is the position where the child is a mother? If she has the mental capacity, does she have the legal capability of giving consent for her child to be treated or is it necessary to obtain the consent of her own parents, i.e. the baby's grandparents? As an example, many health visitors treating the child of an underage mother protect themselves by obtaining both the consent of the underage mother and also of a grandparent. From the cautious words of the majority judges sitting on the Gillick case in the House of Lords, it would appear that, provided the underage mother had the requisite mental capacity to consent to treatment on the child's behalf, this would be a valid consent.

Another interpretation of section 8(3) of the Family Law Reform Act 1969 is that statutory powers given to a child of 16 or 17 to give a valid consent do not remove the ability of the mature child below 16 years to give a legally valid consent to treatment.

Where a child is refusing life-saving treatment, the test of Gillick competence will not be the only factor in determining the case, as Case 13.5 shows. In this case, the ruling in *Re W* was followed.

Case 13.5 *Re L*

Refusal by 14-year-old Jehovah's Witness[25]

A 14-year-old girl had sustained extensive and severe burns. Her life was considered to be at risk unless she underwent surgical treatment, which involved the possibility of a blood transfusion, although, as a practising Jehovah's Witness, she felt unable to consent to this. Her clearly expressed refusal was consistent with two earlier advance directive/release forms that she had completed, the last being only two months before her injuries. The hospital applied for leave to administer blood and blood products in the course of essential treatment without her consent.

The court granted the application on the grounds that:

1 She could not be said to be Gillick-competent. (Information had been withheld from her about the horrible death brought on by the onset and spread of gangrene, if blood were not transfused; and she had led a sheltered life, very much under the influence of the family.)
2 Even had she been found to be Gillick-competent, the extreme gravity of the case would, nevertheless, be sufficient basis for the order to be made.

A young person under 16 years could in theory rely on Article 3 of the European Convention on Human Rights (see the website of this book) or on Article 9 and his or her freedom to practise a specific religion to justify his or her refusal of life-saving treatment in conjunction with Article 14 and the right not to be discriminated against in the recognition of the Convention rights. However, the younger the age, the less likely the courts would be to find in favour of the youngster.

Clash between parents and child under 16

A case is considered in chapter 16 (Case 16.1) where a 15-year-old child's refusal to have a transplant was overruled by the court[26] together with cases where the wishes of the child were respected.

Overruling the parent

While parents have the power in law to give consent to the treatment of the child, this is not an absolute power. If their consent or their refusal to give consent is considered to be against the best interests of the child, then the court can intervene.

Case 13.6 *In re D* (1976)

Sterilisation of a mentally handicapped girl[27]

A girl of 11 years of age suffered from Sotos syndrome, the symptoms of which included accelerated growth during infancy, epilepsy, general clumsiness, an unusual facial appearance and behaviour problems, including emotional instability, certain aggressive tendencies and some impairment of mental function. The mother, taking the advice of the consultant paediatrician that her daughter would remain substantially handicapped and that she would always be unable to care for herself or look after any children, discussed with the obstetrician the possibility of her daughter being sterilised. An operation was arranged. However, before it was performed, the educational psychologist applied for the girl to be made a ward of court. Mrs Justice Heilbron, who heard the case, was not convinced that the operation was in the best interests of the girl and so ordered that the operation should not proceed.

It can be seen from this case how fortuitous it was that the case ever came before the courts. Had it not been for the strongly held views of the educational psychologist, the operation could well have gone ahead. This should not be so in the future. In a House of Lords' case,[28] where the judges agreed to a sterilisation proceeding on 'Jeanette', they made it clear that, in future, every such case of a sterilisation on a mentally handicapped child should receive the approval of the court before it proceeded. In that case, they did not make the distinction between therapeutic and non-therapeutic sterilisation, which Mrs Justice Heilbron had made *In re D*. In theory, every case of sterilisation on a child should come before the courts, even though the operation is performed because of the presence of a malignancy. This is further discussed in chapter 15.

The important point for children's nurses is that if they feel that a particular procedure or treatment agreed between the parents and the medical staff is not in the best interests of the child, then the nurse should raise it with her senior management who could, if necessary, arrange for the matter to be brought before the courts.

In a dispute between a family and the doctors, violence erupted on the wards as the family fought to prevent morphine, which would depress the respiratory functions, being administered to their child.

Case 13.7 *R v. Portsmouth Hospitals NHS Trust ex p Glass* (1999)

Dispute over treatment[29]

A boy of 13 was severely disabled with only a limited lifespan. The mother wished him to receive whatever medical treatment was necessary to prolong his life. Following an incident in which the hospital gave the child morphine against the mother's wishes, family members resuscitated the child and prevented him from dying. There was a complete breakdown of trust between the family and the hospital. The mother sought a declaration as to the course doctors in the hospital should take if the boy were admitted for emergency treatment and disagreements arose as to the treatment to be given to or withheld from the child. The judge refused the mother's application for judicial review and she appealed to the Court of Appeal.

The Court of Appeal held that it would be inappropriate to grant a declaration in anticipation and indicate to doctors at a hospital what treatment they should or should not give in circumstances that had not yet arisen. The best course was for the parents of a child and the medical staff to agree on the approach to be taken for the treatment of that child, but if that were not possible and a grave

conflict arose, then the actual circumstances must be brought before the court so that the court could resolve what was in the best interests of the child in the light of the facts existing at that time. The principles recognised by the Court of Appeal were as follows.

1 Sanctity of life.
2 Non-interference by the courts in areas of clinical judgement in the treatment of patients where that could be avoided.
3 Refusal of the courts to dictate appropriate treatment to a medical practitioner, subject to the court's power to take decisions in the child's best interests.
4 Treatment without consent, save in an emergency, was a trespass to the person.
5 The court would interfere to protect the interests of a minor or a person under a disability.

The Court of Appeal dismissed the appeal.

Ms Glass subsequently appealed to the European Court of Human Rights, which held that the failure of the NHS trust to seek a declaration from the court before administering diamorphine to her son without her consent and in writing him up for DNR instructions without her knowledge was a breach of her Article 8 rights.[30]

Members of the family were prosecuted for their violence in the hospital. (See also chapter 14 for the case of Charlotte Wyatt and other cases of severely disabled babies.)

DNA and parental consent

Concerns have been expressed by the Human Genetics Commission about parents giving consent to their children's DNA being tested on the grounds that this could infringe their rights to take health decisions for themselves when they are adults. Such tests should be confined to cases where there is an immediate and compelling medical reason[31] (see chapter 22).

Transplants and the interests of the child

Practical Dilemma 13.2 Sisterly transplants

Mary, aged 7 years, had an incurable blood disease and was found to be compatible only with her younger sister Janet, who was 4 years old. The parents therefore agreed that Janet would provide a bone marrow transplant for Mary. Staff Nurse Bryant was concerned by the legalities of the proposed transplant.

The parents have the right to consent to any treatment that is in the interests of the child (subject to any statutory limitations). However, in this case, there is a clash between the interests of Mary and the interests of Janet. Any operation, no matter how small, involves some risk to the patient and Janet would be put at risk for the benefit of Mary. In the case of a bone marrow transplant, it could be argued that the risk is so small and the psychological benefit for Janet when she becomes older so immense that it would be inhuman not to allow Janet to be a donor. If she were asked, she would probably agree herself, although her capacity to understand would be very limited. The situation would come under the legislation relating to transplants from live donors and the provisions of the Human Tissue Act 2004 (see chapter 16). The situation that would arise if Janet were mentally incapacitated and in an institution is discussed in chapter 17.

A further extreme example of using one child for the benefit of another arose in October 2000 when it was reported from the USA that parents had had a baby selected by *in vitro* fertilisation (IVF) who would provide compatible bone marrow for treating their daughter who suffered from a serious blood disorder.[32] The Human Fertilisation and Embryology Authority has stated that IVF is available for parents

who wish to ensure that the selected embryo will be a match for an existing child. This situation is now covered by the Human Fertilisation and Embryology Act 2008 and is considered in chapter 22.

In 1993 the court held that a blood transfusion should be given to a premature baby girl who suffered from respiratory distress syndrome and whose parents were Jehovah's Witnesses. The order authorising medical treatment was to be made under the court's inherent jurisdiction rather than pursuant to the Children Act 1989.[33]

In 2000 the future of conjoined twin girls came before the Court of Appeal.[34] The Court of Appeal decided that the operation could proceed. The case is discussed in chapter 14.

Withholding consent by parents

Where the parents refuse to give consent to treatment, which the doctors determine is in the best interests of the child, then there is a well-tried procedure for taking the appropriate action. No child should die because the parents have unreasonably refused their consent to a necessary treatment. In March 2014 a judge gave permission for a baby boy to have blood transfusions during an operation despite his parents' objections. The parents were Jehovah's Witnesses and the judge was told that the baby had no long term prospect of survival without cardiac surgery. The parents had agreed to the surgery but not to a blood transfusion.[35]

Practical Dilemma 13.3 Blood transfusion

Eric, aged 3 years, is admitted with an operable tumour. The neurologist reassures the parents and says that Eric can be saved. The parents say that on religious grounds they could not agree to Eric's having a blood transfusion. Mr Sharpe, the neurosurgeon, replies that he would not be prepared to carry out such an operation with such a restriction, as it is highly likely that blood would be required in the operating theatre. The parents therefore refuse their consent to the operation. Since the tumour is operable, the neurosurgeon cannot let the child die, so he has two options. He can either proceed and justify his action on the basis that he is acting in the best interests of the child in an emergency; or he can arrange for an application to be made to the court for Eric to be made a ward of court, and for the operation to be ordered to proceed.

In the case of an emergency, when there is insufficient time to obtain a declaration from the court, essential action must be taken to save the life of the child, if that is clinically in the best interests of the child.

Case 13.8 *In re B (A Minor)* (1981)

Down's syndrome[36]

A child who was born suffering from Down's syndrome and an intestinal blockage required an operation to relieve the obstruction if she were to live for more than a few days. If the operation were performed, the child might die within a few months, but it was probable that her life expectancy would be 20–30 years. Her parents, having decided that it would be kinder to allow her to die rather than live as a physically and mentally handicapped person, refused consent to the operation. The local authority made the child a ward of court and, when a surgeon decided that the wishes of the parents should be respected, they sought an order authorising the operation to be performed by other named surgeons. The judge in the High Court decided that the wishes of the parents should be respected and refused to make the order. The local authority took the case to the Court of Appeal, which said that the operation should proceed.

The court decided that the question before it was whether it was in the best interests of the child that she should have the operation and not whether the parents' wishes should be respected. Since the effect of the operation might be that the child would have the normal lifespan of a person with Down's syndrome, and since it had not been demonstrated that the life of such a person was of such a nature that the child should be condemned to die, the court would make an order that the operation be performed.

One significant case in which the courts did not follow the medical views was where parents refused to permit a liver transplant to take place on their toddler. The Court of Appeal held that in the very specific circumstances of the case (the parents lived abroad and as health professionals they believed the transplant not to be in the best interests of the child) the transplant would not be ordered against their wishes.[37] (See chapter 16 for further discussion on transplants and consent.)

The court will review any decision where parents are withholding consent or giving consent and decide whether the treatment should be given in the light of the best interests of the child. It is open to any interested party to ask the court to determine this question when he or she is concerned at what is proposed or not proposed.

Parents have a legal duty to care for their children. Where they fail to obtain medical treatment, they could be guilty of a criminal offence. A father was convicted of manslaughter and imprisoned and the mother given a suspended sentence for failing to give their diabetic daughter insulin.[38] The couple refused to allow their diabetic daughter to receive modern medicine because of their religious beliefs. In September 2002 a couple were jailed for starving their tortured 2-year-old daughter to death.[39] In March 2014 parents pleaded guilty to manslaughter after their 5-month-old baby died of rickets caused by severe vitamin D deficiency. They had failed to seek proper medical care because of their religious beliefs despite the advice of their relatives.[40] The father was jailed for 3 years and the mother for 2 years 3 months. An inquiry is to be carried out at the hospital because of its failure to advise the couple properly and to prescribe vitamin supplements.

Letting die

The Down's syndrome case (Case 13.8) above raises the issue of whether it is permissible in law to allow a severely handicapped child to die or even assist him to die. In what circumstances does the doctor cease to have a duty to keep the child alive? Certainly, as the case of *In re B* shows, the views of the parents are not the deciding factor. The point was raised in the case of Dr Arthur, who was prosecuted for murder (later changed to attempted murder), since he prescribed, with the consent of the parents, the substance DF118 for a Down's syndrome baby who also suffered from severe abdominal abnormalities. A jury acquitted him.[41]

The law does not recognise any form of euthanasia, but in practice it is left to the discretion of the medical staff to determine the extent of heroic medicine that is justified for severely handicapped babies. This discretion is reviewable in the courts. It is not an easy situation for medical staff and the Royal College of Paediatrics and Child Health has published guidelines to assist practitioners,[42] as has the British Medical Association.[43] This issue is discussed further in chapter 14 in the section on special care baby units and in chapter 29 in relation to adults.

In a Northern Ireland case (*A Health and Social Care Trust* v. *M and others*[44]) the court ruled that a 5-month baby with catastrophic and irreversible brain damage could be removed from a ventilator and made the subject of palliative care only. The father had obtained expert evidence which suggested that neuro-stimulation would assist the boy and the Trust's application for the ventilation to be withdrawn should be refused or adjourned for at least two weeks. Such evidence was contradicted by the other experts.

Child protection

The children's nurse needs to be aware of the possibility that injuries or illness in a child may have been caused by another person. This applies not just to bruising or lacerations, but also to undernourishment

and other ailments, including psychological damage. The possibility of sexual abuse must also be borne in mind if the relevant symptoms are present. The parents have a legal duty to provide care for their dependent children under section 1(1) of the Children and Young Persons Act 1933.

The nurse is confronted by the following problems. What action should she take if she suspects a child of being the object of abuse of any kind? What are the potential consequences for her if she is mistaken? What powers does she have to prevent a parent removing a child from the ward when the child has been placed under an emergency section of the Children Act? What would her position be in relation to a court hearing? Does she have to make a statement to the police?

Practical Dilemma 13.4 Child abuse?

Jane, a girl of 6 months, was admitted to the children's ward with a suspected chest infection. She was immediately placed on antibiotics and sputum samples taken. While the nurse was changing her, she noticed some bruising to the upper legs and a possible burn mark on her back. The nurse pointed these marks out to the junior doctor, who suggested that the registrar should be called in, as it was possible that these marks were the result of abuse.

A procedure for dealing with suspected child abuse should be available on every ward. If child abuse is suspected, the nurse should be particularly vigilant in not leaving the child unattended with the parents. In addition, it is quite likely that she could be called on to give evidence to the court as to the nature of the relationship and interaction between the parents and the child in hospital and also as to the physical and mental state of the child on admission. It is essential, therefore, that her record keeping should be detailed and clear to enable her to answer questions at some later time. Where cot death is feared, a new procedure has been introduced since January 2004 following the acquittal of several mothers who were imprisoned for killing their babies. The consent of the Director of Public Prosecutions must be obtained where the prosecution of parents is contemplated in respect of the death of a young child, in order that the possibility of cot death can be ruled out. The acquittals resulted from the discrediting of evidence of Munchausen by proxy relied on by the expert witness Professor Sir Roy Meadows, a paediatrician (see chapter 14).

Statute 13.2 Children Act 1989: protection of children

A Part IV	Care and supervision order, Sections 31–42
B Part V	Protection of children, Sections 43–52
C Part XII	Miscellaneous and general, Section 100 Restriction of wardship; jurisdiction of High Court still exists in emergency situations
Section 43	Child assessment order
Section 44	Orders for emergency protection of children
Section 45	Duration of emergency protection orders
Section 46	Removal and accommodation of children by police in cases of emergency
Section 47	Local authority's duty to investigate
Section 48	Powers to assist in discovery of children who may be in need of emergency protection
Section 49	Abduction of children in care
Section 50	Recovery of abducted children
Section 51	Refuges for children at risk
Section 52	Risk and regulation relating to emergency protection order

The social services department of the local authority can apply for a child assessment order or an order for the emergency protection of the child under Part V of the Children Act 1989 to care for the child initially, pending the outcome of the full proceedings for the care of the child.

The orders that can be made in respect of a child suspected of being abused are contained in the Children Act 1989, set out in Statute Box 13.2. Failure by a local authority to take reasonable precautions to prevent abuse can lead to payment of compensation. In September 2007 Hackney agreed, in an out-of-court settlement, to pay £100,000 to a woman of 39 years and her two younger siblings, because it failed to remove them as children from their abusive home.[45] Jake Pierce won £25,000 compensation because of failures by social services. A social services department had returned him to the care of his parents without making a proper assessment and the court held that this fell short of the standard of practice to be expected of a reasonably competent local authority and it was therefore negligent. Pierce had been subjected to almost daily beatings by his parents and was kept in squalid conditions.[46] The House of Lords considered the nature of the duty of care owed by a local authority to children under the Children (Leaving Care) Act 2000 in a case where it held the duty of care owed by the local authority's children's services unit to look after a homeless child could not be fulfilled by referring the child to the homeless persons unit.[47]

The Court of Appeal held in July 2013 that for the purposes of sections 23C(4) of the Children Act 1989 as amended by the Children (Leaving Care) Act 2000 a child who had been in care up to the age of 18 was entitled to have his educational expenses met by the local authority and these included university tuition fees.[48]

Further provisions relating to the transition for children to adult care and support are made in the sections 58–66 of the Care Act 2014 and shown in Statute Box 13.3.

Statute 13.3 Sections 58–66 Care Act 2014

58	Assessment of a child's needs for care and support
59	Child's needs assessment: requirements etc.
60	Assessment of a child's carer's needs for support
61	Child's carer's assessment: requirements etc.
62	Power to meet child's carer's needs for support
63	Assessment of a young carer's needs for support
64	Young carer's assessment: requirements etc.
65	Assessments under sections 58 to 64: further provision
66	Continuity of services under other legislation

Working together to safeguard children[49]

This is a guide to inter-agency working to safeguard and promote the welfare of children. The edition of 2013 replaces the publication *Working Together under the Children Act 1989*, published in 1991, which was revised in 1999 in 2006, 2010 and 2013. It sets out how individuals and organisations should work together to safeguard and promote the welfare of children. The guidance provides a national framework within which agencies and professionals at local level – individually and jointly – draw up and agree on their own ways of working together to safeguard and promote the welfare of children. It covers the areas shown in Box 13.2. The document can be downloaded from the website www.workingtogetheronline.co.uk.

Duties in the Children Act 1989 that require inter-agency cooperation include:

Section 27 enables a local authority to request help from: any local authority; any local education authority; any local housing authority; any health authority and any person authorised by the Secretary of State or, in Wales, the National Assembly. The request must be responded to.

Box 13.2 Contents of inter-agency guidance

1 Assessing need and providing help
2 Organisational responsibilities
3 Local Safeguarding Children Boards
4 Learning and improvement framework
5 Child death reviews

Appendices: A. Glossary; B Statutory Framework; C Further sources of information

Under Section 47, a duty is placed on such organisations or persons to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm.

Where a child had been assaulted by one or other of two people, the court was not required to identify which one was the perpetrator.[50]

Following the inquiry conducted by Lord Laming into the death of Victoria Climbié[51] the Department of Health published a detailed response, 'Keeping Children Safe',[52] and this was followed by a single source document for safeguarding children.[53] This document aimed to provide a single set of advice for all those involved in the care of children, which replaced local guidance. It was followed by a Green Paper, 'Every Child Matters',[54] published in September 2003. The Green Paper focused on four main areas:

1 supporting parents and carers
2 early intervention and effective protection
3 accountability and integration – locally, regionally and nationally
4 workforce reform.

Five outcomes were considered as key to well-being in childhood and later life: being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being.

A Children's Commissioner (one was already appointed in Wales) has been established as an independent champion for children. (The functions set out in section 2 of the Childrens Act 2004 are replaced by section 107 of the Children and Families Act 2014.) In addition, legislation to create a Director of Children's Services accountable for local authority education and children's social services was proposed. A Minister for Children, Young People and Families has been created in the Department for Education. The Children Act 2004 provides the legal underpinning for 'Every Child Matters' and its provisions are shown in Box 13.3. Significant features include the new Local Safeguarding Children Boards, and the duty on local authorities to appoint a Director of Children's Services and a lead member for children's services. Regulations for the Local Safeguarding Children Boards were issued in 2006[55] and amended in 2010.[56]

The Children and Families Act 2014 makes provision on the adoption and contact (Part 1); family justice (Part 2); those with special educational needs (Part 3 – supplemented by regulations[57]); childcare (Part 4); welfare of children (Part 5); the Children's Commissioner (Part 6); statutory rights to leave and pay; time of work, antenatal care and flexible working (Parts 7–9) (See chapter 10) and General Provisions (10).

Concerns were expressed by Ofsted in 2014 that another Climbié abuse case could be forthcoming because of the large unknown private fostering arrangements which are not reported to LA as required by law[58].

Box 13.3 Provisions of the Children Act 2004

Part 1 Children's Commissioner
Part 2 Children's services in England
- Co-operation to improve well-being
- Arrangements to safeguard and promote welfare
- Information databases
- Local Safeguarding Children Boards: establishment, functions, procedure and funding
- Children and young people's plans
- Director of Children's Services
- Lead member for children's services
- Inspections of children's services

Part 3 Children's Services in Wales
Part 4 Advisory and support services for family proceedings

Following the Lord Laming inquiry into the death of Victoria Climbié, the Joint Chief Inspectors have reported on safeguarding arrangements for children and young people in England. The Healthcare Commission contributed to the third Joint Chief Inspectors' Report on Safeguarding Children, published in October 2008. The children's inspectorate is now the Office for Standards in Education and Social Care and it reviews the work of Local Safeguarding Children Boards. Section 11 of the Children Act 2004 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children. The Department for Children, Schools and Families (DCSF) issued statutory guidance on the duty in 2005 and a revised version was published in April 2007. Part 1 of the guidance sets out the arrangements that are likely to be common to all or most of the agencies concerned. Part 2 deals with implementation in each particular agency to which the Section 11 duty applies. The DCSF stated that:

> **These arrangements require all agencies to have:**
> **senior management commitment to the importance of safeguarding and promoting children's welfare**
> **a clear statement of the agency's responsibilities towards children, available for all staff**
> **a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children**
> **service development that takes account of the need to safeguard and promote welfare, and is informed, where appropriate, by the views of children and families**
> **training on safeguarding and promoting the welfare of children for all staff working with, or in contact with, children and families**
> **safe recruitment procedures in place**
> **effective inter-agency working to safeguard and promote the welfare of children**
> **effective information sharing.**

In 2010 the DCSF was replaced by the Department of Education (DE).

The RCN has published guidance on child protection and the nurse[59] and emphasises the need of each trust to have a designated or named nurse for child protection, have child protection procedures in place and have a defined policy on raising concerns about colleagues. A self-assessment tool for child protection arrangements for clinicians was updated and relaunched by the Healthcare Commission in 2004 and is available from the CQC website. Guidance was provided in 2007 for practitioners and managers to help them identify and deal with abuse which may be linked to a belief in spirit possession. The guidance followed the research report on child abuse linked with accusations of possessions and witchcraft published in June 2006.[60] The establishment of children's trusts (see page 371) may assist in improving child protection provisions by improving cooperation across the agencies.

- National agency to oversee reform implementation. Cabinet minister responsible for success.
- Social work students must get child protection training and work experience before starting their job
- Increased quality of degrees; introduction of a children's social worker postgraduate qualification
- Court fees for applying to take children into care should be scrapped if they affect decisions
- Ofsted inspectors examining children's social services to have child protection experience
- A national strategy to address recruitment problems
- Guidelines on caseloads
- Directors with no child protection experience should appoint an experienced social work manager to support them

Figure 13.1 Recommendations from Lord Laming's Report in March 2009

The case of Baby P

Baby P died in Haringey as a result of appalling abuse, despite being seen on over 60 occasions by health professionals, social services staff, police and others. He was known to be at risk. The Director of Children's Services was dismissed. (She eventually was awarded £679,452 by the Court of Appeal for unfair and unlawful dismissal, the Department of Education being required to contribute to that sum because the then Secretary of Education had issued unlawful directions to Haringey about her future.)

The GP who saw Baby P eight days before his death was found guilty by the GMC of a serious breach of a professional duty for not acting upon the visible signs of child abuse. Lord Laming was invited to report on the failings which had led to Baby P's death. Lord Laming's report,[61] published on 12 March 2009, put forward 52 recommendations for improving child protection services, some of which are shown in Figure 13.1. A consultant paediatrician, Dr Kim Holt, who raised concerns about the clinic that sent Baby P home to die, is suing the NHS for compensation after complaining that she was forced out of her job and suffered a nervous breakdown.[62] She has subsequently received an apology from Great Ormond Street hospital and in 2014 was appointed as a professional adviser to the CQC.

Lord Laming found that many authorities had failed to adopt the reforms recommended in the Victoria Climbié Inquiry in 2000. It was also hoped that the £4,000 court fee (a rise from £125) introduced in May 2008 for taking a child into care would be scrapped. In February 2009 it was reported that two-thirds of hospitals fail to conduct routine checks on injured children suspected of being at risk, despite warnings after the death of Baby P.[63] There have been many official reports into the circumstances surrounding the death of Baby P. Two have been carried out by Haringey Council itself; the Audit Commission on children's services reported on 4 March 2009 and the Laming Report on Baby P was published on 12 March 2009. The Healthcare Commission's investigation of the NHS care surrounding Baby P was published by the CQC in May 2009.[64] This report found systematic errors in how the NHS trusts dealt with the case of Baby P and made recommendations to the trusts involved. These included:

- The NHS trusts should ensure that their staff are clear about child protection procedures and have received safeguarding training to an appropriate level.
- A sufficient number of appropriately qualified paediatric staff should be available when required, in line with established guidelines.
- The adequacy of consultant cover should be reviewed at one hospital.
- All four NHS trusts need to establish clear communication and working arrangements with relevant social services departments and, in particular, ensure that there is no delay in establishing contact between agencies once a safeguarding referral has been made to social services.

- The trusts must ensure that appropriate arrangements are in place to enable:
  - safeguarding supervision;
  - staff to attend multi-agency child protection case conferences;
  - appropriate training to be undertaken;
  - signing off the trusts' own declarations against core standards, assuring themselves that they can do so and do so adequately.

The Baby P case shows that coordination between the various services involved meant that no one took control and that there were serious failures by doctors and health visitors to detect evidence of non-accidental injuries. There were also poor links between health and social services. As a consequence of government action, £60 million was to be made available to bring about changes in child protection. These changes include: all children's services directors were sent for compulsory training in the realities of frontline social work under plans to drive up standards in child protection to be announced on 13 March 2009.[65]

The government's initial response to Laming was published in 2009 and a year later, in March 2010, it published a progress report.[66] It looked at National Leadership in the form of a Cabinet forum on which four key Secretaries of State sat: the appointment of a Chief Adviser on the Safety of Children; the establishment of a National Safeguarding Delivery Unit (NSDU); the setting up of safeguarding national indicators and targets and revisions to working together to safeguard children. It also reviewed the system for regulation and inspection and the role of the CQC (see chapter 5). It considered the revised guidance for Area Child Protection Officers on Investigating Child Abuse and Safeguarding Children and the comprehensive toolkit for forces to incorporate into practice. A table sets out a comparison of Laming's recommendations in 2009, the Government's response in May 2009 and the progress in March 2010. An annex provides a template for serious case review executive summaries. *Working Together to Safeguard Children and Families* was updated in the light of the recommendations (see Box 13.2).

Criticism of the care system was made by the cross-party Children, Schools and Families Select Committee on 20 April 2009. The Committee called for a new national framework of fees and allowances for foster parents, who look after about two-thirds of the 60,000 children in the care system, in order to attract and retain better families. Other criticisms related to the fact that many children left care at 16 years, encouraged by local authorities on financial grounds, yet this was the time when they could go off the rails, and of the lack of training of staff in care homes. Care should become a positive experience for the child. The House of Commons Education Committee held in March 2014 that children in residential care should not be placed more than 20 miles from their own homes.

A review of the culture and barriers within the care of children was chaired by Sir Ian Kennedy who reported in September 2010[67] and made significant recommendations on how the services should be radically revised. One of its conclusions was that GPs and nurses should receive extra training in the care of children as a matter of urgency because young people's welfare is such a priority for the NHS. The RCPCH welcomed the report and said that the challenge was how the Kennedy Report would fit in with the other changes proposed by the government that affect children.[68]

Many of the findings in Kennedy's report were incorporated into the Department of Health's plans for the health of children and young people.[69] This emphasises the importance of ensuring that decisions are made with the family; that information is available on an age-specific basis; services should be child-centred; reducing the bureaucracy of children's trusts and respecting the wishes of the Gillick-competent child.

In November 2010 the cross party Public Accounts Committee found that following the Baby P case the children's family court service was unable to cope with the surge of children being taken into care and did not have a contingency plan to deal with the influx of cases.[70]

In April 2010 it was reported that following an Audit Commission finding that children's services in Doncaster Council were not fit for their purpose, the government was prepared to use statutory powers to appoint commissioners and take over the running of the Council.[71] The Audit Commission had sent

inspectors into the borough after two brothers of 10 and 11 in the care of social services were sentenced for an attack on children aged 9 and 11.

Any nurse must also be alert to the possibility of a colleague causing harm to a patient. This is considered in the section on whistleblowing in chapter 4. The RCPCH published guidance in 2009 on fabricated or induced illness by carers which is available on its website. Other issues that arise in relation to non-accidental injury include disclosure of confidential information (this is covered in chapter 8) and giving evidence before the court (covered in chapter 9).

The case of Daniel Pelka

A serious case review was set up following the death of Daniel Pelka aged 4 who had been starved and battered to death by his mother and stepfather, both of whom were convicted of his murder and given life sentences. The report was published on 17 September 2013 and found that numerous opportunities were missed by social workers, the police, teachers and doctors all of whom had contact with Daniel and his family. No single agency or individual was blamed for the death. The report called for improvements in the identification and reporting of domestic abuse and better reporting by schools of injuries to children. There was no record of any conversation held with Daniel about his home life, his experiences, his wishes and his feelings. The report is available on the Coventry website[72]. It emphasised the importance of integrating the lessons which had been learnt into safeguarding practice. *The Times* in its leader[73] stated that if one adult had taken responsibility then he might be still alive and suggested that a named social worker should be assigned to every at-risk child in the country and be responsible for his or her welfare. A report by the Coventry Safeguarding Children Board found that health professionals had delayed passing on information and that there were unacceptable delays in circulating the minutes of a strategy meeting that looked at a broken arm suffered by Daniel in 2011.[74] On 21 March 2014 an Ofsted Report found that children's services at Coventry City Council remained inadequate: their leadership, management and governance were condemned and Ofsted questioned the effectiveness of the local children safeguarding board.[75]

Provision for amending section 1 of the 1933 Children Act to widen the offence of failing to care for children has been included in the Serious Crime Bill, which at time of writing had completed all stages in the House of Lords but no timetable had been fixed for passage through the House of Commons. The 1933 Children Act enables prosecution if an adult has deliberately assaulted, abandoned or exposed a child to suffering or injury to their health.

Child-sex abuse: mandatory reporting

Following the scandals of mass sex abuse and grooming of girls in Rotherham and Rochdale the Home Affairs Select Committee published a damning report on 10 June 2013 recommending changes to the law and suggesting that the government should examine creating a mandatory duty for every professional to report suspicions of child-sex abuse.[76] The government responded in September 2013[77] to each of the recommendations. It was not, however, considering any plans to introduce mandatory reporting of child abuse and neglect, given the robust reporting procedures already in place under Working Together to Safeguard Children. It stated that there is sufficient legislation and statutory guidance to tell professionals what should happen if they are concerned about a child. However, on 9 July 2014 the Prime Minister announced that a statutory duty to report suspected child abuse cases was under consideration.

Mandatory reporting of child abuse has been supported by the Children's Commissioner Maggie Atkinson and by Keith Starmer the former Director for Public Prosecution. A private GP who had failed to report sex abuse claims about two children aged 4 and 6 and who said that he did not wish to read about procedures for safeguarding children was struck off by the GMC.[78]

A report published by Kids Company and the Centre for Social Justice think-tank called for a royal commission on child protection. It feared that budget cuts have left children subject to 'unscrupulous

and illegal practices' by local authorities who order social workers to downgrade the dangers children are facing so that they can be given cheaper forms of help or none at all.[79] Kids Company have launched an Independent Children's Task Force chaired by Sir Keith Starmer former Director of Public Prosecutions to redesign children's social care and mental health services.

Liability of local authorities for abuse of children

Recent cases have held the local authority (LA) liable in respect of failures to take action to prevent abuse and in making negligent adoption and fostering arrangements. In 2001 the ECHR overruled the House of Lords' decision that the LA was not liable in negligence or for breach of statutory duty to children who had been abused by their parents.[80] The ECHR held that the local authority had a duty of care to the children, whose Article 3, 6 and 13 rights had been breached.[81] Two people who had been abused as children by their stepfather succeeded in their claim that the LA had failed to provide an appropriate means of obtaining a determination of their allegations. These allegations were that the LA had failed to protect them from serious ill treatment[82] and therefore were in breach of Article 13. (Article 13 requires there to be an effective remedy before a national authority for any breach of human rights notwithstanding that the violation has been committed by persons acting in an official capacity.) (Article 13 is not included in Schedule 1 of the Human Rights Act 1998 (see the website of this book).) On the facts, there was no breach of Article 3. In contrast, in another case the ECHR held that where the LA failed to protect children from sexual abuse by the stepfather, the LA was in violation of Article 3 and Article 13 and was held liable to pay damages.[83] In another case against a local authority, this time by a couple who adopted a violent child, the couple won their case that they should have been notified by the LA of the boy's serious and emotional behavioural difficulties.[84] The court held that the LA could be held vicariously liable for negligence by its employees in failing to fulfil their duty of care owed to those who might foreseeably be injured if the duty was carelessly exercised. Research conducted by the Fostering Network suggested that over half of foster parents had been given inadequate information about the children in their care which had put themselves and their own children at risk.[85]

Errors in identifying child abuse and human rights

There have been misdiagnoses of child abuse. For example, in one case,[86] following a case conference, a baby was taken into care on the basis of medical evidence that suggested that a spiral fracture of her femur was evidence of non-accidental injury. Subsequently, it was discovered that the baby suffered from brittle bone disease and the child was returned to the parents 9 months after the hospital admission. The parents sued and action was also brought in the name of the child arguing a case of negligence, and breach of Article 8 of the European Convention on Human Rights. The claims failed on the grounds that the child had suffered no injury for which the law recognised a remedy; a duty of care was not owed by the defendants to the parents (the doctor owed a duty of care to the child and his obligations within the multidisciplinary process militated against the doctor owing any additional duty to the parents in relation to the diagnosis which commenced such a process) and to hold the doctor liable to the parents would cut across the statutory scheme set up for the protection of the child. The Human Rights Act came into force on 2 October 2000, was not retrospective and the cause of action arose in September 1998 and June 1999. In one case[87] in East Berkshire, a mother was suspected of Munchausen's syndrome by proxy when her son suffered from allergic reactions following birth and he was placed on the 'at risk' register. However, it was subsequently discovered that he did have allergy problems. The mother claimed compensation on the grounds that the original diagnosis was made negligently. The House of Lords held that it would not be fair, just or reasonable to impose a duty of care on a doctor in respect of a negligent clinical diagnosis where there was a concurrent and potentially conflicting duty of care towards a child patient. No duty of care was owed to the parents. However, in 2010 the ECHR held that a duty of care was owed to parents and there were breaches of the European Convention on Human Rights.[88] The parents who had failed in their applications before the House of Lords[89] succeeded in their claim for compensation.

In the case of *MAK and RK* v. *the UK* the ECHR held that the taking of blood samples and intimate photographs of a girl aged 9 years without her parents' consent violated Article 8 of the European Convention on Human Rights, which guaranteed the right to respect for private and family life (see the website of this book). There was also a violation of Article 13 because of the absence of an effective remedy. The ECHR ordered the UK to pay MAK (the mother) €2,000 and RK €4,500 and €15,000 jointly for their costs. The circumstances of the case were that bruising was noticed on the girl's skin and the paediatrician suspected abuse by the father. The paediatrician delayed in referring the girl to a dermatologist who diagnosed a rare skin disease.[90]

Surrey County Council social workers who enlisted the help of the police in removing a child of one from her parents were criticised by Mrs Judge Theis who held that the claims against the parents were not borne out by the evidence and social workers had misunderstood many issues. The girl had been born with heart problems and required surgery at 10 days old. She was in hospital for 11 months and the parents were taught how to care for her and coped for months with round the clock care regime, with professional support until concerns were raised about their care of the girl.[91]

In another case, Mrs Justice Pauffley said that she was profoundly alarmed at the discovery that family courts were effectively in cahoots with social services through clandestine arrangements which undermined the independence of the justice system. Courts were routinely removing children from their mothers into care without adequate investigation.[92]

The Court of Appeal in a decision involving two cases deplored failures, particularly by public bodies such as a local authority, to comply with court orders.[93] In the cases parents had appealed or opposed adoption orders and the local authorities had failed to comply with the orders.

In another case the ECHR held that failure by the LA to conduct a risk assessment, resulting in a child being placed with foster parents, was a breach of the Article 8 rights of the parent (AD) and the child (OD).[94] The paediatricians had noticed several fractures to the child's ribs and concluded that they were sustained non-accidentally, dismissing the possibility that the child might have brittle bone disease. Subsequently, the child was found to have brittle bone disease and normal handling could have caused the fractures. The Court of Appeal held that the LA did not owe a duty of care and there was no evidence that the child had suffered any actionable damage.[95] The ECHR found that there was both a breach of Article 8 rights and also Article 13 since the mother had no effective remedy for her complaints contrary to Article 13.

As a result of these cases it is now clear that the LA does have a duty of care to potential foster parents to ensure a risk assessment is carried out and to parents accused of child abuse to ensure that other causes of a child's injuries are examined prior to a child being taken into care.

Protection of Children Act 1999

This Act requires organisations to refer persons considered unsuitable to work with children to the Department of Health for inclusion on their list (see chapter 10).

Parental care and the nurse

Practical Dilemma 13.5 Mum knows best

The children's ward at Roger Park Hospital introduced a scheme for mothers and other relatives to undertake some of the tasks in caring for the children. Originally, the scheme covered only the day-to-day routine care of dressing, feeding, bathing and amusing the child. Subsequently, however, it was extended to nursing and extended-role tasks, including the care of nasal-gastric feeding and

intra-venous medication. The reason for this extension was that several of the mothers of long-term chronically ill children undertook all these tasks in the community. The nurse or doctor had the task of ensuring that the mother had the appropriate training and the necessary equipment.

Mrs Tait agreed to give her 4-year-old child, Robin, who had a chronic lung condition, the appropriate drugs intravenously every six hours. She had undertaken several such treatments on her own before and was familiar with the routine and procedure. On the ward, she was given the keys to help herself to the necessary drugs. This was contrary to the accepted practice, but was permitted because it was felt that she could be trusted. She gave Robin the 8.00 a.m. treatment without problems. She had to leave the hospital in the afternoon, but told another parent that she would be back for the afternoon treatment. Unfortunately, she did not return until 3.30 p.m. because of an unexpected traffic holdup. Robin was with some other children watching *Teletubbies*. Mrs Tait immediately went to the staff nurse to get the keys to draw up the drugs for the next treatment. She took the boxes from the cupboard and started to make up the syringes. She then took Robin into the single room to give him his treatment. As she was giving the medication, Robin became very ill and she called for help. It was then discovered that the afternoon dose had already been given to Robin and although this had been written up into his notes, the nurse who did so was at tea when Mrs Tait returned and she herself did not check Robin's notes as it was never her practice to do so. Robin suffered severe renal failure as a result of an overdose of an antibiotic. Is the accident entirely the mother's fault or does the nurse carry some responsibility?

What is the situation where responsibilities like this are divided between several people? In legal terms, it is probably true to say that the care of the child in hospital is primarily the responsibility of the nurse under the clinical supervision of the medical staff. In a sense, the nurse is delegating to the mother those duties that she is capable of performing and probably performs on her own at home. The nurse should only delegate those tasks that she feels the mother is competent to perform and, in addition, she should ensure that the mother (or, of course, any other relative, friend or volunteer) has the correct amount of training and supervision to undertake the task safely. The nurse would be responsible in negligence if she delegated an unsuitable task to the mother or failed to provide her with the appropriate instructions or gave her inadequate supervision. If, however, the nurse has satisfied all those requirements and something still goes wrong because the mother makes a mistake, then it would be the mother's responsibility for any harm caused to the child as a result of the mistake.

In the above situation, there is clearly a failure in communication between nurse and mother. It would have been preferable to set up a procedure whereby the mother was told to look at the drug chart, to fill it in when she gave the drugs to the child and also to check that the drugs had not already been given. She should also be supervised in her administration of the drugs. It is questionable whether the mother should have been allowed direct access to the medicines. Clearly, the nurse would be at fault in failing to set up this procedure and the supervision, and the mother would bear some responsibility for failing to check that they had been given, although in mitigation it could be said that the person responsible for the ward at the time she returned should have known the child had already had his medication and informed the mother accordingly. The problems relating to supervision and instructing others are dealt with more fully in chapter 24. The RCN has provided guidance on administering intravenous therapy to children in the community.[96] The Department of Health has published an NHS childcare strategy to provide affordable and accessible quality childcare and is attracting more staff to work in the NHS. Further information is available from the DH website.

Disciplining a child

Practical Dilemma 13.6 The nurse *in loco parentis*

Adam was a bright 7-year-old who appeared totally undaunted by his stay in hospital for a hernia operation. Unfortunately, his mother could spend very little time with him as she had two younger children and her husband was overseas. Once Adam had recovered from the immediate effects of his operation, he was uncontrollable. He wandered around the wards into the single-bed wards, ignoring all the nurses' instructions and delighting in disobeying them. In one of the single rooms, a child was being barrier nursed with suspected meningitis. Staff Nurse James saw Adam about to enter this room and in her anxiety and her impatience with him, she hit him hard on the leg. Adam screamed and other nurses came running. Staff Nurse James was disciplined by the nursing officer and Adam's mother said that she was going to make a formal complaint against the nurse and the hospital. Staff Nurse James argued that in the circumstances there was little else she could have done to prevent Adam entering that room and, in any case, she had the powers of a parent to discipline a child who needed to be controlled.

The ECHR has ruled that severe corporal punishment to discipline children was a breach of Article 3 of the European Convention on Human Rights.[97] In the case, a stepfather had beaten a 9-year-old boy on several occasions with a garden cane. The stepfather had been prosecuted for assault occasioning actual bodily harm, but had been acquitted by the jury who accepted his defence that the caning had been necessary and reasonable to discipline the boy. The ECHR held that ill treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. It depended on all the circumstances of the case, such as the nature and context of the treatment, its duration, its physical and mental effects and, in some instances, the sex, age and state of health of the victim. In finding that there had been a breach of Article 3, it awarded the boy £10,000 against the UK government and costs. The UK government acknowledged that the UK law failed to provide adequate protection to children and should be amended. Subsequently, guidance was issued by the government on the use of corporal punishment against children. Guidance for good practice in restraining, holding still and containing children has been issued by the RCN.[98] The Joint Committee of House of Lords and House of Commons,[99] in monitoring the UK compliance with the UN Charter on the Rights of the Child, considered that the retention in UK use of the defence of 'reasonable chastisement' is incompatible with the provisions of Article 19 of the Convention. Subsequently, the Children Act 2004 was enacted and section 58 is shown in Statute Box 13.4.

Statute 13.4 Section 58 Children Act 2004

1 In relation to any offence specified in subsection (2) below, battery of a child cannot be justified on the ground that it constituted reasonable punishment.
2 The offences referred to in subsection (1) are:
  (a) An offence under Section 18 or 20 of the Offences against the Person Act 1861 (wounding and causing grievous bodily harm)
  (b) An offence under Section 47 of that Act (assault occasioning actual bodily harm)
  (c) An offence under Section 1 of the Children and Young Persons Act 1933 (cruelty to persons under 16).
3 Battery of a child causing actual bodily harm to a child cannot be justified in any civil proceedings on the ground that it constituted reasonable punishment.
4 For the purposes of subsection (3) 'actual bodily harm' has the same meaning as it has for the purposes of Section 47 of the Offences against the Person Act 1861.
5 In Section 1 of the Children and Young Persons Act 1933, omit subsection (7) (Section 1(7) made any parent or person having lawful control or charge of a child to administer punishment an exception to the offence of assaulting or wilfully ill-treating a child).

The effect of this section is that a parent who causes harm to her or his child and is prosecuted under the Offences Against the Person Act sections 18, 20 or 47 or under the Children and Young Persons Act 1933 section 1 cannot use a defence that the battery constituted reasonable punishment. The same applies in civil proceedings where actual bodily harm is caused.

In 2007 the Children's Commissioner for England called for a complete ban on smacking children[100] as a consultation on the effect of the change in the law was initiated. As a result of the review the Children's Minister ruled out a total ban on smacking children on 26 October 2007.[101] In March 2010 Sir Roger Singleton, Chief Adviser on the Safety of Children, published an independent report on 'Physical punishment: improving consistency and protection', which made three recommendations.

1 The current ban on physical punishment in schools and other children's settings should be extended to include any form of advice, guidance, teaching, training, instruction, worship, treatment or therapy and to any form of care or supervision which is carried out other than by a parent or member of the child's own family or household.
2 The government should continue to promote positive parenting strategies and effective behaviour management techniques directed towards eliminating the use of smacking. Parents who disapprove of smacking should make this clear to others who care for their children.
3 The development of appropriate safeguarding policies in informal education and learning organisations should continue to be promoted. Legal changes which flow from adoption of these recommendations will need to be communicated effectively.

The government of the time accepted these recommendations.

It therefore follows that corporal punishment should not be used when acting in the place of the parents. In the above example, Staff Nurse James has acted illegally and other methods of control would have been preferable. There were other ways of stopping him entering the room other than hitting him and, in the circumstances, it seems more likely that she lost her temper and was unreasonable.

A respect for the rights of the child and good nursing practice would advocate no use of physical force against a patient. A nurse faces both criminal and civil proceedings against her personally if she uses corporal punishment on a patient. She would, however, be entitled to use reasonable force to protect herself or other people by restraining the child if she or others were threatened with violence. The implications of this for staffing levels are clear and the degree of unruliness in children and the extent of parental help could affect the level of staffing required. Guidance on the use of restraint and therapeutic holding in the care of children and young people is provided by the RCN.[102] Training for staff in coping with unruly children is essential.

Education of children in hospital

It is estimated by the Department for Education that in any given year there are some 100,000 children and young people who require education outside school because of illness or injury. The special education of children in hospitals was provided for in the National Health Service Act 1946. Section 62 empowered regional hospital boards and teaching hospitals to arrange with a local education authority (LEA) or voluntary body to use as a special school any premises forming part of the hospital. By 1955 there were 120 hospital special schools providing teaching for 8,476 pupils in addition to 1,425 children receiving individual or group tuition. In 1971 responsibility for the education of children in hospitals for the mentally handicapped was transferred to the education service (1975 in Scotland).

The Education Act 1993 (s. 298(1), now consolidated in section 19(1) of the Education Act 1996) placed a duty on LEAs to provide suitable education for children out of school for reasons of illness, exclusion from school or otherwise. This duty applies to children of compulsory school age and the duty is mandatory, i.e. the LEA *shall make arrangements*. In contrast, the duty in relation to those above compulsory school age is permissive and is set out in section 19(4) of the Education Act 1996. Suitable provision is defined in relation to a child or young person in section 19(6) as 'efficient education suitable to his age, ability and aptitude and to any special educational needs he may have'.

Home tuition is an important part of the education service for ill or handicapped children and there are signs that demand is growing. The nurse should be aware that every child has a right to education, even when in hospital, and that, provided his medical condition permits it, every effort should be made to ensure that the child is receiving schooling, preferably off the ward area. The nurse has a positive role to play in encouraging the child to take part. The Special Educational Needs and Disability Act 2001 strengthens the general duty to provide a mainstream school place for a child with special educational needs, where their parents want that, and as long as that is compatible with the efficient education of other children. Codes of practice for special educational needs and under the Disability Discrimination Act 1995 are available from the Department of Health website. The then DfES, in collaboration with the Department of Health, produced guidance, 'Children missing education because of medication reasons' in 2008 and 'Absence for trivial medical reasons', also in 2008. Both reports and further guidance are available from www.gov.uk.[103] In 2010 the Supreme Court held that a delay of a year in arranging a special school for a child was not a breach of his rights to education under Article 2 of the First Protocol to the European Convention on Human Rights[104] (see chapter 1).

Under Section 100 of the Children and Families Act 2014 governing bodies, proprietor or management committees of schools have a duty to make arrangements for supporting pupils at the school with medical conditions and in meeting the duty must have regard to guidance issued by the Secretary of State. The Education Act 1996 is to be read as including this section.

Children's trusts

In a Department of Health press release in October 2002,[105] the Secretary of State announced the intention to set up children's trusts, which would be responsible for some of the following services: disabled children, children with special educational needs, child protection, identification, referral and tracking of children at risk, speech and language therapy, child and adolescent mental health services and areas where social care, health and education services needed to work together. In July 2003 the Children's Minister announced the creation of 35 children's trusts, which would unite children's social, education and health services in a single local structure. The aim was to break down professional rivalries and improve communication between different agencies responsible for child welfare. Each trust was given £100,000 a year for three years to get established. The Children's Trust Board was placed on a statutory footing from April 2010,[106] the number of statutory relevant partners was increased and the Board was given responsibility for monitoring the extent to which the children's trust partners act in accordance with their commitments. Further information on the status and role of the children's trusts and the boards can be found on the Every Child Matters section on the DE website.[107]

National Service Frameworks (NSFs)

The NHS Plan[108] envisaged that National Service Frameworks (NSFs) would be established to improve services through setting national standards to drive up quality and tackle existing variations in care. The Children's NSF was published in September 2004. Part One sets out five core standards for the NHS, local authorities and partner agencies to achieve high-quality service provision for all children and young people and their parents or carers.

Standard 1: promoting health and well-being, identifying needs and intervening early

The health and well-being of all children and young people is promoted and delivered through a coordinated programme of action, including prevention and early intervention wherever possible, to ensure long-term gain, led by the NHS in partnership with local authorities.

Standard 2: supporting parenting

Parents or carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.

Standard 3: child, young person and family-centred services

Children and young people and families receive high-quality services which are coordinated around their individual and family needs and take account of their views.

Standard 4: growing up into adulthood

All young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood.

Standard 5: safeguarding and promoting the welfare of children and young people

All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

Part Two sets standards for the following areas:

Children and young people who are ill
Children in hospital
Disabled children and young people and those with complex health needs
The mental health and psychological well-being of children and young people
Medicines for children and young people.

(Part Three, relating to maternity services, is considered in chapter 14.)

The NSF should have had a major impact on children's services and the role of the children's nurse in ensuring that minimum standards are available in her department. Further information about the NSF is available from the Department of Health website at www.gov.uk.[109] The Care Quality Commission (CQC) uses the Children's NSF as a measure of quality in the delivery of services to children and young people and its predecessor, the Healthcare Commission, carried out a major review of services for children in hospital in 2006, reporting on its findings in 2007 and outlining the improvements which need to take place to improve the quality of services. Further information on the CQC's role in assessing these services and its reports and those of its predecessor can be found on its website.[110]

The Royal College of Paediatrics, Child Health, Barnados and 21 other organisations wrote to *The Times* expressing concerns that children are suffering as a result of a lack of investment in their care, compared to the priority given to the elderly.[111] Specific concerns about child services have been raised in relation to several specialties:

diabetes[112] – it is suggested that one in four children with diabetes is at risk of amputation and blindness because the condition is out of control;
cancer[113] – survivors get lost in the healthcare system and are not receiving appropriate and timely follow-up care according to the Chief Executive of Macmillan Cancer Support;
mental health – NICE has recommended that primary school teachers should be trained to detect emotional problems in pupils;[114]
eating disorders in the under-5s is a growing concern[115] – social services in Newport, south Wales took a five-year-old who weighed 10 stone into care.[116]

The Secretary of State has the power through the mandate for NHS England to prioritise specific services (see Chapter 5).

Adolescents

Some hospitals have set up adolescent units for those between 13 and 16/17 years so that special provisions can be made for those in this group. Difficult problems can arise, as Practical Dilemma 13.7 illustrates.

Practical Dilemma 13.7 Refusal to obey the rules

David, aged 15, suffered from cystic fibrosis and required regular IV antibiotic treatment. Roger Park Hospital had set up a specialist unit for youngsters suffering from cystic fibrosis, and rules had been laid down about the conduct of the patients. David frequently took his own discharge from hospital, returning with alcohol, and staff also feared that he was taking soft drugs. They tried to reason with him but he was not cooperative. His parents said that he should be made to comply with the hospital regime. What is the law?

In Practical Dilemma 13.7, the managers of the unit are entitled to lay down the terms on which patients and visitors may enter. If David is Gillick-competent, then he could agree an understanding with the unit that he will be admitted for treatment only on the basis of accepting the rules that have been laid down. If he refuses to agree to those conditions, including the prohibition on alcohol, then he could be told that he cannot be treated in the unit. In law his parents could give consent to his having treatment, but it is difficult for staff to maintain IV treatment if the young person is objecting to having it. In the long term, it may be possible for the CF patients and other patients with chronic conditions to agree on the 'house rules' and how they are to be implemented and thus bring peer pressure to bear on David. It is essential that the unit manager makes clear that the rules, especially relating to alcohol and illegal drugs, are enforced and those who do not accept the conditions cannot be cared for there. Where the adolescent is over 16 years and lacks capacity to give consent to a specific decision, the Mental Capacity Act 2005 would now apply. Action can be taken in the best interests of the young person. If there is a dispute about the lack of capacity or what would constitute 'best interests' for a particular patient, an application could be made to the Court of Protection. (See chapter 7 for further consideration of the Mental Capacity Act 2005.) The RCN has published several papers providing guidance for members on caring for adolescents. They include 'Adolescent Transition Care. Guidance for nursing staff',[117] which aims to secure a seamless transition for those with chronic diseases from children's to adult services. The RCN has also published 'Adolescence: boundaries and connections', which is an RCN guide for working with young people.[118] This guide resulted from an RCN survey which highlighted the need for person-centred, adolescent care. It includes practical tips that nurses can use in their daily work and addresses issues such as adolescent development, confidentiality, consent and local resources. It also includes comments from young people themselves. The RCN Adolescent Forum has developed information to offer guidance to nurses involved in caring for the needs of young people covering consent to treatment, primary care and nurse training.[119]

Teenage sexuality

There was considerable concern within the Department of Health at the rise in sexually transmitted diseases and at the high rate of teenage pregnancies in the UK. In November 2001 the Department of Health[120] announced the launch of a national information campaign to promote sexual health as part

of its national strategy for sexual health and HIV. Subsequently, a Teenage Pregnancy Unit website[121] was set up as a cross-government unit located within the then DfES. The unit was set up to implement the Social Exclusion Unit's report on teenage pregnancy. The Teenage Pregnancy Unit website contained lists of other useful websites for teenagers and parents providing advice on sexual health and related issues. An Independent Advisory Group (IAG) on sexual health and HIV was established in 2003 as part of the implementation of an action plan for the national strategy for sexual health and HIV. In 2004 the IAG published its response to the Health Select Committee on Sexual Health.[122] It considered access to services, capacity, commissioning and prioritisation, funding prevention, education and sexual health promotion and the patient voice. It agreed with the select committee's conclusions on the six key factors that were the principal causes of the current situation:

- A failure of local NHS organisations to recognise and deal with this major public health problem.
- A lack of political pressure and leadership over many years.
- The absence of a patient voice.
- A lack of resources.
- A lack of central direction to suggest that this is a key priority.
- An absence of performance management.

It also believed that sexual health and HIV must be explicitly prioritised at both a local and national level. In reply to a request for information about abortions under the Freedom of Information Act 2000,[123] the DH reported that the Teenage Pregnancy Strategy was working and between 1998 and 2004 the under-18 conception rate had fallen by 11.1 per cent and the under-16 rate by 15.2 per cent, with both rates at their lowest for 20 years. The Healthcare Commission, in its findings on a review of data on sexual health in 2007,[124] stated that in spite of these falling rates, the rate of under-18 conception in the most deprived 10 per cent of wards was still four times higher than the rate in the least deprived wards. The Healthcare Commission recommended improving data, information and planning and ensuring that progress, standards and effectiveness are maintained through the national strategy for sexual health and HIV. It also found that chlamydia increased by more than 300 per cent between 1996 and 2005.

The IAG on Sexual Health reported in 2007 that the high rate of teenage pregnancy and sexually transmitted diseases was related to the culture of drinking and drug-taking among the young. It urged the government to do more to join up its campaigns on drugs, binge drinking and under-age sex.[125]

The British Medical Association published a report in December 2003 on adolescent health and highlighted weaknesses in controlling the epidemic of sexually transmitted infections. A ministerial letter was published giving guidance for local authorities and primary care trusts on teenage pregnancy in 2006.[126] The aim was to halve the under-18 conception rate by 2010. *Every Child Matters* sets out the key features in the DH's strategy to reduce teenage pregnancy. It can be accessed on its own website.[127] In February 2010 it was reported that the 10-year strategy to reduce teenage pregnancies had failed to make any serious impact.[128] However, figures published in November 2010 suggested that teenage pregnancies had fallen to their lowest rate for a decade. There were fears that the situation would deteriorate with the closure of the Teenage Pregnancy Independent Advisory Group and other cost-cutting measures.[129]

Figures published in February 2014 showed that the number of teenage pregnancies had fallen to the lowest level since 1969. However, whether this could be attributed to the Teenage Pregnancy Strategy is open to debate.[130] In 2014 NICE issued guidance on contraceptive services with a focus on young people up to the age of 25 years.[131]

For some of the complex legal issues that can arise in this field, see the author's article.[132] Legal issues relating to abortion are considered in chapter 15 and pregnancy in chapter 14.

Court proceedings and the child or young person

Special rules relate to bringing or defending legal action in the name of a person under 18 years to protect the interests of the child or young person. The details can be found in Part 21 of the Civil Procedure

Rules.[133] In addition, (as noted in chapter 6) where a child has been injured, the time limit within which any claim for compensation must be brought does not commence until the person becomes 18 and if that individual suffers from a mental defect, the time limit does not start until the defect ends (usually not until death).

In criminal cases a child under the age of 10 is exempt from criminal responsibility and cannot be found guilty of a crime. The infant is known as *doli incapax*. Minors over 10 years are presumed to be responsible for their actions but there are considerable procedural differences from the way in which an adult is proceeded against (see chapter 2). There has been recent concern about the bullying of child witnesses, particularly when giving evidence in sex abuse cases. The Justice Secretary is giving consideration to ways in which they can be spared the ordeal of being cross-examined before juries and defendants,[134] with measures including the pre-recording of child evidence. Judges chosen from a panel of specialist judges will try cases involving child sexual abuse.

Major reforms to the hearing of family proceedings have taken place including the establishment of the Family Court and the transfer of proceedings from magistrates' and county courts to the Family Court.[135]

There is a move to create greater openness in the Family Court hearings while at the same time protecting the identity of children involved. Sir James Munby, President of the High Court's Family Division has asked family courts to ensure that decisions on parental access to children and court orders should be publicised unless there are compelling reasons to prevent judgments being released. The aim was to ensure greater transparency in the work of the Family Court.[136] The Supreme Court stated that a child of 13 should have a say in where she lives.[137] The child had lived with her parents in England, but following the breakdown of the marriage she moved to Spain with her mother. She and her brothers visited England for a holiday with her father but failed to return to Spain as agreed. The Supreme Court held that her state of mind could be taken into account when determining whether she had achieved a sufficient degree of integration into a social and family environment so as to be habitually resident in that country.

Conclusions

It is clear from the cases of Baby P and Daniel Pelka that the reforms to child protection following the Children Act 2004 have not been effective in preventing deaths of children, even when these cases were well known to health and social care professionals. Figures released to the *Sunday Times* under the Freedom of Information Act suggest that up to 110 deaths have occurred from neglect or abuse at home since the Baby P case.[138] The Alexis Jay Independent Inquiry into the child sexual exploitation in Rotherham between 1997 and 2013 raises major concerns about child protection safeguards and the accountability of senior officers in the local authority and police. The Labour government prior to the Coalition government had published a 10-year Children's Plan which included a comprehensive review of Child and Adolescent Mental Health Services, the primary school curriculum, speech and language therapy and special educational needs, the development of Master's level qualifications for all new teachers, a national plan to tackle child obesity, a review of poor housing and a Youth Crime Action Plan.[139] The Coalition government published its vision for child services[140] and it remains to be seen the extent to which this can be implemented at a time of considerable cuts in public expenditure. There will continue to be considerable pressure on nurses working with babies, children and adolescents in this high-profile, challenging area of nursing. The Children, Schools and Families Act 2010 Part 2 gives the media enhanced access to family proceedings which are thus likely to receive more publicity. The Children and Families Act 2014 (Part 2) makes significant changes to improve the operation of the family justice system. In private family law, couples are required to attend a family mediation, information and assessment meeting before being able to apply for certain orders, both separated parents should be involved in the children's lives if that is safe and consistent with the welfare of the child. A

child arrangements order replaces residence and contact orders. In public law a maximum 26-week time limit is set for completing care and supervision proceedings, with the possibility of an extension of up to 8 weeks at a time if necessary to resolve proceedings justly. The Court of Appeal has held that there was no longer a supposed 'rule' that where two parents had parental responsibility for a child, neither could unilaterally change the child's habitual residence. What was required was a factual inquiry tailored to the circumstances of an individual case.[141]

Reflection questions

1 What is the difference between a child of 15 and one of 16 years as far as consent to treatment is concerned? What is the effect of the Family Law Reform Act 1969 Section 8?

2 The occupier's duty of care for the safety of the visitor should take into account the possibility that children require greater care (see Statute Box 12.8). What is meant by this and how does it affect the work of the children's nurse?

3 Consider the extent to which your department allows parents to take part in the care of children in hospital. What additional responsibilities does this place on the nurse?

Further exercises

1 Examine the UN Charter of the Rights of the Child. What impact does this have on the care of the child in hospital?

2 Obtain a copy of your NHS trust's procedure on the care of suspected non-accidental injury cases and familiarise yourself with it.

3 If you were faced with a very disobedient child, how would you control him?

4 Does the law require that every effort be made to save every child no matter how handicapped? (See also chapter 14 on special care.)

5 Access the procedures for child protection prepared by your organisation and familiarise yourself with their implications for your work.

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Chapter 14

Midwifery

This chapter discusses

- Midwifery Committee
- Midwives' rules and code of practice
- Law relating to consent in midwifery care
- Liability of the mother for harm caused to the baby
- Taking the newly born into care
- Midwifery practice and standard of care
- Breastfeeding
- Cord blood collection
- Medicines and the midwife
- Congenital Disabilities (Civil Liability) Act 1976
- Nurseries within midwifery departments
- Special care baby units
- Cot deaths
- Registration of births and stillbirths
- Use of fetal tissue and placenta
- Record keeping and midwifery
- AIDS and the midwife
- National Institute for Health and Clinical Excellence (NICE)
- National guidelines on midwifery practice
- Project 2020
- Human Rights and birth
- Morecambe Bay NHS Trust
- Independent midwifery
- The future

Introduction

The midwife has always been in a special position compared with the general nurse in relation to her powers and duties. She is recognised as an independent practitioner with considerable powers in the prescribing and administration of certain drugs that in the past were not possessed by the general nurse. There have, however, been recent extensions to the prescribing powers of the nurse and other professionals (see chapter 28). This section considers the special position of the midwife in law and the effects of some recent cases on midwifery practice.

Midwifery Committee

The Midwifery Committee is a statutory committee of the NMC required by Article 3 of the Nursing and Midwifery Order[1] (see chapter 11). Its role is to advise the Council, at the Council's request or otherwise, on any matters affecting midwifery (Article 41(1)). The Council is required to consult the Midwifery Committee on the exercise of its functions in so far as it affects midwifery, including any proposal to make rules under Article 42 (Article 41(2)). Under Article 42(1) the Council is required by rules to regulate the practice of midwifery and the aims of the rules are set out in Box 14.1.

The NMC identifies the role of the Midwifery Committee as including:

- setting standards for LSAs
- supervision of midwives in accordance with the Nursing and Midwifery Order
- compliance with Rule 44 of the midwives' rules and codes of practice
- equity of access to a supervisor of midwives
- communications between supervisors of midwives
- record keeping systems
- supervisory systems
- investigation of misconduct allegations
- supporting and developing future leaders.

Midwives' rules and code of practice

Under Article 42 of the Nursing and Midwifery Order 2001,[2] the NMC must make rules regulating the practice of midwifery. Box 14.1 indicates the purpose of these rules. One of the most significant rules is set out in Box 14.2. Rule 5[3] (replacing Rule 6 of the earlier version) is much simplified and further details of the Scope of Practice are set out in the standards.

Box 14.1 Aims of the midwives' rules (Article 42(1) of the Nursing and Midwifery Order 2001)

1 To determine the circumstances in which and the procedure by means of which midwives may be suspended from practice.
2 To require midwives to give notice of their intention to practise to the local supervising authority (LSA) for the area in which they intend to practise.
3 To require registered midwives to attend courses of instruction in accordance with the rules.

Box 14.2 Rule 5 scope of practice

A practising midwife who is responsible for providing care or advice to a woman or care to a baby during childbirth must do so in accordance with standards established and reviewed by the Council in accordance with Article 21(1)(a) of the order.

The note on this rule requires that in providing care to a woman or a baby during childbirth, the midwife 'must do so in accordance with *The Code: Standards of conduct, performance and ethics for nurses and midwives* (2008)'.

In addition to the midwives' rules which were updated and came into force on 1 January 2013, standards amplify the rules replacing the original Code of Practice.[4] The standards are complementary to the rules but, unlike the practice rules, they do not have the force of law. The current rules and standards replace those which came into force on 1 August 2004 SI 2004/1764 (Midwives Rules) and SI 2004/1654 (Fitness to Practise). The revised rules, which include guidance outlining how best to deal with issues arising from a midwife's practice, supersede the standards for the supervised practice of midwives of 2007. The NMC rules and standards 2012 can be downloaded from the website of the NMC.[5] Of course, midwives would also be expected to comply with the NMC Code of Professional Conduct and other guidance from the NMC. It is not the intention to consider every one of these rules and codes in detail, but rather to consider some of the more common problems concerning the midwife. Every midwife should ensure that she has copies of all the relevant NMC guidance. The Midwifery Committee's recommendations of pre-registration training for midwifery are considered in chapter 11.

A pre-registration student would not usually be subject to the fitness to practise procedures of the NMC but where she is already a registered practitioner in another discipline, this does not apply. For example, a registered nurse, Sheldon, who was training to be a midwife, was reported to the NMC after she had forged the signatures of two midwives in her practice placement record of hours and had falsified her labour ward record card. The student admitted the charges but disputed the NMC's conclusion that this impairment of fitness to practise justified suspending her nurse registration and she appealed to the Court of Sessions in Scotland, which held that the panel had followed the NMC guidance on fitness to practise hearings and her appeal did not succeed.[6]

Local supervising authorities

Midwives are subject to statutory supervision that is regulated through local supervising authorities (LSAS), which arrange for the appointment of supervisors of midwives. LSA arrangements differ across the UK: in England the LSA is the Commissioning Board (NHS England), in Scotland the Health Boards, in Wales the Health Inspectorate and in Northern Ireland, the Public Health Agency. (For further information see the LSA midwifery officers Forum UK.[7]) The NMC has the power to prescribe the qualifications of persons who may be appointed by the LSA to exercise supervision over midwives in its area and no one shall be appointed who does not comply with these. The Nursing and Midwifery Order 2001[8] Articles 42 and 43 provide detailed rules on the establishment and functions of the LSAs and the supervisor of midwives and these are supplemented by the midwives' rules and standards.[9] If rules are made requiring midwives to give the notice of intention to practise, the LSA must inform the Council of any notice that has been given to it (Article 41(2)). Rule 8 sets out the duty of the LSA to appoint supervisors of midwives (LSAMOs), Rule 9 the LSA's responsibilities for supervision of midwives, and Rule 10 the publication of the local supervising authority procedures.[10] The LSA has the following duties set by Article 43:

1 To exercise general supervision in accordance with the rules made under Article 42 over all midwives practising in its area.

2 To report to the Council where it appears that the fitness to practise of a midwife in its area is impaired.
3 To exercise power in accordance with the rules made under Article 42 to suspend a midwife from practice.

In addition the LSA must publish an annual report to the NMC – guidance on such a publication was issued by the NMC in 2011.[11]

Under Article 43(3) the Council is required to set rules establishing the standards for the exercise by LSAs of their functions and may give guidance to LSAs on these matters.

There have been criticisms of the present arrangement for midwifery supervision following the Morecambe Bay Inquiry, and the Ombudsman has suggested that there is a conflict inherent within midwifery supervision (see page 411).

A full-time supervisor was appointed at Barking, Havering and Redbridge University Hospitals NHS Trust following concerns raised by the CQC's review of its maternity services in 2011.[12] This may be an option for the future considering the criticisms in the Morecambe Bay report.

Following the Francis Inquiry, the National Advisory Group on the Safety of Patients in England published the report *A Promise to Learn – a Commitment to Act*.[13] Its recommendations in relation to midwifery are considered by Jessica Read and Verena Wallace[14] (see chapter 5).

In a move to separate functions and clearly delineate the differences in roles and responsibilities between supervisors of midwives and Local Supervisor Authority Midwifery Officers (LSAMO), from 1 April 2008 all LSAMOs ceased to act as supervisors of midwives.[15]

New Fitness to Practise procedures came into force on 1 November 2013 – which can be downloaded from the NMC website. Guidance and answers to frequently asked questions are also available.

An appeal by a midwife (Okeke) against her striking off by the NMC succeeded before the High Court which held that the panel's decision to strike her off after a series of interim suspensions was made on a wrong view of the law and the fact that a four and a half year delay in making the decision to strike off was a breach of her Article 6 right to a fair hearing.[16]

In the earlier case of Duthie[17] an independent midwife won her appeal against being struck off, the High Court finding that she should have been specifically charged with fraud if the NMC were claiming that her typed notes were false and the panel had concluded that the parents' testimony had to be accepted because the midwife's records may not have been fully accurate was not reasonable.[18]

Law relating to consent in midwifery care

Opposition to the midwife

Practical Dilemma 14.1 Refusal to have a midwife

Sharon Keene made it clear when her pregnancy was diagnosed that she wanted a natural birth and would not wish the midwife to attend. Sheila Armstrong, a community midwife, visited her and found her aggressive and hostile. She made it clear to Sheila that she did not want to be confined in hospital, but wanted her co-habitee, Jason, to deliver the baby. Sheila told her that if that were to occur, Jason would be acting illegally and Sheila attempted to explain to Sharon the help and assistance that could be made available from the midwifery services. As the pregnancy progressed, Sharon refused all antenatal care and failed to attend clinic appointments. Where does Sheila stand if she discovers that Sharon intends to proceed with Jason delivering the baby?

Midwives occasionally meet women who are keen to 'go it alone' and not receive help during the pregnancy and also wish to have the baby delivered at home. There is no legal action that can be taken to prevent this if the woman is a mentally competent adult. She can refuse treatment and help for a good reason, a bad reason or, indeed, for no reason at all (see *Re MB*, Case 14.1 on page 387). Sheila cannot compel Sharon to receive help. Neither could Sharon be prevented from having a home birth. Even if this is not clinically desirable, there is no legal power to compel a mentally capacitated woman to come into hospital for the confinement.

Criminal offence

It is, however, a criminal offence for a person, other than a midwife or doctor, to attend at a confinement except in an emergency. The actual wording of Article 45 of the Nursing and Midwifery Order 2001[19] is as follows:

1 A person other than a registered midwife or a registered medical practitioner shall not attend a woman in childbirth.
2 This paragraph does not apply:
   (a) where the attention is given in a case of sudden or urgent necessity, or
   (b) in the case of a person who, while undergoing professional training with a view to becoming a medical practitioner or becoming a midwife, attends a woman in childbirth as part of a course of practical instruction in midwifery recognised by the Council or by the GMC.
3 A person who contravenes paragraph (1) shall be liable on summary conviction to a fine not exceeding level 5 on the standard scale.

Thus if Jason (in Practical Dilemma 14.1) delivered the baby himself, he would be committing a crime. The only exception would be if there were an emergency and the baby arrived before they were aware of it. It is, of course, very difficult to prove that it was not an emergency and that there was no intention to call the midwife. Sheila would be able to warn the couple of the law and she would, of course, record this warning in her notes and also inform her supervisor of midwives. There have been some prosecutions under this section and its predecessor. For example, Rupert Baines from Bristol was found guilty of delivering a baby without assistance and Brian Radley from Wolverhampton was charged with attending a woman in childbirth otherwise than under the direction and personal supervision of a duly qualified practitioner and was fined £100 (August 1983). The difficulty confronting the midwife is in ensuring that she is aware of when the baby is imminent, since the aim is to protect the mother and child rather than take proceedings after the birth.

If she were obstructed by an aggressive partner during a home confinement, the midwife would be able to call on police powers to assist her.

Guidance on delegation of tasks by a midwife was provided by the NMC in January 2004 and is discussed in chapter 24.[20]

Admission and treatment

Choice of treatment by mother – home births

Practical Dilemma 14.2 | Consent

Glenys Brown was expecting her first child. From the first moment the pregnancy was diagnosed, she was totally absorbed in her condition and the forthcoming event. She joined the local childbirth group and was very soon the local secretary. She attended psychoprophylactic and yoga classes and

avidly read books, journals, leaflets and all available information. She had clear ideas on how her own baby was to be born and while she would have preferred total immersion in water, she accepted the fact that this would not be available in her local hospital. She was, however, adamant that she would not agree to an epidural, gas, an episiotomy or any other unnatural procedures. She was admitted to the delivery ward and after 12 hours of contractions the doctor set up a drip to speed the delivery as it was feared that the fetus was in danger. Glenys was eventually given an episiotomy despite her protests. She is now threatening to sue the midwife and doctor. Where do the midwife and doctor stand in law?

The basic principles relating to consent to treatment (set out in chapter 7) apply to midwifery. There are no separate statutory laws covering the situation. The general principle is that the mentally competent patient has the right to refuse treatment, and any touching or treatment without her consent is a trespass to her person. If the mother were to sue the midwife for assault, the only defence of the midwife would be that either the woman gave consent or the woman was mentally incompetent and that action was taken without her consent in her best interests in accordance with the provisions of the Mental Capacity Act 2005. There is no statutory right to compel a mentally capacitated mother to go into hospital for the birth of a child whatever the clinical indications. If the mentally capacitated mother refuses admission, then the midwife has to do all that is reasonable to support her at home. Evidence suggests that many mothers, who would have wished to have had a home birth, are being discouraged from that in spite of the principles set out in the Cumberlege Report, *Changing Childbirth*. The UKCC issued a position statement,[21] 'Supporting Women who Wish to Have a Home Birth', enabling more women to be able to opt for home birth. This statement clarified the professional position of the midwife in respect of the provision of midwifery care for women who wish to have a home birth. In May 2005 the NMC Midwifery Committee approved a report provided by Julie Magill-Cuerden on home births[22] which concluded that despite the lack of random controlled research:

> **Nonetheless, the evidence for the safety of home birth is mostly consistent from the studies undertaken. The issue of trust between professionals and women and respecting their individual choices appears to be a key area in developing a home birth service.**

In March 2006 the NMC published a circular on 'Midwives and home birth'.[23] This outlines the professional duty of the midwife to support the woman and the woman's right to a choice for care, including the place of birth. It states:

> **Should a conflict arise between service provision and a woman's choice for place of birth, a midwife has a duty of care to attend her.**

It suggests that each LSA should have a plan of action in place to support home births.

The National Perinatal Epidemiology Unit is leading research into women's experiences of maternity services and the safety and quality of care. 'Birthplace' is an integrated programme of research designed to compare outcomes of births planned at home in different types of maternity units, and in hospital units with obstetric services. The results provide evidence of the outcomes of the different places of birth. It is also intended to contribute to the implementation of Standard 11 of the NSF (see page 409). Further information is available on the National Perinatal Epidemiology Unit (NPEU) website. The document *Maternity Matters*,[24] envisages that all women have the choice of a home birth (see page 410).

In 2010 the Labour government published its five-year programme of reform of maternity and early years services.[25] It suggested that pregnant woman should have a legal right enshrined in the NHS Constitution (see chapter 5) to choose where they give birth, including the option of a home birth. It remains to be seen whether the Coalition government is prepared to implement this and other plans in the strategy in the light of the cutbacks in public expenditure.

Further fuel to the controversy over the comparative safety of home births was added by an article by Julian Savulescu at the Centre for Practical Ethics at Oxford University and Lachlan de Crespigny an obstetrician and gynaecologist at the University of Melbourne who compared a home birth to driving a child without a seat belt. They said that it is an unreasonable risk for no great benefit.[26] At present 2 per cent of births take place at home. The authors of the study say that the government's focus should be on making birth in hospital more appealing.

In contrast, in research published in 2011 the 'Birthplace in England' study showed that for low-risk multiparous women there are no differences in poor perinatal outcomes between planned births at home or in a midwifery-led unit compared to planned birth on an obstetric ward.[27]

The Royal College of Midwives is campaigning for normal birth and encouraging home births.[28]

The essential feature is a thorough risk assessment prior to the decision over location of the birth and the willingness of the mother to be guided by the results of that assessment. NICE issued draft guidance in May 2014 stating that home births are no more dangerous for young women without existing illnesses who have already had a child, but there is a risk for first-time mothers. Midwifery-led units are as safe as traditional labour wards. The clinical guideline director for NICE said that 'every woman should ultimately have the freedom to choose where she wants to give birth and be supported in her choice'.[29]

Consent to Caesarean section

There are no statutory powers to compel a mentally competent woman to receive treatment or admission against her will. In an early case, *In re S*,[30] a woman was compelled to have a Caesarean section against her will, but the basis for this decision is no longer acceptable. Subsequently, the High Court agreed that a Caesarean could be carried out without the consent of a woman who was suffering from mental disorder.[31] Section 63 of the Mental Health Act 1983 permitted treatment to be given to a detained patient for mental disorder and the Caesarean was considered to come within the definition of treatment for mental disorder. In a second case,[32] a compulsory Caesarean was declared lawful where a woman with a history of psychiatric treatment denied that she was pregnant. The judge held that there was evidence that the woman was mentally incapacitated and that there was power to act at common law in an emergency out of necessity to use reasonable force in her best interests. In a third case,[33] a woman was declared mentally incompetent and a Caesarean authorised against her will. These cases (two of which were heard by the same judge) led to considerable concern among midwives and women over the protection of the rights of the women.

Two decisions by the Court of Appeal have clarified the law on compulsion.

Case 14.1 *Re MB (An Adult: medical treatment)* (1997)

Capacity and compulsory Caesarean[34]

Miss MB required a Caesarean section in order to save her baby. However, while she gave consent to the operation, she suffered from a needle phobia, which caused her to panic and refuse the preliminary anaesthetic. The trust applied for a declaration that the Caesarean could take place. The judge held that the woman was mentally incapacitated as a result of the phobia and the operation could therefore proceed in her best interests. The same day the Court of Appeal upheld that decision. In a reserved judgment it set out how capacity was to be determined (see Box 14.3) and the general principles that apply to the refusal of treatment (see Box 14.4).

Box 14.3 Determining capacity: *Re MB*

A person lacks the capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when:

(a) The patient is unable to comprehend and retain the information that is material to the decision, especially as to the likely consequences of having or not having the treatment in question.
(b) The patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.

Box 14.4 Principles laid down in *Re MB* and incorporated in guidance issued by the Department of Health[35]

1 The court is unlikely to entertain an application for a declaration unless the capacity of the patient to consent to or refuse the medical treatment is in issue.
2 For the time being, at least, the doctors ought to seek a ruling from the High Court on the issue of competence.
3 Those in charge should identify a potential problem as early as possible so that both the hospital and the patient can obtain legal advice.
4 It is highly desirable that, in any case where it is not an emergency, steps are taken to bring it before the court, before it becomes an emergency, to remove the extra pressure from the parties and the court and to enable proper instructions to be taken, particularly from the patient and, where possible, give the opportunity for the court to hear oral evidence, if appropriate.
5 The hearing should be *inter partes*.
6 The mother should be represented in all cases, unless, exceptionally, she does not wish to be. If she is unconscious she should have a guardian ad litem.
7 The Official Solicitor should be notified of all applications to the High Court . . .
8 There should in general be some evidence, preferably but not necessarily from a psychiatrist, as to the competence of the patient, if competence is in issue.
9 Where time permits, the person identified to give the evidence as to capacity to consent to or refuse treatment should be made aware of the observations made by the Court of Appeal in this judgment.
10 In order to be in a position to assess a patient's best interests the judge should be provided, where possible and if time allows, with information about the circumstances of any relevant background material about the patient.

The Court of Appeal emphasised that every person is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted. A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event, the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests, objectively considered, does not arise.

The ruling in *Re MB* was followed by the Court of Appeal in a case brought against St George's Hospital.[36] In this case, the pregnant woman had refused treatment for pre-eclampsia. She was detained under section 2 of the Mental Health Act 1983 and a declaration sought from the High Court that a Caesarean section could proceed. The declaration was given and the operation carried out. The patient subsequently appealed to the Court of Appeal and won on the grounds that she was wrongly detained

under the Mental Health Act 1983 and the Caesarean section should not have been ordered. Guidelines were subsequently issued by the court where there were serious doubts about a patient's capacity to accept or refuse treatment.[37]

In a more recent case heard under the Mental Capacity Act 2005 a judge determined that AA, (who had been diagnosed as suffering from bi-polar disease but had failed to take her medication, was detained under section 5(2) and then section 2 of the Mental Health Act (see chapter 20)) lacked the requisite mental capacity to make decisions and he granted the NHS trust the right to perform a Caesarean section and all other necessary procedures including examinations, the taking of bloods, and cannuation without her explicit consent.[38] The case is considered in detail by Andrew Symon.[39]

In *Re T* (1992),[40] which is discussed in chapter 7 (Case 7.5), the Court of Appeal emphasised that professionals had a duty to check on the validity of a patient's refusal to have treatment to ensure that the patient is mentally capacitated and is not under an undue influence. The Mental Capacity Act 2005 would now apply to situations where it is alleged that the pregnant woman lacks the mental capacity to make her own decisions.

Acting in the best interests of a mentally incapacitated woman

While a woman who is deemed mentally capacitated can make a decision to refuse life-saving treatment, once it is determined that a woman lacks the requisite mental capacity to make decisions on her own behalf, then decisions have to be made in her best interests. In Scotland, the Adults with Incapacity (Scotland) Act 2000 covers the situation and since October 2007 the Mental Capacity Act 2005 makes provision for England and Wales, replacing the common law powers which had been recognised by the House of Lords in the *Re F* case.[41] Under the Mental Capacity Act 2005 action must be taken in the best interests of the adult who lacks the requisite mental capacity to make her own decisions. The Mental Capacity Act 2005 sets out the steps which must be taken in deciding what is in the best interests of the person who lacks the requisite capacity to make a specific decision (see chapter 7, page 168). Where serious medical treatment is being considered and there is no informal carer or person to be consulted, an independent mental capacity advocate must be appointed who could report on the person's best interests.

In a case on 11 December 2013 the Court of Protection ruled that a Caesarean section could be performed on a mentally ill woman if necessary against her wishes.[42] The woman was 36 weeks pregnant and there was a risk that a scar from a previous Caesarean might rupture during delivery and put her life at risk. Publicity from this case led to the publication of papers by the Court of Protection on its decision on 23 August 2012[43] when an Italian woman was forced to have a Caesarean and subseqently ordered to give the baby up for adoption. The operation took place after she was sectioned under the Mental Health Act. The decision on the adoption was to be reviewed by Sir James Mumby the most senior family law judge.[44] (See also the case of DD[45] who was held to lack capacity to consent and a Caesarean was ordered which is discussed in chapter 17.)

Midwives should be aware of the Forced Marriage (Civil Protection) Act 2007 since they are in an ideal position to assist the victims of forced marriages.[46] Guidance is available from the Foreign and Commonwealth Office.

Liability of the mother for harm caused to the baby

Civil liability

If a mother refuses treatment that is necessary in the interests of the child (for example, an episiotomy), does the child have a right of action for compensation against the mother because of the harm that she or he suffered? The only right of action for a child who was injured prenatally is under the Congenital Disabilities (Civil Liability) Act 1976 (see page 397). This Act enables a child who is born injured as a

result of negligence, which led to his or her suffering harm while a fetus, to sue the person responsible. However, under the Act, the mother can only be sued by the child's representative if she was driving a motor vehicle when she knew or ought reasonably to have known that she was pregnant and failed to take care for the safety of the unborn child. (In practice, the child would be suing the company that insured the mother as driver.) The Act, therefore, excludes the right of a child to sue for any harm that the mother may have caused the fetus, for example, by smoking, drinking, taking drugs or refusing treatment that is necessary in the best interests of the fetus.

Criminal liability

The mother could be liable in the criminal law under the Infant Life Preservation Act 1929. This makes it a criminal offence for any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother (section 11). There is a defence if the act that caused the death of the child was done in good faith for the purposes only of preserving the life of the mother. An abortion lawfully carried out under the 1967 Act is not an offence under the 1929 Act (see chapter 15). There are also criminal provisions relating to attempting to procure an abortion by administering drugs or using an instrument or supplying the same under the Offences Against the Person Act 1861 sections 58 and 59. For further discussion on this, see chapter 15.

However, in the context we are considering here, i.e. where a pregnant woman is smoking, addicted to drugs or drink or is refusing a Caesarean, it is not thought that she would have the necessary intent to be found guilty of a criminal act under these provisions. This issue is at the present time being considered by the courts. A local authority is taking a case to court arguing that the mother of a 6-year-old girl who suffered from brain damage during the pregnancy is the victim of a crime. It argues that her mother criminally poisoned the unborn child because it has evidence that she was warned of the risks if she continued to drink. Lawyers acting for the council are representing 80 children nationally who suffered physical and mental damage from their mothers drinking alcohol while pregnant. They are seeking compensation from the criminal injuries compensation scheme. An Administrative Appeals Chamber ruled in January 2014 that although there had been administration of a poison or other destructive or noxious thing, so as thereby to inflict grievous bodily harm, a crime had not been committed since the child was unborn at the time and therefore not a person.[47] The Court of Appeal held that there was no criminal offence since the fetus was not 'any other person'. (*CP (a child)* v. *First Tier Tribunal (criminal injury compensation)* [2014] EWCA Civ 1554). In 2012 the Criminal Injury Compensation Scheme changed the rules in 2012 to prevent fetal alcohol syndrome being seen as a crime of violence for the purposes of compensation (see chapter 2).

Similarly, a pregnant woman who refused to consent to an episiotomy in the circumstances outlined above would not be committing a criminal offence unless this refusal was made with the intention of causing the death of the fetus and unless this refusal to give consent could be defined as an offence under the 1929 Act. It was reported that pregnant women are being asked to take blood tests to determine their drinking habits in order to reveal long-term drinking levels.[48] It must be emphasised that such a test can only be used if the woman gives consent without any duress. NICE has recommended that midwives should test all women with carbon monoxide kits at antenatal appointments to check if they are telling the truth about smoking in an attempt to reduce the 21 per cent of women who smoke during pregnancy. The tests could not be administered without the consent of the woman but the RCM is concerned that some women might not realise that they are voluntary and this could damage the relationship between midwife and expectant woman.[49]

In January 2014 a mother who killed her baby after three days and nights without sleep pleaded guilty to infanticide and was given a 3-year supervision order.[50] A review of her care by the Hull Safeguarding Children Board found that she should have been offered more support but that the baby's death could not have been prevented. Her GP diagnosed postnatal depression but did not share this information with the health visitor and no arrangement was made to follow her up.

Planning for the baby of a young teenage mother

Where the mother is very young, then both she and her baby may be the subject of proceedings under the Children Act 1989 (see chapter 13 on children). In a case in 2000[51] the Family Division held that while there were no general principles that the babies of young teenagers should be adopted, it was not appropriate to concentrate on the welfare of the mother to the exclusion of the needs of the unborn baby. It was essential that the local authorities began planning for the baby as well as the mother as soon as possible. In this case, the mother, aged 13, and her baby were both living with a foster family where the foster mother was caring for the mother who had returned to full-time schooling. Mrs Justice Bracewell held that there was no general principle that the babies of young teenagers should be adopted, but each case had to be considered on its own facts. She laid down the following principles.

1 Planning for the baby as well as the mother should begin immediately. It was not appropriate to concentrate on the welfare of the mother to the exclusion of the needs of the child to be born.
2 There was a need to complete social work and expert assessments well before the birth to ensure that effective and timely planning could be undertaken.
3 If care proceedings under Section 31 of the Children Act 1989 were necessary, they should be issued on the day of birth and where the mother was very young should be transferred to the High Court and a separate guardian *ad litem* appointed for the mother and the child.
4 The baby's interim placement should be determined on the evidence before the court at an early hearing as a matter of urgency.
5 Early final determination of the case was vital.
6 Twin-track planning and/or concurrent planning was essential where one of the possible outcomes was adoption.
7 It was a misconception for social workers to consider that there was a prohibition on identifying suitable adopters before the final decision of the court, provided that decision was not pre-empted.

The advice of the Family Division is extremely helpful, but one of the usual difficulties in such pregnancies is that the pregnancy comes to light only at a very late stage, requiring very speedy action to be taken by health and social services professionals.

Taking the newly born into care

A child can be taken into care as soon as it is born, if the requirements of the Children Act 1989 are satisfied. This may be so if there is evidence of the woman's conduct in relation to other children in the family.

Case 14.2 *In re D (A Minor) v. Berkshire County Council* (1987)

Pre-birth conduct[52]

At birth (12 March 1985), the child was suffering from symptoms caused by withdrawal from narcotics. The mother had been a registered drug addict since 1982, had continued to take drugs in excess of those prescribed during her pregnancy and had known that by taking drugs while pregnant she could be causing damage to the child. The child was kept in intensive care in hospital for several weeks immediately following the birth. A place of safety order was obtained on 23 April 1985, followed by successive interim orders.

The House of Lords, in a unanimous judgment, stated that the provisions of section 1.2(a) of the Children and Young Persons Act 1969 (which stated that if the court is satisfied that the child's 'proper development is being avoidably prevented or neglected or he is being ill-treated . . . and also that he is in need of care and control then . . . the court may, if it thinks fit, make such an order' (now re-enacted in the Children Act 1989)) should be given a broad and liberal construction that gives full effect to their legislative purpose. They saw no reason why the courts should not look back to the time before the child had been born. However, in this case, the mother was still a drug addict and there was thus a continuum between the prenatal and postnatal period. The decision of the House of Lords against the mother cannot be used as a precedent for arguing that if the mother has failed to take care of herself and the fetus during pregnancy, this will constitute grounds for a care order irrespective of her postnatal care of the child. There is no recognition in law of a child's right to receive, prenatally, a responsible standard of care from its mother. The Court of Appeal[53] has said that a care order is not available in respect of an unborn child (see Case 14.5 on page 400).

Where a woman is known to be a potential danger to her unborn child it is essential that a court order should be obtained before the child is removed from her at birth. In the case of *R (on the application of G) v. Nottingham City Council*[54] where the birth took place at 2.00 a.m. and the baby was immediately handed over to social services without a court order, the court held that there was a breach of the Children Act 1989 and also a breach of Article 8. In the case of Coventry City Council and C, B, CA, CH[55] the court gave guidance on the application of section 20 of the Children Act 1989 under which the mother had agreed to the removal of her baby after birth. She had claimed that the LA was in breach of her human rights. The LA accepted that it should not have sought consent under section 20 and that the removal of the baby was not a proportionate response to the risks that then existed and that there was a breach of Article 8 rights of both mother and child. The case can be viewed on the Bailii website.[56] The guidance of the court is set out in paragraph 46.

Midwifery practice and standard of care

Midwives' Rule 5 (see Box 14.2) states that a midwife must provide care 'in accordance with standards established and reviewed by the Council in accordance with article 21(1)(a) of the order'. This general rule embraces a principle that applies to all NMC practitioners and is in keeping with the Bolam Test which is considered in chapter 3. The standards on Rule 5 state that except in an emergency the midwife 'must not provide any care, or undertake any treatment, that you have not been trained to give'.

Midwife and doctor

In 2011 the NHS Litigation Authority reported that there had been a sevenfold increase in compensation paid for midwifery and obstetric errors in relation to the interpretation of CTGs, rising from £11.8m in 2006 to £85.8m in 2010. Awards in cases following negligence at birth are among the highest. For example, in July £12 million was awarded to Toby Hart who suffered serious brain damage when doctors failed to spot that his heart rate had slowed drastically as a result of which he was starved of oxygen. South Tees Hospital NHS Trust was required to pay £2 million as a lump sum and an annual payment of almost £500,000.[57]

£5.5 million was the agreed assessment of damages in a brain injury case where liability was disputed. The Court of Appeal refused to overturn the decision of the High Court that there was negligence in failure to monitor the fetal heart and an episiotomy should have been performed 10–15 minutes earlier. The baby suffered from a severe form of cerebral palsy.[58] The standard of care provided by doctor and midwife is central to such allegations. The principles relating to the duty and standard of care discussed in chapter 3 apply to the role of the midwife, but specific concerns can arise over the respective role of midwife and doctor. The midwife would be expected to follow the standard of care as defined by applying the Bolam Test. Research findings and publications by the National Institute for Health and Care

Excellence (see page 407) and recommendations from professional bodies such as the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives also provide evidence for deducing what would be a reasonable standard of care. Rule 40 has been the subject of considerable debate and its successor, Rule 5, is at the heart of the debate of the respective roles and relationship of midwife and doctor.

The Care Quality Commission has published essential standards for healthcare (see chapter 5) which it uses as the bases for its inspections. It gives an example from midwifery practice on how the standard is enforced:

An Example of the hospital's duty to constantly check the quality of its services:

A particular hospital's maternity unit has good clinical practice in place to make sure that mothers and their babies are protected from any risks of harm. When a serious incident happens, there is an immediate case review, chaired by a representative of the hospital's management board. An action plan is put in place as a result of this and all staff in the unit are told about it. The mother concerned is involved throughout the process. We (the CQC) make an unannounced visit to the hospital, speak to pregnant women in the unit and independently review the hospital's action plan for improvement. Once we are happy that the hospital is meeting this essential standard of quality and safety, we share with the public what we have found by publishing a report.

Case 14.3 Midwife and doctor mix-up

A 25-year-old woman was delivered of a normal baby by Caesarean section in a small district hospital. The general practitioner who gave the anaesthetic had no specialist anaesthetic qualifications. The procedure lasted for two hours and was technically difficult because of adhesions from a previous Caesarean section. In the immediate postoperative period, the patient developed peripheral cyanosis with a drop in blood pressure (88/60) and was treated with intravenous fluids and oxygen. When she seemed to have improved, the doctor left the hospital.

An hour later, the patient developed a cough and tachycardia and the nurses gave linctus pholcodine. Ninety minutes later, the doctor was informed by telephone that the patient had a persistent cough and he ordered oral aminophylline. After another 90 minutes, he was summoned urgently because the patient had severe progressive respiratory distress and cyanosis. An X-ray confirmed Mendelson's syndrome and the patient was transferred to the main hospital where she required intensive resuscitation; she had sustained brainstem infarction with pseudobulbar palsy, spastic quadriparesis and cortical blindness. The Medical Defence Union (MDU) considered the claim for damages to be indefensible.

In Case 14.3, although the time of gastric aspiration was uncertain, it was felt that the nursing staff had not adequately appraised the doctor of the patient's deteriorating condition and on this basis the hospital's solicitors accepted a proportion of liability. The inadequate attention paid to the patient by the general practitioner in the early postoperative period was thought to be of major significance. The MDU paid two-thirds of the agreed damages.[59] The acceptance of the nurse's partial liability in this case shows how important communication between the practitioners is in the care of the patient and the degree of responsibility that falls on the nurse's shoulders in ensuring that the doctor is adequately informed of the patient's progress or deterioration. The case also shows the importance of detailed and accurate records. In other circumstances, it could well be that the nurse appreciated the severity of the patient's condition, but that the doctor failed to respond to the entreaties to come. Accurate recordings of the times that phone calls were made, together with their content, will be partial evidence of the nurse's understanding of the situation. In serious cases, it may not be sufficient to rely on the judgement

of one doctor and it may be necessary to take alternative action, which is a difficult dilemma for junior nursing and midwifery staff.

The standard of care must also include the use of the appropriate equipment and technology. For example in a case at the University Hospital of Wales, the Ombudsman found that the hospital had probably been diagnosing miscarriages for as long as five years by failing to use transvaginal scans as well as Dopple Ultrasound and a transabdominal scan according to the guidelines issued by the Royal College of Obstetricians and Gynaecologists. The errors came to light when a woman who had been informed that she had suffered a silent miscarriage and required a uterine evacuation, subsequently had another scan at a different hospital and was told the fetus was alive and she subsequently gave birth. The hospital announced that it had made immediate changes to its practices and gave Ms Wheatley £1,500 in compensation.[60]

Failure by staff to notice that a woman had an infection following a Caesarean section and to treat her with antibiotics, despite four high temperature readings led to the woman requiring a life-saving hysterectomy. The Heart of England NHS Trust reached an out-of-court settlement of £10,000 before the case was scheduled to be heard in the High Court without admitting liability.[61]

The NMC held a professional conduct case into the actions of two midwives, Yvonne Musonda-Malata and Christine Onade, who put a baby in a stationery cupboard while the mother caught up on her sleep. They were also accused of failing to record feeds given to the baby.[62] The CCC found the facts proved against the first midwife. The second midwife was cleared of all charges. In another case, £1.6m was awarded to a city high-flyer for botched birth injuries. She received insufficient treatment after undergoing an episiotomy that caused a third-degree tear. Subsequently she experienced constant pain and severe difficulty in controlling her bowels. There was no proper examination carried out post-delivery so that the severity of the tear remained undetected. The consultant obstetrician admitted liability for her pain and suffering, future medical and surgical costs and psychiatric care but disputed her claim for loss of past and future earnings (prior to the birth she was earning £10,700 a month net). The judge held that her injury put paid to her ability to return to any form of work in the financial sector and severely limited the nature of any future employment.[63]

Litigation, time limits and record keeping

Litigation in obstetrics and midwifery is increasing more than in any other specialty and the levels of compensation are, because of the costs of keeping a severely brain-damaged person for 40–50 years, among the highest payments. In addition, although the usual time limit for adults bringing a civil action for compensation is usually three years from the date of the negligent incident or the knowledge of it or the harm suffered (see chapter 6), where there is mental disability, the time limits do not come into force until the mental disability ends (which usually is not until death). The result is that many cases may not come to court for many years after the events, as the following case shows.

Case 14.4 *Midwife and health visitor mix-up*[64]

When Sonja Taylor was born in 1974, both the midwife and the health visitor thought that the blood test for phenylketonuria had already been performed. The hospital records were not consulted. As a result, the child became seriously brain-damaged and the parents were not aware of the problem until it was too late to rectify it. Had the test been conducted, the child could have been placed on a diet and the harm prevented. In March 2000, £2.5 million was awarded in respect of this act of negligence.

Community midwife

Practical Dilemma 14.3 Community midwifery

A very active community midwifery service existed in Roger Park District Health Authority. The midwives were proud of the fact that there was a much higher proportion of community confinements than in the rest of the country. In the community, medical support was provided by those general practitioners who had opted to care for obstetrical cases. Not all these GPs had received recent training in obstetrical practice. One such GP was Dr Marks, a 65-year-old doctor who had not attended a revision course in the past 30 years. He was a doctor of very fixed ideas. Grace Edwards had been practising midwifery for 18 years and had recently undertaken her statutory revision course at a large London hospital. She was called to Brenda Rice's home at 3.00 a.m. Grace realised that the birth was imminent. She phoned Dr Marks, advising him to come immediately and giving him details of the mother and fetal condition that were giving her cause for concern. On arrival, Dr Marks disagreed with Grace's view of the severity of the situation and refused to agree to an ambulance being called. He considered that a forceps delivery could be performed safely. Unfortunately, this proved not to be so and the baby was stillborn.

In a dilemma such as that in Practical Dilemma 14.3, the midwife cannot avoid responsibility for her actions by saying that she obeyed the GP. If it is clear that his advice is mistaken and she fears for the health of the mother or baby, then she has a personal professional duty to them and would have to take further action. In extreme circumstances, this might mean summoning an ambulance or calling out an obstetrician from the hospital despite the objections of the GP. This example also illustrates the importance of ensuring that the community midwife should be experienced. In August 2010 the King's Fund, following an inquiry, reported that GPs must be given more responsibility for the health of women in pregnancy to improve the continuity of care they receive.[65] It recommended that GPs play a much more active role through all pregnancy stages and work closely with midwives and consultants in providing joined-up services. NHS England published a resource pack to support clinical commissioning groups in their commissioning of maternity services[66]. It quotes the consensus statement of the RCGP, RCM and RCOG on the role of the GP in maternity care.

In 2014 a coroner referred a case to the Crown Prosecution Service to investigate whether there were grounds for criminal prosecution under the Corporate Manslaughter Act. A mother of six bled to death after giving birth to twins by an elective Caesarean at Croydon University Hospital in June 2010. Errors by staff included failing to record the level of her blood loss, failing to declare a major haemorrhage, to monitor her following surgery or to react to the seriousness of her condition.[67]

Breastfeeding

The Breastfeeding etc. (Scotland) Act 2005 made it an offence deliberately to prevent or stop a person in charge of a child from feeding milk to that child in a public place or on licensed premises. An exception to this offence is if the child at the material time is not lawfully permitted to be in the public place or on the licensed premises otherwise than for the purpose of being fed milk. Under section 2 anything done by a person in the course of that person's employment shall be treated for the purposes of this Act as done also by that person's employer, whether or not it was done with the employer's knowledge or approval.[68] This Act only applied to Scotland but the Equality Act 2010 (see chapter 10) defines less favourable treatment of a woman to include a woman who was breastfeeding and therefore a protected characteristic from direct discrimination (s. 13(6)(a)). Section 17 also defines discrimination against a

woman in the 26 weeks after giving birth as including treating her unfavourably because she is breastfeeding (s. 17(4)). The DH has stated that it is fully committed to the promotion of breastfeeding and has provided guidance on maternal and infant nutrition.[69] The RCN has provided guidance for its members on good practice in breasteeding.[70] A study organised by the University of Sheffield is trialling a scheme whereby mothers are given shopping vouchers as an incentive to breastfeed, in the hope that the stigma against breastfeeding in some poor areas may be removed.[71] The Royal College of Midwives emphasised that the motive for breastfeeding cannot be rooted by offering financial reward. It has to be something that a mother wants to do in the interest of the health and well-being of her child. The CQC in its survey of maternity services since 2010 found that some mothers felt that they were bullied into breastfeeding.[72] Other findings of the CQC were that there had been an improvement in maternity services since 2010 but that one in five said her concerns were not taken seriously during labour. Others complained of dirty hospitals, poor pain relief and never seeing the same midwife twice. A report on 18 March 2014 stated that a woman was not permitted to breastfeed her 6-week-old baby in a hospital waiting room but had to go to a private room. RCM and the National Childbirth Trust[73] have called for legislation comparable to Scotland's.

Cord blood collection

The Human Tissue Authority has warned that since 5 July 2008 it has been illegal for staff to collect cord blood if they have not been trained or their unit does not have an HTA licence. Parents who are interested in cord blood banking should discuss this with the unit well before the baby is due.

Medicines and the midwife

In chapter 28, the law relating to medicines and administration and prescribing is considered. Here the specific powers of a midwife in relation to medicines are considered.

Under the Misuse of Drugs Regulations 2001 Clause 11,[74] a registered midwife who has notified the local supervising authority of her intention to practise may possess and administer any controlled drug in so far as is necessary for the practice of midwifery and may surrender to her appropriate medical officer any stocks no longer required. A midwife may lawfully possess only those drugs that she has obtained on a midwife's supply order signed by the medical officer. The midwife's supply order must specify in writing:

1 name
2 occupation of midwife
3 purpose for which the drug is required
4 total quantity required.

Midwives' standards on Rule 5 cover the administration of any medicines. Paragraph 5 of the standard on Rule 5 is shown in Box 14.5.

Box 14.5 Rule 5 Scope of Practice – Midwife standards, paragraph 5

You must only supply and administer those medicines, for which you have received training as to use, dosage and methods of administration and for which you are exempt.

In March 2003 the NMC issued a circular on the supply and administration of all non-prescription-only medicines and general sales list medicines by registered midwives in the course of their professional practice.[75] It stated that a registered midwife can supply and administer all non-prescription-only medicines and a student midwife, during the course of her programme of education, can administer those medicines under the guidance of a practising midwife, for which the registered midwife remains accountable. The midwife is able to supply and administer medicines from the categories of medicines specified in the Medicines (Pharmacy and General Sale Exemption) Order SI 1980 No. 1924, including nitrous oxide and oxygen without a patient group direction.

On 1 June 2010 amending legislation[76] came into force which expanded and updated the range of prescription-only medicines that may be sold, supplied or administered by a registered midwife. The NMC explained the changes as follows:

> **It was decided to remove certain substances from the list as they were rarely, if ever, used and to add a number of additional medicines which were considered to have more clinical value in contemporary midwifery practice.**
>
> **Registered midwives may supply and administer, on their own initiative, any of the substances that are specified in medicines legislation under midwives exemptions, provided it is in the course of their professional midwifery practice.**
>
> **If a medicine is on the midwives' exemption list, a Patient Group Direction (PGD) is not required. We also recommend that the term standing orders is no longer used as there is no legal definition for this under medicines legislation.[77]**
>
> **Exemptions are distinct from prescribing as this requires the involvement of a pharmacist in the sale or supply of the medicine. Midwives may only prescribe if they have successfully completed an accredited prescribing course and once the NMC's professional register has been annotated to indicate their prescribing status.**
>
> **It is important to note that registered midwives must only supply and administer those medicines, including analgesics, in which they have received the appropriate training as to therapeutic use, dosage, side effects, precautions, contraindications and methods of administration.**

The full list of midwives' exemptions can be found on NMC circular 06/2010.

The current rules and standards are set out in the Nursing and Midwifery Council Midwives Rules and Standards.[78]

Midwives are able to train as independent prescribers if they have had at least three years' post-registration experience. They are also able to act as supplementary prescribers after the appropriate training. They must have agreed a clinical management plan with the independent prescriber and must follow the rules on supplementary prescribing discussed in chapter 28. Midwives must keep a record of their supplies of controlled drugs in their register and make this available for inspection to their supervisors. They are responsible for their safe and secure storage. A record is kept in the woman's home of the administration of the drugs. Alternatively, a GP might write a prescription for controlled drugs for the patient which are kept in the home. Further details of the reforms to the procedures relating to controlled drugs[79] which followed the Shipman Reports are discussed in chapter 28. Midwives, if independent prescribers, are able to prescribe controlled drugs under recent legislation[80] (see chapter 28).

Congenital Disabilities (Civil Liability) Act 1976

The Congenital Disabilities Act 1976 was enacted because, following the thalidomide tragedy, it was not clear in law whether the child, once born, had a claim in respect of pre-birth injuries. The Act enables a child who is born alive to sue any person (except the mother, apart from one situation (see page 399)) who has caused him to be born disabled as a result of an act of negligence. In order for an action to succeed under the Act, it must be established that the harm that occurred was caused by the wrongful act. For example, a pregnant woman could be assaulted and subsequently go into premature

labour. The child might suffer from some mental and physical handicaps. It must be established that these disabilities were caused by the assault. Causation in brain damage is particularly difficult to trace, as vaccination cases show. The law does not recognise the fetus as having a legal personality and it therefore cannot have legal rights of its own until it is born and has a separate existence from its mother. Once born, it does then have the right to sue under the Congenital Disabilities (Civil Liability) Act for pre-birth injuries. The 1976 Act was amended by the Human Fertilisation and Embryology Act 1990 by adding section 1A to the Act. This is shown in Statute Box 14.1 below and gives a right of action to a child who is born disabled as a result of fertility treatment. (The Act can be seen on the website of this book.)

Statute 14.1 Section 1A of the Congenital Disabilities (Civil Liability) Act

In any case where:

1 a child carried by a woman as the result of the placing in her of an embryo or of sperm and eggs or her artificial insemination is born disabled,
2 the disability results from an act or omission in the course of the selection, or the keeping or use outside the body, of the embryo carried by her or of the gametes used to bring about the creation of the embryo, and
3 a person is under this section answerable to the child in respect of the act or omission, the child's disabilities are to be regarded as damage resulting from the wrongful act of that person and actionable accordingly at the suit of the child.

Liability of the midwife

If it can be shown that the midwife has failed without justification to follow the approved accepted practice and, as a consequence, the fetus is harmed and the child is born disabled, the mother has a right of action against her and also against the NHS trust for the injury she has suffered. In addition, the mother can bring a claim in the name of the child for any harm suffered by the child. This latter action can be brought under the Congenital Disabilities (Civil Liability) Act 1976.

Professional standards

Section 1(5) of the Act defines what is meant by professional standards and is set out in Statute Box 14.2.

The working of the Act can be seen in another context. Imagine that another thalidomide-type situation were to occur. It might be possible that the mother had asked the midwife's advice in relation to a particular medicine/food during pregnancy. The midwife might reassure her that the particular product was fine. If, in fact, it then caused defects to the baby, would the midwife be liable to the baby under the Congenital Disabilities (Civil Liability) Act? The answer is that, if, at the time, her advice was reasonable in relation to what was known about the product and she was following the approved practice in recommending it, she would be unlikely to be found negligent. The mother might, of course, have other remedies such as against the manufacturers (see chapter 12 and product liability).

Although there was no successful case in the UK against the makers of thalidomide, Distillers, Diageo (which bought Distillers) have paid out compensation to the victims and in 2013 agreed a settlement of £52 million with more than 100 thalidomide sufferers in Australia and New Zealand.[81]

Statute 14.2 Section 1(5) Congenital Disabilities (Civil Liability) Act 1976

The defendant is not answerable to the child for anything he did or omitted to do when responsible in a professional capacity for treating or advising the parent, if he took reasonable care having due regard to then received professional opinion applicable to the particular class of case; but this does not mean that he is answerable only because he departed from received opinion.

Child's action is derivative

The child's right of action under the 1976 Act is derivative, i.e. only if the defendant would have been liable to one of the parents is the defendant then liable to the child. The father can be sued by the child. However, if the action concerns an occurrence that took place prior to conception, the defendant is not answerable to the child if at that time either or both of the parents knew of the risk of their child being born disabled. If, however, it is the child's father who is the defendant, the action can continue if he alone knew of the risk, but not the mother. To explain this provision, consider the following circumstance.

Practical Dilemma 14.4 HIV

Bill was aware that he was suffering from AIDS. He was unwilling to allow the special clinic to inform his wife and he refused to give them his address. However, he continued to have sex with her and she became pregnant. She was not aware that she might become HIV-positive. The baby was found to be HIV-positive.

In this situation, it is possible that the child could maintain a successful action against the father under the provisions of the Act. Bill was in breach of the duty of care owed to the mother in that he failed to warn her that he was suffering from AIDS and as a consequence the baby was born HIV-positive. It could be argued, however, that the father's negligence was in failing to prevent the baby from being born, not in actually causing harm to the child and therefore the child would have no claim under the Act. This is discussed in connection with the McKay case.

If both parents are aware of the possibility of the child being born disabled, no action can be commenced.

Mother's liability under the Act

The mother is liable to the child under the Act only if (section 2) she is driving a motor vehicle when she knows (or ought reasonably to know) herself to be pregnant. Under this provision, she is to be regarded as being under the same duty to take care for the safety of her unborn child as the law imposes on her with respect to the safety of other people; and if, in consequence of her breach of that duty, her child is born with disabilities that would not otherwise have been present, those disabilities are to be regarded as damage resulting from her wrongful act and actionable accordingly at the suit of the child. In practice, of course, the child would be suing the company who insured the mother.

Rights of the child

An unborn child is not recognised in law as having a legal personality. At birth, however, he or she is able to bring an action in respect of any harm he or she has suffered.

The following case has made it clear that the courts have no power to make an unborn baby a ward of court.

Case 14.5 *In re F (in utero)* (1988)

The rights of the unborn[82]

The mother was aged 36 and had suffered from severe mental disturbance since 1977. Throughout 1982, she had led a nomadic existence, wandering around Europe. She had returned in 1983 and had been settled in a flat in south London. Her only means of support was supplementary benefit. The local authority was concerned about the baby expected towards the end of January. Early in January, the mother disappeared. The local authority instituted wardship proceedings.

The Court of Appeal was of the opinion that if it had the power to institute wardship proceedings it would do so, but did it have the power? It concluded that it did not. There was no jurisdiction for the court to make a fetus a **ward of court**. The court pointed out the difficulties of enforcing such an order against the mother: 'If the law was to be extended so as to impose control over the expectant mother, where such control was necessary for the benefit of the unborn child then it was for Parliament to decide whether such controls could be imposed and, if so, subject to what limitations. In such a sensitive field affecting the liberty of the individual it was not for the judiciary to extend the law' (per Lord Justice Balcombe).

Action for wrongful life

Case 14.6 *McKay v. Essex AHA* (1982)

German measles[83]

Mrs McKay was pregnant and suspected that she had contracted German measles in the early weeks of her pregnancy. Blood tests were arranged to see if she had been infected. Unfortunately, she was wrongly informed that she had not been infected. When the baby was born, it was found to be disabled as a result of the effect of German measles.

The Court of Appeal held that the child's claim for wrongful life (i.e. if there had been no negligence, the child would have been aborted) could not be sustained. Although this child was born before the Congenital Disabilities Act 1976 was passed, the court still held that an action for wrongful life could not stand, even under the provisions of the Act. This decision does not, of course, affect the rights of the mother to sue for damages resulting from the negligence in informing her of the results of the tests and Mrs McKay brought her own action on that point. The decision of the Court of Appeal was concerned solely with the rights of the child.

Nurseries within midwifery departments

Problems can sometimes arise within the midwifery department over the responsibility for the nursery nurse staff and those who are caring for the babies. It is essential that clear lines of accountability and responsibility are laid down so that there is no confusion on this point: local practices might differ.

Special care baby units

These units may or may not be under the control of the midwifery department. Some may be under the paediatric department. The nature of the control should not affect the standard of care. The shortage of staff in these units has received much publicity and undoubtedly the pressure on resources has created difficulties for staff. (Resource issues are considered in chapter 4.)

A coroner ruled that the death of a newborn baby in an overstretched maternity ward was due to a scandalous shortage of midwives, poor monitoring and a catalogue of other problems.[84] He stated that lives would continue to be at risk at Milton Keynes General Hospital unless system failures that contributed to her death were resolved. The baby, who was full term, had a faint heartbeat when she was delivered by Caesarean section and died less than 20 minutes after her birth. The CQC stated that the inquest findings would be used in a follow-up to an earlier report it had published on the maternity unit.

An inquest recorded an open verdict on a midwife who was found hanged after a baby had died. It was stated that she feared that she would be struck off but the inquest heard that the baby was so poorly that he was unlikely to have survived anyway. The midwife had failed to attend a meeting to discuss the case with her and to offer her support during the investigation.[85]

A report[86] by the National Confidential Enquiry into Patient Outcome and Death in June 2010 stated that in almost a third of infant cases there were delays in recognising the need for artificial nutrition and further delays in starting it in 17 per cent of cases. In 37 per cent of cases the nutrition was considered inadequate for babies' needs, and complications were avoidable in 19 per cent of cases. Similar findings were made in relation to artificial feeds for adults.

Care of the grossly handicapped

Those who work in special care baby units face the problem of determining the extent to which heroic measures should be used to prolong the lives of grossly underweight babies or should be given to severely handicapped babies.

Case 14.7 *Re K* (2006)

Withdrawal of treatment of a 5-month-old child[87]

An NHS trust sought a declaration that a feeding tube could be removed from the abdomen of a premature baby who suffered from a severe congenital neuromuscular disorder. The parents agreed that life-prolonging treatment should cease.

The judge granted the declaration. It was in the child's best interests to cease the total parenteral nutrition at a time when she was clinically stable, so that she could die in peace and in a comparatively short space of time, relieved by palliative care treatment. The situation came within categories 3 and 4 of the Royal College of Paediatrics and Child Health.[88]

It is illegal for doctors to prescribe, either intentionally or recklessly, a substance to bring about the infant's death. The courts have, however, ruled that there is a legal distinction between killing and letting die, and have applied this principle in several cases relating to severely disabled babies. (This legal distinction is considered in more detail in chapter 29.)

The Court of Appeal made a declaration in the case of *Re C*[89] that an infant ward of court who was terminally ill, suffering irreversible and severe brain damage, was to be treated in accordance with the specialist's advice. The paragraph included by the trial judge relating to details of the treatment

permitted, preventing the prescribing and administering of antibiotics and preventing the setting up of intravenous fusions or nasal-gastric feeding regimes, was deleted by the Court of Appeal.

In the case of *Re J* (1990),[90] the baby suffered from severe disabilities and was likely to develop serious spastic quadriplegia and be both deaf and blind. He was not, however, on the point of death or dying. In deciding whether he should be put back on to a mechanical ventilator, the Court of Appeal held that the test to be applied 'must be whether the child in question, if capable of exercising sound judgment, would consider the life tolerable'.

In the case of *Re J* (1992),[91] the baby suffered from a severe form of cerebral palsy with cortical blindness and severe epilepsy. The Court of Appeal held that the court will not exercise its inherent jurisdiction over minors by ordering a medical practitioner to treat the minor in a manner contrary to the practitioner's clinical judgment. In the practitioner's view, intensive therapeutic measures such as artificial ventilation were inappropriate. The Court of Appeal has declared that it would be lawful for doctors in their professional judgment to allow a severely disabled child to die. If a baby is born alive following an attempted abortion, then all reasonable care must be taken to ensure that the baby has a reasonable chance of surviving.

The Royal College of Paediatrics and Child Health has published guidelines on when it is appropriate to withhold or withdraw medical treatment.[92] The guidelines distinguish between the following clinical situations:

1 the brain-dead child
2 the permanent vegetative state
3 the 'no chance' situation
4 the 'no purpose' situation
5 the 'unbearable' situation.

In all these situations, the possibility of withholding or withdrawal of curative medical treatment might be considered. The guidance emphasises the importance of the fundamental principles of the duty of care and partnership of care and the respect for the rights of the child as set out in the United Nation's Convention on the Rights of the Child.[93] The guidelines of the Royal College of Paediatrics and Child Health represent its interpretation of the law, but are not the law itself. Further advice has been published by the British Medical Association.[94]

Case 14.8 *NHS Trust v. D* (2000)

Death with dignity and human rights[95]

Since birth a child had suffered from serious disabilities, in particular a severe, chronic, irreversible and worsening lung disease giving him a very short life expectancy, coupled with heart failure, renal and liver dysfunction with a background of severe developmental delay. Doctors advised the NHS trust that it was not in the child's best interests to be resuscitated and the trust applied to court for a declaration. The child's parents opposed the application.

In Case 14.8 the court held that the paramount consideration was the welfare of the child; the high respect for the sanctity of human life imposed a strong presumption in favour of taking all steps capable of preserving it; there could be no question of the court directing treatment that was contrary to the clinical judgement of the doctor; the court held that full palliative treatment was in the child's best interests and would allow him to die with dignity. There was no breach of the European Convention on Human Rights of either the right to life (Article 2) or the right not to be subjected to inhuman or degrading treatment (Article 3). A similar decision was reached in a case in 2006[96] where the parents of

a severely disabled baby sought a declaration that it was lawful and in the baby's best interests for a tracheotomy to be carried out, and the trust sought a declaration that it was lawful to withdraw all form of ventilation from him. The court, applying the principle that his welfare was the paramount consideration, said considerable weight had to be given to prolongation of life but this was not absolute nor necessarily decisive. The court considered that it was not in M's best interests to discontinue ventilation, but that certain procedures which involved the infliction of pain, such as cardiopulmonary resuscitation, electrocardiogram monitoring and IV antibiotics, could be withheld in M's best interests.

Disputes over withdrawal of care

There are considerable advantages in seeking a declaration from the court before active treatment is withdrawn, especially where there are already allegations of negligence over what caused the disabilities. For example, parents accused a hospital of turning off their baby's life support to save care costs. The baby was born with considerable disabilities as a result of the alleged negligence of staff. However, the parents alleged that they were pressured into agreeing to the withdrawal of support treatment because the compensation for a dead baby was £10,000 whereas, had the baby been allowed to survive, compensation would be for the costs of care for the whole of his life.[97]

One example of frequent applications to court during a dispute between clinicians and parents over the care of a severely disabled child is that of the Wyatt case.

Case 14.9 *Wyatt v. Portsmouth Hospital NHS Trust (2004–5)*

Severely disabled baby[98]

The Portsmouth NHS trust sought permission to decline to give invasive medical treatment to prolong the life of a profoundly disabled baby. Charlotte had been born at 26 weeks' gestation, weighing about 1 pound. She had chronic respiratory and kidney problems and brain damage that had left her blind, deaf and incapable of voluntary movement or response. She was capable of experiencing pain. The dispute was over what should be done should she deteriorate and require artificial ventilation. The unanimous medical advice was that to give such treatment would not be in her best interests. However, her parents' view was that such treatment should at least be instituted and that the treatment could best be prepared for by the carrying out of an elective tracheotomy. They believed that it was their duty to maintain life as they did not believe that C was yet ready to die. The court granted the application, that any further aggressive treatment, even if necessary to prolong life, was not in C's best interests. There were two further applications by the parents to the court[99] and an appeal by the parents to the Court of Appeal was dismissed.[100] Subsequently, when she appeared to be making good progress, the parents asked the court to review its decision. The judge decided on 21 April 2005 that the decision should stand but it was subject to review.[101]

The Wyatt case illustrates the difficulties which arise when clinicians and parents are in dispute over what is in the best interests of the disabled child. The courts tend to follow the unanimous recommendations of the clinical staff and there are few cases on record where the court has supported the parents. In one such case the parents opposed a liver transplant recommended by the clinicians (see chapter 13).[102]

In contrast to the Wyatt case, the court ordered that a desperately ill baby of 7 months should be treated against the wishes of the parents who were opposed to a bone marrow transplant and put their trust in God to heal the child.[103] In the more recent case of RB, parents who were separated disagreed over whether their severely disabled baby should be allowed to die. The child, who was then 1 year old, had been on a ventilator since birth and faced a life of intolerable pain. The doctors and mother had gone to court to seek permission for the ventilator to be switched off but this was opposed by the boy's

father. However, he eventually withdrew his opposition and it was agreed that suitable arrangements would be made between the trust and the parents for RB's life to be brought to a dignified end.[104]

In a case in 2014[105] there was a dispute between parents and the NHS trust over the treatment of a 1-year-old boy following his extubation from the ventilator. He had an incurable neuro-developmental disorder and had been in hospital since birth. The parents wanted the child to be reintubated in the 24 hours following extubation. The trust doctors opposed that course of action. The judge decided that it was in the child's best interests to receive bagging (i.e ventilation delivered by hand through a mask and by squeezing a bag) for 24 hours. This was supported by the guardian appointed to represent the child. Thereafter the agreed Emergency Care Plan and Symptom Management Plan would be put into effect.

Case 14.10 *In re A (Minors: Conjoined twins)* (2001)

Separation of conjoined twins[106]

During the antenatal care of a woman in Gozo, an island near Malta, it was realised that she would need facilities for the birth of her baby that were not available locally. Under a quota arrangement between the Malta health authorities and the NHS, the mother came to Manchester where the conjoined twins were born by Caesarean section on 8 August 2000. The bodies of the two girls were fused together at the base of their spines, with their four legs splaying out sideways. They shared an aorta and a bladder and their circulatory systems, muscles and skull were joined together. One of the twins, called Mary, had a primitive brain and her heart and lungs quickly failed and she depended on the heart and lungs of Jodie for her existence. The parents, both devout Catholics, had refused consent to any operation to separate them. The doctors applied to the High Court for a declaration that it would be lawful to separate the twins. Medical evidence presented to the court suggested that Jodie could have a reasonable chance of survival if they were to be separated, but such an operation would mean the death of Mary. If no operation were performed, there was a likelihood that Jodie would not survive for many months, because of the strain placed on her heart. Jodie's death would inevitably be followed by Mary's. The High Court judge issued a declaration that the operation should proceed. The parents appealed against this decision. The Court of Appeal asked for additional medical evidence and also received a submission from the Archbishop of Westminster that the operation should not proceed, but that the twins should be allowed to go to a hospice at Ravenna in Italy and should be treated there until they died.

The Court of Appeal held it was lawful for doctors to carry out the operation to separate the twins. The crucial questions to be answered were:

1 Was it in J's best interests that she be separated from M?
2 Was it in M's best interests that she be separated from J?
3 If those interests were in conflict, was the court to balance the interests of one against the other and allow one to prevail against the other and how was that to be done?
4 If the prevailing interest favoured the operation, could it be lawfully performed?

The court concluded that the operation would give J the prospects of a normal expectation of relatively normal life. The operation would shorten M's life, but she remained marked for death. M was alive because she sucked the lifeblood out of J. She would survive only as long as J survived. The operation could be carried out under the doctrine of necessity. The essential elements of that doctrine were all satisfied:

1 the act was needed to avoid inevitable and irreparable evil
2 no more should be done than was reasonably necessary for the purpose to be achieved
3 the evil inflicted must not be disproportionate to the evil avoided.

The court held that its decision was not in conflict with Article 2 of the European Convention on Human Rights (see chapter 1).

The parents were given leave to appeal to the House of Lords, but decided not to do so. The operation was carried out: Mary died and Jodie recovered and returned to Gozo. The extent of her disabilities is not known.

Cot deaths

In January 2004 the Solicitor General announced that a review of 528 women convicted of killing their babies would be carried out. The announcement followed the quashing by the Court of Appeal of the conviction of Angela Canning for murdering her two babies. The Court of Appeal quashed the conviction which was based on the evidence of Professor Sir Roy Meadows who put forward the theory that multiple cot deaths in the same family were likely to be murder. This theory has now been discredited. A review of previous cases included thousands of cases where children have been taken into care on the basis of the evidence of Professor Roy Meadows. Under new rules the Director of Public Prosecutions personally reviews all 'cot death' cases that have yet to come to trial and sanctions any prosecution.[107]

Registration of births and stillbirths

Births

There is a duty on the doctor or midwife attending a woman in childbirth to notify the prescribed medical officer of the birth or stillbirth within 36 hours. This applies whether the birth is at home or in an institution.

Under the Births and Deaths Registration Act 1953, it is the duty of the father or mother to give information to the registrar within 42 days. If either of them cannot, then there is a duty to do so on the occupier of the house, any person present at the birth or any person having charge of the child. This provision might well involve the midwife. If there is a failure to register within 42 days, the Registrar can compel any qualified informant to attend to give information and sign the Register. The Registrar must give seven days' notice in writing. There are additional powers if there is no registration after that date. The European Commission is developing a EU registration birth document for use in all 28 countries but this is intended as an alternative, not a mandatory replacement to the UK certificate.[108]

Stillbirths

A stillbirth is a child that is stillborn, which issued forth from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any signs of life (section 41 of the Births and Deaths Registration Act 1953 as amended by the Stillbirth Definition Act 1992 section 1). The stillbirth has to be registered and the informant has to deliver to the Registrar a written certificate that the child was not born alive. This would be signed by the registered medical practitioner or a certified midwife who was in attendance at the birth or who has examined the body. A stillborn child should be disposed of by burial in a burial ground or churchyard or by cremation at an authorised crematorium.

What if the fetus is less than 24 weeks' gestation?

If the fetus were delivered without any sign of life, then no registration is necessary. The fetus may be disposed of without formality in any way that does not constitute a nuisance or an affront to public decency. However, it is clear that even though the fetus is under 24 weeks, the bereaved parents should be given the sympathy and care that would be given if the baby were full term.

If the fetus is under 24 weeks' gestation and initially shows signs of life and breathing and then dies, it should be treated as a neonatal death and be registered as a birth and death.

The UK has one of the highest rates of still births among the rich nations with a rate of 4.9 per 1,000 births in 2012. Professor Jason Gardosi of the Perinatal Institute stated in December 2013 that avoidable baby deaths happened at the rate of a classroom a week because hospitals were not using tape measures and charts properly.[109] He and his team had cut stillbirth rates in the West Midlands by 22 per cent over the past five years by standardising how growth is measured and problems were referred to doctors. One in 200 babies is born dead giving Britain one of the worst records on stillbirth in the developed world.

Use of fetal tissue and the placenta

In its Code of Practice on Consent,[110] the Human Tissue Authority makes the following point in paragraph 157:

> **157. The law does not distinguish between fetal tissue and other tissue from the living; fetal tissue is regarded as the mother's tissue. Consequently, fetal tissue is subject to the same consent requirements under the HT Act as all other tissue from the living (see section on tissue from the living, paragraphs 113–151). However, because of the sensitivity attached to this subject, it is good practice to always obtain consent for the examination of fetal tissue and for its storage or use for all scheduled purposes.**

Appendix B of the Code of Practice on the removal, storage and disposal of human organs and tissue[111] published by the Human Tissue Authority provides guidance on the disposal of fetal tissue. It emphasises that pregnancy loss should always be handled sensitively and the needs of the woman or couple should be paramount, and disposal policies should reflect this. The Code of Practice suggests that the information provided should explain who to contact to request a particular disposal option and the timescale for this. Any personal, religious or cultural needs relating to the disposal of the fetal tissue should be met wherever possible and should be documented in the woman's medical notes. It explains the various options for disposal, including: burial, cremation and incineration and the rights of the woman to arrange the disposal. Following a Freedom of Information Inquiry the *Sunday Times* found that at least 15,500 fetuses of less than 24 weeks had been incinerated by 27 NHS trusts since 2011. The NHS England medical director has written to 160 trusts stating that fetuses should not be incinerated as clinical waste. Rather they should be cremated.[112] On 14 March 2014 the Human Tissue Authority announced that it was investigating a delay in the disposal of fetal remains at Manor Hospital Walsall[113] (see chapter 16 on the Human Tissue Act 2004).

The Food Standards Agency is proposing a ban on placenta products which is being seen as a novel food. This follows two prohibition notices served on a producer of placenta products under the Food Safety and Hygiene (England) Regulations 2013 by the local environmental health department. There are no legal restrictions on women who wish to consume their own placenta but it would be contrary to the advice of local authority environmental health departments.[114]

Record keeping and midwifery

The Sixth Annual Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) made many recommendations on record keeping. In particular, it noted that poor record keeping occurred in one-third of cases. The major problem was a failure to document events adequately and the report reiterated recommendations from earlier reports on record keeping:

1 All professionals should make clear and adequate notes. The standard should be that which enables a colleague coming new to the case to be properly informed.

2 The quality of maternity records needs to be improved to enable clear identification of risk factors and documentation of management plans for those during both ante-partum and intra-partum periods. These would be facilitated by a well-designed, universally used national maternity record.

Scotland is the first of the UK countries to have a single national unified maternity record for women. Further information can be obtained on the website.[115] The Scottish Woman Held Maternity Record (SWHMR) Version 6 was published in 2011.

AIDS and the midwife

The possibility of a midwife contracting AIDS from an HIV-positive patient has been a major concern, and midwives have been worried about the possibility of protecting themselves by equipment, gloves and clothing. They have also sought the screening of patients so that midwives are warned of the potential dangers. These anxieties are part of the general dilemmas in relation to AIDS and infectious diseases and are considered in chapter 26.

National Institute for Health and Care Excellence (NICE)

NICE has issued several guidelines relating to obstetrics and midwifery practice (see chapter 5 for more details on NICE). It published its antenatal care guidelines in 2003, covering the routine care for the healthy pregnant woman. They are available from the NICE website.[116] The first draft of its clinical guidance for England and Wales on Caesarean section was issued in September 2003 and the final guidance was published in April 2004. NICE clinical guidelines on intra-partum care were published in September 2007. The guideline supports normal birth as well as setting out what to do if labour does not progress normally. Its key recommendations include a woman in established labour receiving supportive one-to-one care. All NICE guidelines can be downloaded from its website. Statistics published by the NHS Information Centre in November 2010 suggest that there is a huge variation in the maternity services across England. For example, in Cornwall 89.6 per cent of women had their first antenatal appointment within 12 weeks of pregnancy (as recommended by the government), whereas in Walsall the rate was 8.3 per cent.[117] The RCM General Secretary stated that the results show that there is a postcode lottery in maternity services, which is worrying when those services are part of a 'national' health service.

National guidelines on midwifery practice

In April 1991, the House of Commons initiated an inquiry into maternity services because concerns had been expressed that the services did not meet the wishes of women. Its report was published in February 1992 (House of Commons Health Committee Session 1991–92, Maternity Services). It concluded that 'the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety'. It made wide-ranging recommendations covering the development of midwife-managed units, involvement of midwives in junior doctors' training and emphasis on the rights and involvement of the mother. A joint committee supported its recommendations. The government set up an expert committee chaired by Lady Cumberlege to review policy on NHS maternity care, and this committee reported in 1993.[118] *Changing Childbirth* identified three key principles that should underlie effective woman-centred maternity services:

- the woman must be the focus of maternity care
- maternity services can be readily and easily accessible to all
- services must be effective and efficient.

Recommendations were made on action to implement these principles. An implementation committee was established and health authorities and NHS trusts were required to implement the recommendations.[119]

While Cumberlege recommendations are still referred to, subsequent developments have to a certain extent overtaken them. The National Service Framework for Children and Maternity has been prepared (see chapter 13) and can be accessed on the NSF website.[120] This NSF setting minimum standards for children and maternity care should have a major impact on the quality of care provided for pregnant women (see page 409). Under section 45 of the Health and Social Care Act 2008 the Secretary of State (re-enacting section 46 of the Health and Social Care (Community Health and Standards) Act 2003) may prepare and publish statements of standards in relation to the provision of NHS care, must keep the standards under review and may publish amended statements whenever he considers it appropriate (see chapter 5).

In addition, following the NHS Plan,[121] the strategic document *Delivering the Best* was published to identify midwives' contribution to the NHS Plan.[122] This document identified five challenges for midwives:

- excellence in midwifery practice
- dynamic leadership
- partnerships with women
- improving public health
- working with others.

Furthermore, it outlined how they could be achieved. The document should be a useful resource for midwives if they are not receiving the appropriate support from management to develop their skills, in providing the appropriate standards of care for women and generally implementing any national guidance for midwifery and maternity standards. Women may also make use of national guidelines in identifying shortfalls in the services provided and if they or their babies suffer harm may use these deficits as evidence of failures to follow a reasonable standard of care. *Delivering the Best* can also be used as a training device and as a useful tool for discussions between supervisor and midwife.

In 2003 the House of Commons Health Committee looked at two aspects of maternity care: its eighth report[123] looked at inequalities in maternity services and its ninth report[124] considered choice in maternity services. Both reports made fundamental and significant recommendations for the future provision of services. The eighth report recommended that the government investigate the RCM's concerns about the recruitment of midwives from minority ethnic communities and its final recommendation was:

> **We recognise the potential of midwives and of maternity services to play an expanded role in promoting public health. However, maternity care staff must have access to appropriate levels of training and support if they are to be effective in this role. We recommend that the Department should facilitate the implementation of the proposals in 'Making a Difference' by making a detailed assessment of the training and support needs of staff who provide maternity care.**

The ninth report on choice in maternity care suggested that the government should use the opportunity presented by the forthcoming NSF as an opportunity to recast maternity services to the advantage of both women and their carers, since the current delivery of maternity services over-medicalises birth. Barriers to home births were wholly unacceptable. Women should know that they have a right to have a home birth without seeking 'the GP's permission'. Its final recommendation was that the government should consider allocating some one-off resources to maternity units to make changes to their practice so that they could carry out the work recommended in the report, the money going to staff rather than buildings (in contrast to the 2001 allocation).

In 2005, Reform published an analysis of maternity services in the NHS.[125] It found that progress since the Cumberlege Report was modest, that centralisation of services had not produced the expected benefits and the service was under strain in terms of staffing. The report made significant recommendations for a modern framework for maternity services.

NSF for Children, Young People and Maternity Services[126]

Part 3 of the NSF is concerned with midwifery standards and Standard 11 is as follows:

> **Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.**

The expansion of that standard identifies: woman-centred care services; care pathways and managed care networks; improved pre-conception care; the identifying and addressing of mental health problems; choice of options in relation to place of birth; professional skilled in neonatal resuscitation at every birth; post-birth care based on a structured assessment provided by a multidisciplinary team, breastfeeding information and support for mothers.

The National Perinatal Epidemiology Unit (NPEU) carried out a survey on the experience of maternity care to provide a benchmark of current practice and a baseline for measuring change over the period that the NSF is implemented.[127] The Care Quality Commission (succeeding the Healthcare Commission) is responsible for monitoring the implementation of the NSF through its visits and inspections.

The DH has also revised guidance for parents in the form of the *Pregnancy Book 2007*, available on the DH website.

Midwifery management

The Healthcare Commission carried out an investigation into the maternity services and the Northwest London Hospitals NHS trust. As a result of its report special measures were instigated by the Secretary of State. A review team from the NMC made an extraordinary visit and its report is available on the NMC website.[128] This was followed by an action plan identifying objectives, action to be taken, whose responsibility, a completion date and the form of monitoring. In addition, an action plan was devised by the Supervisor of Midwives for the Brent and Harrow Health Authority which was to be reviewed monthly by the Supervisor and the LSA Officer. Both documents can be accessed on the NMC website.

The Audit Commission published a comprehensive survey, A First Class Delivery, in 1995 and this survey was followed in 2006 by a survey by the NPEU on the clinical care and experience of mothers and contrasts the results with those obtained in 1995. It shows that there was an increase in the number of women who were offered home birth. The Caesarean rate had risen from 17 per cent to 23 per cent. The report is available on the NPEU website.

A review of maternity services in England was launched by the Healthcare Commission in May 2007 looking at efficiency and capability, clinical focus and outcomes and the engagement of women. Its aim was to build up a comprehensive picture of maternity care. The report was published in 2008. Further information is available on its successor body, the CQC, website. There is evidence that the pressure on maternity units is not easing. In January 2010 it was reported that hospitals closed their maternity departments to admission on more than 350 occasions in 2009. The reasons included shortage of staff of midwives or of beds.[129] Research in Scotland found that babies born at the weekends or outside the hours of 9 a.m. to 5 p.m. were significantly more likely to die, mainly from lack of oxygen, than those born at other times.[130] There was no reason why these results would not be replicated across the UK, meaning 100 baby deaths a year. The cause was probably lack of immediate access to senior doctors at these times. Temporary closures of the maternity unit in Sidcup, Kent were announced because of shortage of midwives and middle and junior doctors, and two birthing centres in Hampshire were also due to close to enable midwives to be relocated to hospitals.

Calculations by the RCM suggest that the gap between the number of midwives the NHS in England needs and the number it now has will not be closed until 2026.[131] A survey by the RCM in September 2013 found that almost half of maternity units have been forced to turn away women in labour because they are full and struggling to cope with the highest birth rate for 40 years. The response from the Health Minister Dr Dan Poulter responsible for maternity care stated that 'We have already employed

over 1,000 more midwives in our NHS and there are a record number of 5,000 more in training. Last year I announced a £25m fund to pay for improvements to over 100 maternity wards and birthing units.'[132] An analysis of reports on maternity units showed staffing deficits which were possibly associated with maternal and neonatal mortality and questioned the extent to which we staff for average activity alone or if we truly plan for peak demand as well.[133] Australian research published in the *Lancet* showed that the allocation of personal midwives to mothers made for far smoother pregnancies. However, the RCM noted that in the last national survey of women's experiences of maternity care in England in 2010, 75 per cent of women had not met before any of the staff who cared for them during their labour and birth.[134] This is a situation which is likely to grow worse with current staffing difficulties.

The National Audit Office[135] reported in 2013 that one fifth of the NHS maternity budget is spent on negligence claims. Maternity care accounted for a third of the clinical negligence bill in 2012–3. It also found that the maternity services had failed to keep up with a rising birth rate and 2,300 more midwives were needed to meet staffing needs. The NAO made specific recommendations to the Department of Health, NHS England and the clinical commissioning groups on planning maternity services and ensuring that the payment framework is fair and incentivises cost-effective behaviour. Margaret Hodge, chair of the Public Accounts Committee of the House of Commons, said that it was shocking that baby deaths in England were higher than in other countries. The Safer Childbirth study (2007) had recommended that there should be a consultant obstetrician on labour wards 24 hours a day but not one of the 57 maternity units across the country met that standard. Data released in November 2013 showed that half of England's maternity services have cut spending despite a decade long baby boom. The government promised that every maternity unit in the country would have a trained mental health specialist within four years to help women cope with post-natal depression.[136] At present only about half of units have maternal mental health staff even though one in ten women suffer depression while pregnant or after giving birth.

In September 2010 new guidance on the education of maternity support workers (MSWs) was published by the Royal College of Midwives[137] together with an updated and revised position statement on MSWs. Both documents are available on the RCM website.[138] The role of the healthcare support worker is considered in chapter 24.

Maternity Matters

A report on maternity services was published in April 2007.[139] It aimed to secure a service by the end of 2009 where all women would have choice over the type of care that they receive, together with improved access to services and continuity of care. A Westminster Health Forum seminar discussed the extent to which *Maternity Matters* had been implemented in 2010 and concluded that the shortage of midwives was holding up progress.[140]

Project 2020

A project has been initiated to look ahead to how midwifery will work in the year 2020, what changes are needed and how they are to be made.[141] The project has been commissioned by the Chief Nurses of the Health Departments of England, Northern Ireland, Scotland and Wales, and is led by Noreen Kent, Programme Director. On the UK Programme Board are representatives of midwives, educators, service users, researchers, maternity care professionals, strategists and members of the public. A report published in September 2010 set out the key messages for implementing changes to take place over the next 10 years. The project focuses on five main areas:

- The core and developing role of the midwife
- Education and career progression
- Measuring quality public health

- Role of the midwife
- Workforce and workload.

The report sets out the expectations it has of midwives, mothers, fathers, consumers and the maternity care team; of commissioners of maternity services, service providers; educationalists; researchers; and government and the regulators.

A further dimension for investigation raised by the Kings Fund is the role of the GP in maternity services. A report by the Kings Fund[142] reviewed the changing role of GPs in relation to maternity services and suggested that GPs should take a more active role in delivering high quality maternity care by sharing responsibilities with midwives and obstetricians. The report can be accessed on its website.[143]

Human Rights and birth

Birthrights, a charity established to promote human rights in maternity care teamed up with the parenting website Mumsnet to conduct a national Dignity Survey of women's experiences in childbirth, focusing on respectful care and choice in maternity services. The survey was followed by research exploring midwives perceptions of dignity in maternity care. The results were presented to a Dignity in Childbirth Forum held on 16 October 2013[144] and can be seen on the Birthrights website.[145] Birthrights will now work with midwives to consider how to advance the principles of choice and respectful care for women in maternity services.

Morecambe Bay NHS Trust

A 9-day-old baby died from a treatable infection at Furness Hospital, part of the Morecambe Bay NHS Trust. An internal review by the CQC which highlighted weaknesses in its 2010 inspection of the Trust was suppressed by the CQC. Subsequently, CQC commissioned a report from Grant Thornton to investigate the regulatory oversight by the CQC of University Hospitals Morecambe Bay. It reported in June 2013 (available on the CQC website) and identified aspects of poor governance by the CQC and questionable decision making. Subsequently, in 2013 the CQC published a report admitting its failures.[146] In December 2013 the NHS Ombudsman, Dame Julie Mellor, called for urgent changes in regulation to prevent such failures as occurred at Morecambe Bay. Local supervisors of midwifery had failed to identify a series of failures including proper monitoring of women. Dame Julie stated that the failures could happen because midwife supervisors were responsible for both regulation and professional development. This meant that midwives were often investigated by colleagues who might be reluctant to criticise. The NMC responded by stating that the government's commitment to modernise the legal framework provides an opportunity to make any changes needed to maternity care for women and babies.[147] Cathy Rogers discussed whether the abolition of statutory supervision for midwives is the answer to the problems besetting midwifery. She concluded that it is not the answer but considers that it must be shown how statutory supervision fits within the accepted systems of clinical governance.[148]

Reference should also be made to the Frances Inquiry on Stafford Hospital which is considered in chapter 5.

Independent midwifery

The practice of independent midwifery will be severely affected by the new rules coming in on indemnity insurance which is discussed in chapter 4. One to One (North West) Limited was the first non-NHS maternity organisation to gain independent insurance for intrapartum care. Its operation is considered by Maureen Collins and Carol Kingdom.[149]

The future

Three significant reports were published in 2013:

1 National Audit Office, *Maternity Services in England 2013.*
2 Parliamentary and Health Service Ombudsman's report, *Midwifery Supervision and Regulation: recommendations for change 2013.*
3 Care Quality Commission, *Maternity Services Survey 2013.*

All show wide variation in health outcomes for women and babies and raise considerable concern about the state of our maternity services.

Conclusions

Midwifery continues to be under pressure. The Royal College of Midwives estimated in 2007 that 5,000 more midwives were needed to meet the government's target for maternity services and also to meet the rising birth rate. The Cumberlege recommendations have still not been fully implemented across the country, and the shortage of midwifery staff is making it impossible for every woman to have her choice of birth place. The Caesarean rate continues to rise. The strategic document *Delivering the Best* set clear aims for midwives, but this requires considerable support and resources from NHS trust boards and clinical commissioning groups for them to be realised. Furthermore, the strategic document *Building on the Best*[150] envisaged that there would be direct access from woman to midwife, bypassing the GP, if the woman wishes to liaise directly with the midwife. Significant aspirations were contained in the report *Maternity Matters* and further major changes to midwifery care and services are likely to emerge from Project 2020, which is intended to act as a vehicle to re-energise the midwifery profession. Hopefully, in spite of a time of public expenditure cuts, resources will be allocated to support this 10-year strategic plan. If not, the NHS midwifery service is likely to be yet again the victim of good intentions. At the time of writing it is too soon to evaluate the extent to which the guidance on the Commissioning of Maternity Services prepared by NHS England has led to improvements in the standards of service.[151]

Reflection questions

1 What is the legal status of a birth plan? In what circumstances can a mother refuse to give consent to life-saving treatment?
2 Analyse the principles set down by the Court of Appeal in the *Re MB* case (see Box 14.4) and consider the extent to which they have been incorporated into your practice. What are the implications of the Mental Capacity Act 2005 on treatment decisions in relation to those lacking the requisite mental capacity?
3 What are the implications of the Congenital Disabilities (Civil Liability) Act 1976 for the midwife?
4 What statutory duties does a midwife have in relation to the registration of a birth or stillbirth?

Further exercises

1 Consider the key messages of Project 2020 and analyse the extent to which the recommendations are implemented in your own unit. What are the legal implications of any deficiencies?
2 What specific powers and rights does the midwife have in relation to drugs that are not possessed by the registered general nurse? (See chapter 28.)

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Chapter 15

The nurse on the gynaecology ward

This chapter discusses

- Abortion
- Sterilisation
- Female circumcision

Introduction

This chapter considers the areas of particular concern to the nurse who works on the gynaecology ward. For convenience, the chapter also includes the law relating to vasectomies within the topic of sterilisation. For issues relating to fertilisation and IVF, see chapter 22. Reference should also be made to chapter 13 for the law relating to consent by the young person to abortion, sterilisation and family planning and to chapter 17 on the law relating to those with learning disabilities.

Abortion

General principles

Although the unborn child is not a legal personality and cannot sue or be sued until it is born (see chapter 14), its existence is protected in law by the Offences Against the Persons Act 1861, section 58 of which makes it an offence to administer drugs or use instruments to procure a miscarriage, and section 59 which prohibits other activities to procure a miscarriage. In addition, under the Infant Life Preservation Act 1929, it is an offence to destroy the life of a child capable of being born alive. The Infant Life Preservation Act 1929 provides that any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act, causes a child to die before it has an existence independent of its

mother, shall be guilty of felony, to whit, of child destruction. Twenty-eight weeks' gestation was *prima facie* evidence that the child was capable of being born alive. However, these acts are subject to the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act 1990. An abortion that satisfies the legal requirements laid down in this Act is not an offence. Under section 5(1) of the Abortion Act, no offence under the Infant Life Preservation Act 1929 takes place if the abortion is carried out by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of the Act. If these legal requirements are not satisfied, then abortion is an offence that carries a maximum sentence of life imprisonment. The provisions of the Act as amended are set out in Statute Box 15.1.

Statute 15.1 Provisions of the Abortion Act 1967 Section 1(1) (as amended by the Human Fertilisation and Embryology Act 1990)

A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith:

(a) that the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or

(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

5(2) . . . in the case of a woman carrying more than one foetus, anything done with intent to (a) procure her miscarriage of any foetus is authorised by that section if –

(a) the ground for termination of the pregnancy specified in subsection (1)(d) of that section (*see above*) applies in relation to any foetus and the thing is done for the purpose of procuring the miscarriage of that foetus, or

(b) any of the other grounds for termination of the pregnancy specified in that section applies.

Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in deciding whether there is a risk of injury to health under paragraph (a) (s. 1(2)). In December 2003[1] a curate was given approval to have a judicial review of a case where a woman had a late abortion because her fetus had a cleft palate. The curate, who herself had had three operations to correct a congenital jaw defect, argued that a cleft palate did not come within the provisions of section 1(1)(d) of the Abortion Act. Subsequently, the police carried out an investigation and in March 2005 the Crown Prosecution Service stated that they had decided not to prosecute because they were satisfied that the doctors involved had acted in good faith.

The abortion must be carried out in an NHS hospital or a place specifically approved by the Secretary of State or Minister of Health for the purposes of the Act. Emergency provisions are set out in Statute Box 15.2.

New abortion guidance and procedures were published in May 2014 by the Department of Health. It emphasises the following points:

- abortion on the grounds of gender alone is not lawful;
- the expectation that two doctors when certifying that an abortion meets the criteria set out in the Act, must consider the individual circumstances of the woman and be prepared to justify their decision;
- it is good practice for at least one of the doctors to have seen the pregnant woman before reaching a decision about the termination;

- pre-signing of statutory abortion certificates prior to consideration of a woman's circumstances is not compliant with the Act;
- doctors have a legal duty to report all abortions to the Chief Medical Officer.

A Private Member's Bill to amend the Abortion Act to permit certification by only one doctor was due to be heard in the 2014–15 parliamentary session after first reading had taken place on 12 June 2014. However, at time of writing no further dates had been scheduled, so it was uncertain whether the Bill would get any further.

Statute 15.2 Emergency provisions

The provisions set out in Statute Box 15.1, including the requirement to have two registered medical practitioners, do not apply in an emergency when a registered medical practitioner is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Conscientious objection to participation in an abortion

The Abortion Act is one of the few examples where a professional can lawfully refuse to take part in an activity on the grounds of a conscientious objection. Thus section 4 states that:

> **[N]o person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection: Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.**

This right is, however, subject to section 4(2):

> **Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.**

The extent of the protection from being involved in an abortion was considered by the courts in Case 15.1.

Case 15.1 *R v. Salford Health Authority ex parte Janaway* (1988)

The letter[2]

Mrs Janaway, a medical secretary, refused to type a letter referring a patient from a general practitioner to a consultant with a view to a possible termination of pregnancy. She was a Roman Catholic who believed strongly that abortion was morally wrong. The genuineness of her belief was never in dispute. She was asked to type the letter and refused on the basis that she was protected by section 4 of the Abortion Act. She was dismissed by the health authority and subsequently applied for judicial review of the health authority's decision. This was refused and she therefore appealed.

The Court of Appeal held that she was not entitled to claim the protection of section 4 of the Act. It could not be said that by typing the letter she was participating in any treatment authorised by the Act, neither could typing such a letter be regarded as a criminal offence prior to the Abortion Act so

that it could be regarded as now being protected by the provisions of the Act. The House of Lords dismissed Mrs Janaway's appeal.

Case 15.2 *Doogan and Anor Re Judicial Review* [2012] (Glasgow case)

Midwife managers and termination of pregnancy

Two midwives in Glasgow launched an appeal against a court decision that they had to supervise abortions regardless of their conscientious objection. The judge in the Scottish Court of Session[3] told the midwives Mary Doogan and Connie Wood, both labour ward sisters, that the conscience clause in the Abortion Act would exempt them from hands-on involvement in abortions but as senior midwives they had to accept management instructions to oversee abortions performed by other midwives on the labour ward. Their costs were being underwritten by the Society for the Protection of Unborn Children[4]. They won their appeal.

However, the Supreme Court held that the conscientious objection clause only applied to actual hands on looking after and treatment, but the midwives could take their case to the employment tribunal to determine their claim to exercise their religious beliefs without discrimination (*Doogan and Another* v. *Greater Glasgow and CLyde Health Board* [2014] UKSC 68).[5]

Nurses' participation in prostaglandin abortions

Case 15.3 *RCN* v. *The Department of Health and Social Security* (1981)

Prostaglandin drip[6]

The Royal College of Nursing brought a case on behalf of its members against the DHSS because members had complained that they were often left on wards to supervise (sometimes for several days) a patient who was having a prostaglandin-induced abortion. The doctor would set up the drip and then the nurse would undertake the care of the patient. The RCN queried the legality of this in the light of the wording of the Act that the pregnancy should be terminated by a registered medical practitioner. The RCN questioned, in particular, advice given in a DHSS letter and circular relating to the procedures that might be performed by an appropriately skilled nurse or midwife.

In Case 15.3, the House of Lords decided on a majority of three to two that the DHSS advice did not involve the performance of unlawful acts by members of the RCN. Lord Diplock's views are set out in Box 15.1.

Box 15.1 Lord Diplock's view in the case of *RCN* v. *DHSS* [1981] 1 All ER 545

In the context of the Act what was required was that a registered medical practitioner – a doctor – should accept responsibility for all stages of the treatment for the termination of the pregnancy. The particular method to be used should be decided by the doctor in charge of that treatment; he should carry out any physical acts, forming part of the treatment, that in accordance with accepted medical practice were done

only by qualified medical practitioners, and should give specific instructions as to the carrying out of such parts of the treatment as in accordance with accepted medical practice were carried out by nurses or other hospital staff without medical qualifications. To each of them the doctor or his substitute should be available to be consulted or called in for assistance from beginning to end of the treatment. In other words, the doctor need not do everything with his own hands; the subsection's requirements were satisfied when the treatment was one prescribed by a registered medical practitioner carried out in accordance with his directions and of which he remained in charge throughout.

This decision has considerable significance for the scope of professional practice. It could be argued that even where a statute expressly places responsibilities on a registered medical practitioner, the law is still followed when that activity is delegated to another healthcare professional acting under the aegis of the registered medical practitioner. This is the view taken by those who argue that the legislation allows nurses to perform surgical abortions.[7] The possibility of extending the nurse's role in abortions is considered below under future reforms to the abortion law. The scope of professional practice is considered in chapter 24.

When is an abortion illegal?

The simple answer is: under any circumstances other than those permitted under the 1967 Act as amended by the 1990 Act. It is specifically provided that no offence is committed under the Infant Life Preservation Act 1929 if the provisions of the 1967 Act are followed (section 5 as amended by the 1990 Act). The amendments to the 1967 Abortion Act limit termination to 24 weeks or less, but only for section 1(1)(a). Subsections (b), (c) and (d) give no time limit (see Statute Box 15.1). It was reported in May 2007[8] that a woman who had a backstreet abortion when she was 7½ months' pregnant was convicted on a charge of child destruction under the Infant Life Preservation Act 1929 as re-enacted in the Crimes Act 1958. A body was never found.

A man was jailed for 2 years after secretly giving his pregnant partner miscarriage-inducing drugs. He pleaded guilty to administering poison or other noxious things to procure a miscarriage under section 58 of the Offences Against the Person Act 1861.[9]

The Abortion Act does not permit abortion on grounds of the sex of the fetus, yet statistics seemed to show that there was an imbalance in the expected sex ratio of female to male fetuses compared with the actual ratio was particularly notable for mothers born in Pakistan, Bangladesh and Afghanistan.[10] In the light of these findings Sarah Wollaston, an MP and a GP for Totnes, has suggested that the decision to tell parents the sex of their baby at 12 weeks or 20-week scans should be reviewed.

Being born alive

Practical Dilemma 15.1 Birth or abortion?

Mavis Spencer was 15 and her pregnancy was discovered only at a late stage. From the information provided by her and from his own medical examination, the doctor judged her to be about 22 weeks pregnant. He agreed that a termination should proceed and he arranged for her to see a second doctor, who agreed with him. Mavis was immediately admitted for a termination. However, because of unforeseeable delays on the ward, this was not commenced for another week. When the fetus was expelled it appeared to cry out and the nurse felt that it was breathing. She did not know what to do. The doctor told her to put the remains in the bucket for incineration. She was reluctant to do this, however, since she felt it to be a child capable of surviving. Where does the law stand?

If it is clear that there is a live birth, then all reasonable steps should be taken to preserve its life, otherwise there could be a prosecution for murder or manslaughter. A prosecution was brought against Dr Hamilton when an abortion produced a live fetus.[11] However, the case did not proceed beyond the committal proceedings. In the above situation, Practical Dilemma 15.1, if it is apparent that the aborted fetus is breathing and viable, then he or she should be transferred to a special care baby unit. Failure to do so could be grounds for a charge of attempted murder. In addition, of course, even if the child were to die shortly afterwards, it would still have to be registered as a live birth (see registration provisions in chapter 14 on midwifery).

Rights of the fetus

Whether or not the fetus had a right to life under Article 2 of the European Convention on Human Rights was considered in a French case heard before the European Court of Human Rights.[12] A doctor thought a woman (who was pregnant) was attending clinic for the removal of a contraceptive coil, and ruptured the amniotic sac, as a result of which the pregnancy had to be terminated. The claimant alleged that the failure of France to have a criminal remedy for killing a fetus was a breach of the fetus's Article 2 rights. The ECHR held that the fetus was not a person and therefore not directly protected by Article 2, but it was left open as to whether the fetus could claim a version of right to life under the Article and the EU countries could decide the question themselves. Three Irish women alleged that the laws against termination of pregnancy breached their rights by putting their health at risk in forcing them to go abroad for terminations. The ECHR held that the three women's complaints concerning the abortion laws in Ireland under Articles 8, 13 and 14 were admissible. In the case of C (who had become pregnant while suffering from a rare form of cancer and feared for her own life and that of the child if she continued with the pregnancy and was therefore compelled to go abroad for a termination), it held that there had been a violation of Article 8.[13] In a more recent Irish case an Indian dentist died when she was refused an abortion as she miscarried. At the inquest the jury held that she died as a result of medical misadventure. The coroner recommended that Ireland's Medical Council should say exactly when a doctor can intervene to save the life of a pregnant woman.[14]

The fetus is not a person in the eyes of the law and is not simply part of the mother[15] and cannot be made a ward of court[16] (see chapter 14).

Negligence in failing to detect abnormality

In a case in 1991,[17] the plaintiff had an ultrasound scan when she was about 26 weeks pregnant. The radiographer queried a possible abnormality of the spine, but the consultant decided that there was no firm evidence of abnormality justifying further action. The baby was born and found to be suffering from spina bifida. The mother claimed that the defendants were negligent in not ascertaining the possibility of abnormality and thus enabling her to have an abortion. Her claim failed since (under the Abortion Act 1967, i.e. prior to the 1990 amendments) it would have been illegal to have carried out an abortion at that stage, since the baby would have been capable of being born alive within the meaning of the 1929 Act.

If similar facts were to occur now, compensation would be payable if the mother were able to establish negligence, since there is no longer any time limit for securing a termination if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Challenge by the putative father

Case 15.4 *C v. S* (1987)

Father's intervention[18]

An Oxford student whose girlfriend became pregnant sought to stop the abortion on the grounds that the fetus, of between 18 and 24 weeks, was viable and that the abortion would thus be an offence under the Infant Life Preservation Act 1929. In this case, the pregnant woman was given medication to terminate the pregnancy shortly after the time that conception must have occurred. It was assumed that the medication had been effective. She subsequently took anti-depressant drugs and underwent two chest X-rays, one of which was taken without any shielding to protect a fetus. Any of these treatments could have harmed the fetus. When she discovered that she was still pregnant, she obtained the two necessary signatures for abortion. The father brought the court action.

The Court of Appeal decided that the fetus was not capable of being born alive and therefore the termination of the pregnancy would not constitute an offence under the 1929 Act. The medical evidence showed that the cardiac muscle would be contracting and that there would be signs of primitive movement. It was said that these were real discernible signs of life. But the fetus would never be capable of breathing, either naturally or with the aid of a ventilator. Since the amendment to the Abortion Act 1967, the viability of the fetus is no longer in issue. In a Scottish case in 1997,[19] a father was refused an injunction to restrain his wife from having an abortion.

Husband's attempt to stop an abortion

Case 15.5 *Paton v. Trustees of British Pregnancy Advisory Service* (1978)

Husband's rights

In Case 15.4, the putative father was not married to the mother, but it might be asked whether, if he were married, it would give him any rights to prevent the abortion going ahead. This point came before the courts when Mr Paton asked the court to prevent his wife going ahead with a termination. Two doctors had signed that the termination should proceed. Mr Paton claimed that, as the father of the child, he had a right to apply to the court for the termination to be stopped.[20]

The court, however, disagreed. It held that, provided the requirements of the Act were met, then the husband did not have any right in law to prevent the abortion proceeding. He had no *locus standi* before the court. Mr Paton took his case to the European Commission on Human Rights,[21] arguing that the life of the fetus is protected under Article 2 of the European Convention on Human Rights (right to life) and also the father's rights were protected under Article 8 (the right of respect for family life). He failed in both his arguments.

Right to an abortion

An abortion refused

Practical Dilemma 15.2 An enforced child

After having two children, Beryl Edwards considered her family to be complete. They moved to a larger house with a huge mortgage and Beryl took a part-time job to help pay for the additional loan and the extras: meals out and holidays. She was horrified when she discovered that she might be pregnant. Beryl became severely depressed and visited her GP. He was very reassuring, stating that she could have an abortion and within a few days she was referred to a consultant obstetrician. He listened to her case and then informed her that he did not consider that she satisfied the requirements of the Abortion Act and that he would therefore be unable to write a medical recommendation. Beryl's depression became worse and she was unable to work. Eventually, her husband suggested that she should seek another opinion. She was reluctant to do so, not believing that it would be of any value. Eventually, however, under pressure from her husband she paid privately to see another specialist, who informed her that in his opinion she did meet the Act's requirements. However, since she was now 23 weeks pregnant, he would be unwilling to propose an abortion since the pregnancy was too far advanced for an abortion to be performed safely and at this late stage he believed that it could constitute an offence under the Act. Beryl eventually had the child, but is seeking compensation against the first specialist. Is she likely to succeed?

Beryl does not have an absolute right to an abortion. To obtain compensation, she would have to prove that, in making his assessment of her present or foreseeable physical or mental health, the specialist was negligent in failing to take into account factors that approved medical practice would have expected him to have taken into account, and that his assessment had been made negligently. She may get some support from her GP but, of course, it was open to him to refer her to another doctor at an earlier stage. Indeed, the GP's failure to refer her to a second consultant might in itself give rise to a claim of negligence against the GP. However, if the first consultant's report had been adamant that there was no greater risk in proceeding with the pregnancy, then the GP could argue that there was no negligence on his part in accepting that view as the likely prevailing one and therefore a further referral was not justified.

Women may be dependent on the personal views of the doctors when they seek a termination of pregnancy. However, to establish negligence by a GP, there must be clear evidence that the GP failed to follow a reasonable standard of care in advising about arrangements for termination. In one case,[22] a woman visited her GP to seek a termination of pregnancy. She did not know that the GP was opposed to abortion on ethical and religious grounds. The woman alleged that the GP, by stating that it was too late and that it would not be recommended, effectively prevented her from having an abortion and was therefore in breach of the duty of care owed to her. The GP referred her to an abortion counsellor, who told her of a private clinic at which an abortion could be obtained. She continued with the pregnancy and following an *ante-partum* haemorrhage gave birth to a brain-damaged child. Her claim against the GP was dismissed on the grounds that in the light of the contemporaneous records and what she and her boyfriend had said in other contexts, the evidence showed that she had changed her mind and gone on to arrange antenatal care.

A woman who changed her mind about having an abortion was paid £27,500 in an out-of-court settlement by an NHS trust which ignored her attempts to withdraw her consent.[23]

There is concern that the availability of abortions varies according to where you live and therefore women who would satisfy the legal requirements of the Abortion Act 1967 may not receive a termination. A survey conducted by the Abortion Law Reform Association[24] in December 1999 showed that obtaining an abortion on the NHS depended on criteria such as whether you have had one before, your

age, finances and whether you have been using contraception. The Royal College of Obstetricians and Gynaecologists[25] has recommended a maximum waiting time of 21 days from first doctor consultation to the surgical procedure and that 14 days should be the aim. This is clearly an area where NICE could make recommendations for uniformity of NHS provision across the country. (See chapter 5 on the work of NICE.) The House of Commons Scientific and Technology Committee recommended in October 2007 that the inequality across the country should be eradicated.

The RCN has provided guidance on abortion care for nurses, midwives and public health nurses.[26] The guidance aims to provide clear and accurate information for nurses; to improve knowledge about abortion and abortion care; to empower nurses to develop their roles in abortion care; and to protect the public by identifying relevant legislation and standards of care.

In 2011 the total number of abortions for women resident in England and Wales was 189,931, 0.2 per cent more than in 2010 and 7.7 per cent more than in 2001. The rate for women between 15 and 44 was 17.5 per 1,000, while the under-16 abortion rate was 3.4 per 1,000 women. The NHS funded 96 per cent of the abortions, of which over half took place in the independent sector under NHS contract. 91 per cent of abortions were carried out at under 13 weeks gestation, 78 per cent were under 10 weeks. Medical abortions accounted for 47 per cent of the total: 2,307 abortions were carried out under Ground E (risk that the child would be born handicapped).[27] Figures produced in May 2014 showed that more over-35s than teenagers need unwanted pregnancy help. Marie Stopes International reported in April 2014 that one in four women who has an abortion goes on to have another. It urged greater investment in sex and relationship education in schools and more investment in contraceptive training for health professionals. NICE has recommended that women should get the morning-after pill in advance and issued contraceptive guidance for young people under 25 in 2014 (see chapter 13).

A study carried out by the Universities of Southampton and Kent found that half of those women who had an abortion after 12 weeks did not know that they were pregnant for at least two months and a further quarter only discovered their pregnancies at three months or later; two in five said that their periods had continued.[28]

Independent sector organisations that wish to provide abortion services must obtain registration from the Care Quality Commission and comply with the national minimum standards and regulations for independent healthcare and the procedures for the approval of independent sector places for the termination of pregnancy. In 2005 the Chief Medical Officer investigated a complaint that the British Pregnancy Advisory Service (BPAS) broke the law relating to late abortions by advising a Spanish clinic. His report[29] concluded that BPAS had not broken the law, but the investigation raised a number of issues around access to abortions, training of staff and information for women. Recommendations for primary care trusts (now clinical commissioning groups) are contained in a letter he wrote to PCTs and Strategic Health Authorities.[30] Considerable controversy arose when Channel 4 announced that it was running advertisements for Marie Stopes International, a charity that carries out about 65,000 abortions a year.[31] In December 2009, three women living in Ireland challenged the strict laws against abortion in Ireland before the European Court of Human Rights. They claimed that the laws violated their human rights.

Other related offences

The Offences Against the Person Act 1861 section 58 makes it an offence to administer drugs or use instruments to procure an abortion. When a woman is charged, it must be shown that she is pregnant. This is not necessary when another person is charged with an offence. Section 59 of the 1861 Act makes it an offence to supply or procure any poison or any instrument or any other thing knowing that it is to be used with intent to cause a miscarriage whether or not the woman is with child. The Court of Appeal held in 2010 that where a husband duped his wife into going to have an abortion, he was not guilty of an offence under section 59 of the Offences against the Person Act 1861.[32] The facts were that Ahmed's wife, who was three months pregnant, only spoke Urdu and was told by her husband that she was attending the clinic to have a minor operation to remove blisters from her ovaries, which were endangering her baby. The medical staff, who had been told by the husband that it was his wife's wish

to have an abortion, were concerned that she was having a termination at a late stage and arranged for an interpreter before carrying out the termination. Only then did the wife realise that an abortion had been arranged. The Court of Appeal held the *actus reus* (see chapter 2) of section 59 had not been met (i.e. supplying or procuring of an instrument) and he could not be guilty of an offence under that Act, nor was there any other offence known to law with which he could have been properly convicted.

If the requirements of the Abortion Act are complied with, the provisions of the 1861 Act would not apply. Section 60 of the 1861 Act makes it an offence to conceal the birth of a child. Mr Reginald Dixon[33] was prosecuted under section 58 of the Offences Against the Person Act 1861 when he continued carrying out a hysterectomy after discovering during the operation that the patient was pregnant. The patient subsequently said that had she known she would have wanted to keep the baby. He defended the charge on the grounds that he had acted in good faith to preserve the woman from grave permanent injury to her mental health within section 1(1)(b) of the Act. He was acquitted by the jury.

Dr Bourne, a gynaecologist, was prosecuted under section 58 of the 1861 Act after he had terminated the pregnancy of a 14-year-old girl who had been raped. He was found not guilty on the ground that his action was taken to preserve the life of the mother.[34] This situation is now covered by the emergency provisions of the Abortion Act 1967 (as amended).

The courts have considered whether the post-coital contraception pill came under the abortion laws. In *R* v. *Dhingra*,[35] charges against a doctor under section 18 of the Offences Against the Person Act 1861 for inserting an intrauterine device (IUD) were dismissed on the grounds that preventing implantation could not be interpreted as a miscarriage, and in *R (Smeaton)* v. *Secretary of State for Health*[36] the claim by the Society for the Protection of Unborn Children that the sale of the morning-after pill without prescription was an offence under the 1861 Act was rejected.

Termination of one of multiple pregnancy

The Human Fertilisation and Embryology Act 1990 section 37 added a further amendment to the Abortion Act 1967 to cover the situation where one or more fetus(es) in a multiple pregnancy is terminated. The termination may be justified either to protect the health or life of the mother or where there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped (i.e. s. 1(1)(d)). (See statute Box 15.1.)

Confidentiality and illegal abortions

Practical Dilemma 15.3 To tell or keep quiet

Pam Reynolds is admitted in an emergency to the A&E department with severe bleeding. She is transferred to the gynaecology ward where it is clear to nursing and medical staff that she had probably tried to obtain an illegal abortion, although Pam herself is silent as to what happened. It is the third time this month that there has been such an admission and the gynaecologist suspects that one person may be responsible. Does he or the nursing staff have any duty in law to inform the police?

The simple answer is that there is no statute that places a duty on anyone to report a crime of causing a miscarriage or an offence under the Infant Life Preservation Act. If, of course, the police had heard of the illegal abortion and had begun to investigate, then they would be able to subpoena witnesses or obtain information for their enquiries under the procedures laid down under the Police and Criminal Evidence Act 1984. What about notifying them before they are aware of the possible crime? Some would argue that the doctor has a public duty to inform the police in such circumstances; that it is in the public interest for him to disclose the information, but until the law is changed, this is not obligatory

by law, but a nurse may have a professional duty to act in the public interest under NMC guidance. (For those offences that must be reported to the police, see chapter 8.)

Notification

The Abortion Regulations 1968, as amended by subsequent regulations, place a duty on the practitioner to notify the Chief Medical Officer (CMO) on the appropriate forms, but restricts disclosure to anyone other than:

an authorised officer of the DH
the Registrar General
the Director of Public Prosecutions
the police
for the purposes of criminal proceedings
bona fide scientific research
to any practitioner with the consent of the woman
at the request of the president of the General Medical Council for the purpose of investigating whether there has been serious professional misconduct.

Regulation 3[37] requires a certificate of opinion to be given in writing by the registered medical practitioners. Regulations which came into force in 2002[38] amend the notification provisions, enabling it to take place by electronic means and enabling a person authorised by the CMO who is engaged in setting up, maintaining and supporting the computer system to be notified of the abortion. A new Schedule sets out the information to be supplied. Amendments to the Regulations in 2008[39] take account of the appointment of an independent Statistics Board and notification to the National Statistician.

Consent by a pregnant person under 16 years

If a girl of 14 seeks an abortion, do her parents have to consent on her behalf? The answer depends on the competence of the girl and what is in her best interests. Assuming that the girl is not in the care of the local authority and is seeking an abortion, then provided that she has the capacity to make the decision, she could give a valid consent under the Gillick principles discussed in chapter 13 on children's nursing. In the Axon case the High Court upheld the right of a young person under 16 to keep information relating to a prospective abortion from the knowledge of the parents.[40] The High Court upheld the guidance given by Lord Fraser in the House of Lords in the Gillick case and maintained that it did not breach Article 8 of the ECHR (see chapter 13). What, however, if the girl's own parents wanted her to have the child and promised that they would care for it; could they refuse to allow the termination to proceed?

Case 15.6 *In re P (A Minor)* (1981)

Whose choice?[41]

The mother was 15. She already had a son of 12 months and had been in care since she was 13 following a conviction for theft. She lived in a mother and child unit with schooling facilities and was then 12 weeks pregnant. Her own parents objected to the abortion (as they had done during the first pregnancy). Her father offered to take care of his grandson and leave the daughter with the new baby. As a Seventh Day Adventist, he opposed the termination of life on religious grounds. He also thought that the girl would live to regret the decision she had taken. He was convinced that she was still a child and that she should not be allowed to take a decision that she could subsequently regret.

The child was placed under the wardship jurisdiction of the court and Mrs Justice Butler-Sloss ordered that the termination of the pregnancy should proceed. The judge was clearly influenced by the wishes of the girl, who had set her mind on the termination and had not, in fact, contemplated that it might not proceed. She discussed the matter with the girl and formed the opinion that she was of a strong personality and mature views. The judge also held that, on the facts, the risks to the health of the mother and the interests of the existing child satisfied the requirements of the 1967 Act. The grandparents' objections were thus overruled and they were accorded no rights in the matter. In this case, of course, the child was already in the care of the local authority. Where this is not so, it may be the practice for the parents of the pregnant girl to sign the consent form for a termination. Probably, too, if there is a clash between the rights of the mother and the grandparents, the latter may put pressure on the girl to agree to an abortion since she may well be dependent on their help in bringing up the child. Should a health professional become aware of such a conflict between an under-aged child and her parents, she could take action to ensure that the matter was determined by the court under the Children Act 1989.

Abortion and those lacking mental capacity

Under 18 years old

The parents have the right to make decisions on behalf of the minor provided that they are acting in the best interests of the child. The welfare of the child is the paramount consideration. The principles discussed in relation to the sterilisation of the minor by the House of Lords in *In re B* (see Case 15.8, page 430) would thus apply. It is considered necessary to obtain the approval of the court. Where a young person is over 16 years and lacks the mental capacity to make his or her own decisions, this situation would now come under the Mental Capacity Act 2005.

Adult person lacking mental capacity

Case 15.7 *T* v. *T* (1988)

The mother with learning disabilities[42]

The defendant was a woman aged 19 who was epileptic with severe learning disabilities. She was totally dependent on others and was cared for by her mother. She became pregnant and termination of pregnancy was recommended by the medical advisers on the grounds that there would be complications associated with that condition and that she would be incapable of providing and caring for a child. The doctors also recommended that she should be protected from any further pregnancies by being sterilised. The doctors were, however, unwilling to carry out the abortion or sterilisation operation without authorisation. The mother thus applied to the court for a declaration that the procedures could be carried out lawfully.

The court held that the situation was not covered by the Mental Health Act 1983 consent to treatment provisions (see chapter 20), neither did a guardian under the Act have the power to give consent. The court was prepared to grant the declaration requested and declared the proposed treatment lawful and therefore a defence to any action for trespass to the person. The doctors would be carrying out the treatment in the interests of the patient as part of their duty of care to the patient. The court also held that it no longer had a power to act as *parens patriae* (a kind of wardship jurisdiction) and the court could therefore not give consent itself. (It held that this power had been repealed in 1959 and should be reinstated. A subsequent case,[43] however, has held that the courts did have the power to make decisions

on the day-to-day care of mentally incapacitated adults. This case is considered in chapter 19.) The circumstances set out in Case 15.7 would now be covered by the Mental Capacity Act 2005.

Mental Capacity Act 2005

The Mental Capacity Act 2005 which came into force in October 2007 provides that where a person over 16 years lacks the capacity required to make a specific decision, then action must be taken in her best interests according to the statutory provisions. The new Court of Protection has jurisdiction over matters of personal welfare as well as property and finance. Were the situation in Case 15.7 to occur now, once it had been established that the pregnant woman lacked mental capacity, or where her capacity was disputed, an application would be made to the Court of Protection for a declaration as to what was in her best interests. If her mental capacity were in dispute, then the Court of Protection could determine whether she was able to make her own decisions. (The Act is discussed in chapter 7.)

In the case of *Re P*[44] the solicitor who was one of P's deputies queried whether P had capacity in relation to whether to continue with her pregnancy or have an abortion. Hedley J held that she manifestly lacked litigation capacity but did have capacity in relation to continuing the pregnancy. Generally courts and health officials should not try to decide whether P would be able to bring up a child but should instead concentrate on whether the pregnancy itself is in her best interests (the reasoning being that once the child is born, if the mother does not have the ability to care for a child, society had perfectly adequate processes to deal with that). The judge also stated that the purpose of the mental capacity legislation is not to dress an incapacitated person in cotton wool but to allow them to make the same mistakes that all other human beings are able to make and not infrequently do.

In another case[45] the judge held that a woman compulsorily detained under the Mental Health Act had the capacity to decide to have a termination. 'It would be a total affront to the autonomy of this patient to conclude that she lacks capacity to the level required to make this decision.'

Future reforms to the abortion law

There are pressures at present to revise the abortion laws: there are those who maintain that the 24-week time limit should be reduced, and claim that their case is supported by fetal scans; there are those who wish to facilitate earlier abortions and give more responsibility to nurses. The British Pregnancy and Advisory Service recommended in 2006 that there should be legal reforms to allow nurses to prescribe the abortion pill to women within the first nine weeks as a responsible back-up to contraception.[46] The BMA at its meeting in June 2007 was not prepared to support nurses and midwives being allowed to conduct early abortions but it did vote that only one doctor's signature should be required in the first nine weeks. In October 2007 the Science and Technology Committee of the House of Commons published a comprehensive report on the scientific developments relating to the Abortion Act 1967.[47] Among its recommendations it held that:

- there was no evidence on the basis of fetal viability rates below 24 weeks which would justify the reduction of the abortion limit below 24 weeks;
- it considered that there were grounds for the enhancement of the nurse's role in relation to terminations, particularly in relation to signing the HAS 1 form and carrying out early surgical abortions;
- consideration could be given to amending the Act to enable the second stage of early medical abortion to be self-administered in a woman's home;
- NICE should be responsible for clinical guidelines on abortion provision, including health risks associated with abortion;
- the government should consider ways of ensuring that all those who offer pregnancy counselling services make the guidelines available or indicate clearly in their advertising that they do not support referral for abortion.

In 2013 the RCN updated its guidance on the nurse and termination of pregnancy and sets out the role of the nurse and the legal limitations.[48]

Sterilisation

Sterilisation of a minor with learning disabilities

Case 15.8 *In re B (A Minor: Wardship Sterilisation)* (1987)

Sterilisation[49]

Jeanette was 17 years old, but was described as having a mental age of 5 or 6. Her mother and the local authority, which held a care order on her, advised by the social worker, the gynaecologist and a paediatrician, considered it vital that she should not become pregnant. She had been found in a compromising situation in her residential home. She could not be relied on to take or accept oral contraceptives. Jeanette was likely to move to an adult training centre at the age of 19 and it would not be possible to provide her with the degree of supervision she had at present.

The House of Lords decided that the paramount consideration was the interests of the girl and, taking account of all the medical evidence, decided that it was in her interests to be sterilised. They made no distinction between non-therapeutic and therapeutic care of the child and recommended that in future all such cases should come before the courts. The Mental Capacity Act 2005 applies to those over 16 years and from 1 October 2007 consideration of whether a sterilisation was in the interest of a girl of 17 years would come before the Court of Protection. Cases concerning children under 16 years would be heard under the Children Act 1989 by the Family Division of the High Court. However, the Mental Capacity Act 2005 facilitates transfers to and from the Court of Protection and High Court.

Sterilisation of an adult with learning disabilities

The House of Lords in the Jeanette case discussed above declared their decision before Jeanette reached 18, so they did not consider the law in relationship to the adult mentally handicapped person. This was considered in the case of *T* v. *T* (Case 15.7), but that decision was taken in the High Court. The view of the House of Lords on this situation was given in the case of *In re F* v. *West Berkshire Health Authority*.

In this case, the court had to decide whether the sterilisation of a mentally handicapped woman, F, aged 35, would be unlawful because of her lack of capacity to give her consent to the operation. Mr Justice Scott Baker in the Family Division granted a declaration that it was in the best interests of F to have the operation. He stated that there was a problem when, because of a mental condition, a patient was unable to give any meaningful consent to treatment for a physical condition. If he did nothing, a doctor could be said to be negligent; if he operated, he, *prima facie*, committed the tort of battery. The law's answer to this was that a professional was not liable if he acted in good faith and in the best interests of the patients. The Court of Appeal upheld this decision. The House of Lords confirmed the power at common law for a doctor to act in the best interests of the patient incapable of giving consent. The court also had an inherent jurisdiction to make declarations on the lawfulness of such treatment. Court involvement in cases of sterilisation was highly desirable as a matter of good practice.[50] A practice note was issued providing guidance on the procedure that should be followed for making medical and welfare decisions on behalf of adults lacking capacity.[51] The Mental Capacity Act 2005 would now apply and such issues would be heard before the Court of Protection.

There can be disputes over what the best interests of a patient are and in a more recent case the Court of Appeal held that it was in the interests of a woman of 29 with severe learning disabilities to be fitted with an IUD rather than undergo a subtotal hysterectomy. The judge had failed to give proper weight to the unanimous medical evidence that supported the less invasive coil treatment.[52] In a case involving male sterilisation, the Court of Appeal held that it was not in the best interests of a man with learning disabilities to have a vasectomy, which his mother wanted to take place.[53] The Court of Appeal held that the best interests of the patient encompassed medical, emotional and all other welfare issues. In relation

to sterilisation, the best interests of a man were not the equivalent of the best interests of a woman because of the obvious biological differences. This contrasts with the case of DE where the Court of Protection agreed that a vasectomy could be carried out on a 36-year-old with learning disabilities[54] (see chapter 17).

The situation in Case 15.8 would now be covered by the Mental Capacity Act 2005. Where serious decisions have to be made on behalf of a person lacking the requisite mental capacity, an application would have to be made to the new Court of Protection to determine the best interests of that person. The Mental Capacity Act requires decisions to be made in the best interests of an adult who lacks the requisite mental capacity.

Unsuccessful sterilisations

Case 15.9 *Emeh* v. *Kensington and Chelsea and Westminster Health Authority* (1985)

Unwanted pregnancy[55]

Mrs Emeh, a mother of three children, underwent an operation for sterilisation in May 1976. In January 1977 she discovered that she was 20 weeks pregnant. She refused to have an abortion. She then gave birth to a child with congenital abnormalities who required constant medical and parental supervision. She claimed damages for the unwanted pregnancy and the birth and upkeep of the child. The trial judge held that the operation had been performed negligently and she could therefore recover damages for the time before she discovered the pregnancy, but since she refused to have an abortion, she was not entitled to the costs thereafter apart from the cost of undergoing the second sterilisation operation. Mrs Emeh appealed to the Court of Appeal and won.

The Court of Appeal held that since the avoidance of a further pregnancy was the object of the sterilisation operation, it was unreasonable after the period of pregnancy that had elapsed to expect the claimant to undergo an abortion. Her failure to do so was not unreasonable. She was therefore entitled to recover damages for her financial loss caused by the negligent performance of the sterilisation operation. She was awarded £7,000 for loss of future earnings, £3,000 for pain and suffering up to the trial and £10,000 for future loss of amenity and pain and suffering that will occur during the life of the child.

This decision is to be welcomed since it reverses an earlier decision.[56] The mother's refusal to have an abortion was not an unreasonable one and it could not be used as a reason to limit the damages payable. It has recently been confirmed in a decision of the House of Lords (see the McFarlane[57] case, Case 15.10) that arranging an adoption or abortion was not a requirement of the parents following the diagnosis of an unwanted child: 'There was no legal or moral duty to arrange an abortion or an adoption of an unplanned child.'

In another case,[58] a woman was sterilised when she was 4 weeks pregnant, a fact unknown to herself and the surgeon. The health authority accepted liability and damages of £96,631 were awarded, which included the future cost of caring for and educating the child. A pregnancy test should have been carried out before the operation for sterilisation was performed. Subsequently, the issue as to whether there should be compensation for bearing a healthy (but unplanned child) has come before the House of Lords.

Unplanned pregnancies

Unplanned healthy baby

The House of Lords has stated that compensation is not payable for the costs in bringing up a healthy child. In *McFarlane and Another* v. *Tayside Health Board*[59], the House of Lords laid down the principles that should apply to any assessment.

Case 15.10 *McFarlane and Another* v. *Tayside Health Board* (1999)

Unplanned pregnancy – compensation for healthy baby[60]

Mr and Mrs McFarlane had four children and Mr M agreed to have a vasectomy. Six months after the operation, he was advised that the sperm counts were negative and he could dispense with contraceptive precautions. Mrs M subsequently became pregnant and gave birth to a healthy daughter. They brought proceedings for damages for the cost of rearing the child and the pain and suffering by Mrs M in carrying and giving birth to her. Her claim was dismissed initially on the ground that such damages were irrecoverable in principle. The appeal succeeded and it was held that the couple should be given the opportunity to prove their loss and damage. The health board appealed to the House of Lords.

The House of Lords held that where medical negligence resulted in an unwanted pregnancy, and the birth of a healthy child, the parents were not entitled to recover damages for the costs of rearing that child, but the mother was entitled to recover damages for the pain and distress suffered during the pregnancy and in giving birth and for the financial loss associated with the pregnancy. Damages for the cost of bringing up a healthy baby were irrecoverable since it was not fair, just or reasonable to impose liability for such economic losses on a doctor or his employer. Lord Steyn held that it was morally unacceptable to allow such a claim having regard to the principle of distributive justice, which focused on the just distribution of burdens and losses among members of a society.

Unplanned baby with disabilities

In the McFarlane case, the House of Lords were considering the birth of an unplanned healthy baby. However, different considerations would arise if the unplanned baby were to be disabled. In the case of *Nunnerley and Another* v. *Warrington Health Authority and Another*[61] (held before the decision of the McFarlane case was known), the mother was given negligent advice that led to the unwanted birth of a disabled child. The High Court judge held that the claim for damages should not be limited to the costs of the care which they themselves had a legal duty to provide, but damages were payable for the cost of care beyond 18 years. The judge held that the normal principle of compensation should apply, i.e. the claimants were entitled to be put in the position that they would have been in but for the wrong done to them and they were therefore entitled to compensation beyond the child's 18th birthday.

In another case,[62] M gave birth to a baby with Down's syndrome. The doctor had failed to inform her of the results of a routine scan that indicated that she was likely to give birth to a child suffering from Down's syndrome. M said that had she been informed of the results of the scan, then she would have chosen a termination. Liability was admitted and she was awarded £118,746. The High Court judge held that the ruling in *McFarlane* v. *Tayside Health Authority* was confined to the birth of a healthy baby. This principle was followed in *Hardman* v. *Amin*[63] where a doctor misdiagnosed rubella as tonsillitis in a pregnant woman, who therefore did not have a termination. The doctor subsequently admitted negligence. The mother successfully claimed the costs of the upbringing of a severely disabled baby.

In *Gaynor and Vincent* v. *Warrington HA and Liverpool HA*,[64] where damages were sought for the birth of an unplanned child, who was disabled, the Court of Appeal held that it would be contrary to the general rules of the law of negligence and damages to enforce a cut-off when a child reached the age of 18 years. There was a considerable body of family law that indicated that the liability of the defendants towards a disabled child and the parents who cared for that child should continue beyond the age of 18. In another case a sterilisation operation was carried out when the claimant was pregnant and the defendant was deemed negligent in not carrying out a pregnancy test and advising about a termination. The baby suffered from disabilities following the mother's exposure to bacteria during childbirth. The

defendant was held to be responsible for the foreseeable and disastrous consequences of performing her services negligently and therefore liable for the costs of bringing up a disabled child.[65] In the case of *Parkinson* v. *St James and Seacroft University Hospital NHS Trust*,[66] the Court of Appeal held that the extra expenses associated with bringing up a child with a significant disability could be claimed.

Unplanned baby to a mother with disabilities

Case 15.11 *Rees* v. *Darlington Memorial Hospital NHS Trust* (2003)

Unplanned pregnancy – compensation for healthy baby to a blind mother[67]

Mrs Rees suffered a severe and progressive visual disability such that she felt unable to discharge the ordinary duties of a mother. She therefore wished to be sterilised and made her wishes known to a consultant employed by the defendants. The operation was performed negligently. She bore a healthy and normal child and sought damages for his upbringing. The Court of Appeal (in a majority decision) held that she was entitled to the additional costs attributable to her disability. The defendant appealed to the House of Lords.

The House of Lords allowed the appeal, and, following the unanimous decision in *McFarlane* v. *Tayside Health Board*[68] held that a disabled mother who gave birth to a normal, healthy child after a failed sterilisation operation could not recover by way of damages the extra costs of rearing him which were referrable to her disability. However, she was a victim of a legal wrong which it was appropriate to recognise by the award of a conventional sum. This was put at £15,000 to be added to the award for pregnancy and birth.

Failure to warn of risks of pregnancy

There have been cases where no negligence in the performance of the operation has been proved, but compensation has been claimed on the grounds that the patient was not warned that there was a possibility of the operation being reversed and the patient becoming fertile or pregnant. This occurred in the following case.

Case 15.12 *Gold* v. *Haringey HA* (1987)

No warning[69]

Mrs Gold, who had two children, decided when she became pregnant again that she would not have any more children. She was referred to the consultant obstetrician who suggested sterilisation, but did not discuss the possibility of the husband having a vasectomy which had a slightly lower failure rate, neither did he discuss the risk of failure with her. The sterilisation operation was performed the day after the birth of the child, but was not a success and Mrs Gold gave birth to a fourth child. She sued the health authority for negligence because she had not been warned of the risk of failure and the statement that the operation was irreversible was a negligent misrepresentation.

Initially Mrs Gold was awarded £19,000 damages on the grounds that, although the operation had not been negligently performed, the defendants had been negligent in failing to warn her of the

possibility of failure of the operation. The defendants appealed and the Court of Appeal allowed the appeal for the following reasons.

1 The standard of care required of the medical practitioner was the same as that required of members of the profession, i.e. the ordinary skilled member of that profession who exercised and professed that special skill (see chapter 3 for further details on this standard). Where medical advice had been given, the standard of care required did not depend on the context in which it was given, but on whether there was a substantial body of doctors who would have given the same advice. Since, in 1979, a substantial body of responsible doctors would not have warned her of the risk of failure of the sterilisation operation, the health authority was not liable in negligence.
2 The statement that the operation was irreversible could not reasonably be constructed as a representation that the operation was bound to achieve its objectives. Mrs Gold therefore lost the case.

The Court of Appeal made it clear that it did not accept any distinction between advice given for a therapeutic procedure and that for a non-therapeutic procedure. The same standard should be applied to both, i.e. the Bolam Test.

Private healthcare

What if the case concerns an operation carried out in the private sector? Do any different principles apply? The significant difference between NHS care and private care is that there is a contract between patient and hospital in the provision of private care and failure to perform a satisfactory operation could lead to claims for breach of contract as well as a claim for negligence. In the case of *Thake* v. *Maurice*, the High Court awarded compensation for failure to warn the husband and the wife about the risks of the sterilisation failing. The Court of Appeal[70] decided that the standard of care required in the law of negligence would be the same as the standard to be given under a private contract for healthcare:

> **The reasonable man would have expected the defendant to exercise all the special care and skill of a surgeon in that specialty; he would not in my view have expected the defendant to give a guarantee of 100 per cent success. (Neill LJ)**

Similar arguments could not be used in an NHS context since there is no contractual relationship between an NHS patient and the health authority or doctor. The possibility of action arising from failed sterilisations has led to much more meticulous wording of the agreement and warnings in relation to the possibilities of failure.

Where a child is born as a result of a failed sterilisation the legal situation is as follows:

(a) The costs of bringing up a healthy child are not payable (*McFarlane* v. *Tayside Health Board*)
(b) Any extra costs directly due to the child being significantly disabled are payable (*Parkinson* v. *St James and Seacroft University Hospital NHS Trust*)
(c) The mother can claim damages for the pain and suffering of the pregnancy and childbirth and financial loss (*McFarlane* v. *Tayside Health Board*)
(d) A disabled mother is entitled to a set award of £15,000 in recognition of the harm that she has suffered (*Rees* v. *Darlington*).

(The sterilisation of a child under 16 is considered in chapter 13, which also considers the law relating to contraceptive advice for the under-16-year-old.)

Rights of the spouse

There is no legal requirement that if a person wishes to be sterilised the agreement of his or her spouse or partner must be obtained. Clearly, however, joint discussion with the couple of the implications is desirable.

Practical Dilemma 15.4 The husband says 'no'

Audrey Rich was expecting her seventh child. Her eldest child was 10 years old and they lived with the husband in a four-bedroomed council house. She felt she could not cope with any further pregnancies and sought advice as to the possibility of being sterilised after the birth of the seventh. An appointment was arranged with the obstetrician for Audrey and Steve, but Steve refused to attend, claiming that he would never give his consent to Audrey's being sterilised. Audrey went on her own to see the obstetrician, who told her that he could not carry out the operation without her husband's consent.

There is no duty in law to obtain the consent of the spouse before sterilising the partner. In the past, there was a legal duty when the husband had a right of consortium and could sue any person who caused him to lose this right. However, this right to sue for loss of consortium was repealed by the Administration of Justice Act 1982 section 2(a). The woman has never enjoyed such a right; the House of Lords refused to extend it to women in 1952.[71] There may be considerable advantages in obtaining a signature to say that the spouse knows of the intended operation, since if this is obtained the doctor is less likely to be summoned as a witness in divorce proceedings where one spouse is alleging that the operation was performed without his/her knowledge. However, a form signifying knowledge of the operation is very different from a form of consent.

In the situation outlined above, Audrey could obtain a solicitor's letter confirming the law, but this, of course, does not place any duty on the doctor to perform the operation. She could request referral to a doctor who would perform the operation or even apply to the health authority for assistance. Ultimately, she could seek a judicial review from the court of the refusal to perform the operation and obtain a declaration that such an operation could proceed without the husband's consent.

Female circumcision

Under the Prohibition of Female Circumcision Act 1985 female circumcision was a criminal offence. There was, however, evidence that some girls from ethnic minorities were being taken overseas to be circumcised. This led to the 1985 Act being replaced by the Female Genital Mutilation Act 2003 (FMG), which strengthens the law against female genital mutilation (FGM). Under Section 1(1) of this Act it is a criminal offence for any person to:

> **[E]xcise, infibulate or otherwise mutilate the whole or any part of a girl's labia majora or labia minora or clitoris.**

The word 'girl' includes woman. Section 1(1) is subject to section 1(2), which states no offence is committed by an approved person who performs:

(a) a surgical operation on a girl which is necessary for her physical or mental health, or
(b) a surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth by an approved person.

An approved person is defined as:

(a) in relation to an operation falling within subsection 1(2)(a), a registered medical practitioner
(b) in relation to an operation falling within subsection 1(2)(b), a registered medical practitioner, a registered midwife, or a person undergoing a course of training with a view to becoming such a practitioner or midwife.

There is also no offence if a person performs a surgical operation falling within section 1(2)(a) or (b) outside the UK and exercises functions corresponding to those of an approved person.

Section 1(5) states that for the purpose of determining whether an operation is necessary for the mental health of a girl, it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual.

Section 2 makes it an offence for a person to aid, abet, counsel or procure a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.

Under section 3, it an offence to aid, abet, counsel or procure a person who is not a UK national or permanent UK resident to do a relevant act of female genital mutilation outside the UK. An act is a relevant act of female genital mutilation if it is done in relation to a UK resident and it would constitute an offence under section 1. Exceptions in relation to surgical operation and childbirth by approved persons apply. The Act also extends the offences to any act done outside the UK by a UK national or permanent resident.

Ann Clwyd, the Labour MP who introduced the legislation leading to the 2003 Act, complained at the lack of prosecutions under the legislation. A report suggested that African village elders were being flown into the UK to circumcise young girls.[72] The Metropolitan police offered £20,000 to anyone giving information which leads to successful prosecution for female genital mutilation.[73] The House of Lords overruled a Court of Appeal decision that held that a 19-year-old from Sierra Leone was not protected by the asylum laws since she did not belong to a particular social group fearing prosecution. The House of Lords held that the fear of genital mutilation if she were to return enabled her to stay in Britain.[74] Baroness Hale stated that female genital mutilation is in breach of international human rights law and standards. A campaign for a worldwide ban on female genital mutilation was launched at the United Nations in September 2010.[75]

The lack of prosecutions has led to widespread efforts to eradicate FGM.

In 2013 the International Development Select Committee of the House of Commons recommended better enforcement of the 2003 Act in the UK to provide greater protection for girls[76]. The government responded in September 2013 but disagreed with the Select Committee's recommendation on an up-to-date binding document requiring all service providers to play their part. The government considered that the existing cooperation between departments and the integrated approach to tackling FGM was successful. A helpline was set up by the NSPCC to assist those fearing genital mutilation on 24 June 2013.[77] A coalition of medical royal colleges and civil society groups published a report in 2013 stating that about 66,000 women in Britain have undergone FGM yet there has never been a prosecution. As many as 23,000 girls were currently at risk, mainly from African communities. The report urged that there should be a national campaign similar to the ones on HIV and domestic violence to highlight the problem.[78]

It was stated that government discussions were taking place with teaching unions to require teachers to report suspicions of FGM being planned. International Development Minister Lynne Featherstone, while spearheading the campaign to reduce FGM, was shocked that 8 in 10 teachers had received no child protection training in FGM.[79] In July 2013 it was announced that eight police files on alleged female genital mutilation had been passed to the Crown Prosecution Service with a view to bringing the first prosecutions in the UK.[80]

In January 2014 a conference was held to launch a report[81] which confronted the lack of prosecutions for FGM in comparison with France where over 100 prosecutions have been brought. The report's author pressed for mandatory reporting by health professionals, teachers and others to report suspected cases to the authorities immediately. The former Director of Public Prosecution Sir Keith Starmer agreed, saying that the authorities had been too passive over a crime that annually put at risk an estimated 65,000 girls under the age of 13. See also the work of the campaigning GP Dr Phoebe Abe.[82] In March 2014, in a submission to the Home Affairs Select Committee, the Ministry of Justice suggested that a new civil court order could be created to be used by a young girl who fears being subjected to FGM. Breach of the order would lead to the violater being brought to court and jailed for 2 years for contempt of court.

Well-known figures such as the Duchess of Cornwall and Baroness Ruth Rendell have supported the campaign to eradicate FGM, charities such as FORWARD, Daughters of Eve and the NSPCC are all giving publicity to the Campaign against FGM. The Mayor of London Boris Johnson urged hospitals to share details of victims of FGM with the police and social services, and on 17 March 2014 he recommended that the law should be changed to make it obligatory for health professionals to report FMG. In February 2014 the Secretary of State for Education met with campaigners to discuss ways of combating FGM through the schools and agreed to warn all head teachers about the risk of pupils being subjected to FGM.[83] It was reported on 20 March 2014 that nearly 4,000 women have been treated in London hospitals since 2009 for complications following FGM.

In another move, Scotland Yard is to cooperate with the UK Border Agency to stop parents suspected of taking their daughters to Africa for FGM and there are proposals that overseas aid should not be given to countries which allow the practice of FGM. The House of Commons Health Select Committee held an inquiry into FGM the week beginning 24 March 2014, which coincided with the announcement of the first UK prosecution for FMG on 21 March 2014.

In May 2104 the Medical Practitioners Tribunal Service found a doctor guilty of offering to assist in arranging FGM following a *Sunday Times* undercover operation.[84]

Conclusions

Decisions relating to abortion and sterilisations for adults who lack the mental capacity to make their own decisions now go to the Court of Protection and the decisions are made in accordance with the Mental Capacity Act 2005. This Act creates a framework for the law relating to sterilisation or abortion and other decisions on behalf of those adults who lack the requisite mental capacity. The debate on changing the law on abortion is ongoing, with those in favour seeking to remove the rule that two doctors are required to authorise the abortion and suggesting that a nurse should be able to prescribe an abortion pill and carry out early surgery for termination, and those against arguing that the 24-week time limit should be reduced to 21 weeks (Nadine Dorries presented a Bill to Parliament calling for the limit to be reduced to 21 weeks in November 2006). However, the discussions on abortion in Parliament during the debates on the Human Fertilisation and Embryology Bill did not lead to any changes to the 24-week time limit. There is also controversy as to whether termination on grounds of the gender of the child, irrespective of any sex-linked genetic condition should be made illegal.[85] Because of the controversial nature of the subject, pressure for legislative change is likely to continue.

Reflection questions

1 What is the legal situation if an aborted fetus is found to be breathing?

2 What do you consider should be the registered nurse's role in the termination of pregnancy?

3 What information do you consider should be given to a patient before his or her consent is given to an operation for sterilisation? What are the legal requirements? (See also chapters 7 and 17).

Further exercises

1 Obtain a set of the documentation that has to be completed when an abortion is performed and examine the legal requirements as shown in these forms.

2 What forms are completed in your hospital when an operation for sterilisation is performed? Can you see any significant differences in the form completed by the patient and the form (if any) completed by the spouse?

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Chapter 16

Acute care

This chapter discusses

- Civil liability procedures and practices in theatre
- The theatre nurse and the scope of professional practice
- Accidents in the theatre
- Consent in the theatre
- Recovery room nursing
- Transfusions and blood contamination
- Organ transplantation
- Intensive care units: resource pressures
- Review of critical care services

Introduction

This chapter looks at the acute care and the hi-tech end of nursing, where developments in equipment and technology constantly challenge the registered nurse to keep up to date in maintaining her professional competence. This is also an area where demarcations between different registered health professionals change as the workplace demands. New statutes on transplant law and human tissue and mental capacity change the legal framework within which the nurse functions. Like the ward nurse, the theatre nurse is constantly concerned with the possibility of litigation and also with the problems of her role in relation to the surgeons, the operating department assistants and the anaesthetists. These areas and the others to be covered in this chapter are set out above. Reference should also be made to chapter 24 on the scope of professional practice and chapter 29 on the law relating to death and inquests and the need to report

to the coroner if a patient dies on the operating table or shortly afterwards. Another concern for theatre staff, when an aborted fetus shows signs of life, is considered in chapter 15.

Civil liability procedures and practices in theatre

Professional liability

Practical Dilemma 16.1 Lost swab

Staff Nurse French was the scrub nurse for a hernia operation performed by a registrar. They were running late and still had two patients left on the morning list. The afternoon list was due to start in 10 minutes. Just before the registrar sutured the patient's wound, he asked for a swab count. Staff Nurse French checked the 34 used swabs, which had been hung on the rack, and six unused swabs and two unopened packs with the operating department practitioner. She confirmed that those were the only ones in use and the patient was sewn up. A few days later, just before the patient would normally have been discharged, he reported violent pains and became seriously ill. It was decided to X-ray the patient prior to returning him to theatre. The X-ray showed up a swab. The relatives of the patient were told what had happened and they made it clear that they would seek compensation. An internal investigation was commenced to see if the cause of this error could be found. The conclusions were that there was an extra swab in one of the packs and this had not been spotted when the staff nurse opened and counted them. A dispute then ensued between the registrar and the staff nurse over liability for the incident. The staff nurse claimed that, as she had checked the swabs in front of the registrar, he should accept responsibility for it; the registrar stated that, as the staff nurse had clearly counted wrongly, it was entirely her responsibility and, in addition, the unscrubbed runner nurse had made a second check.

In a dispute like this, the patient would be able to argue that this is a case of *res ipsa loquitur* and the burden should pass to the NHS trust to show that they were not negligent. (This is discussed in chapter 6.) The case of *Wilsher* v. *Essex Area Health Authority*[1] laid down the principle that the courts do not accept any concept of team liability (see Case 4.3, page 72). The NHS trust itself could be directly liable and, in addition, each individual professional could be liable for what he or she personally did or failed to do and would be judged according to the standards expected of them, but the employer would accept vicarious liability.

The actual proportion of responsibility in a case like the above would obviously depend on the actual facts of what went wrong. When the swabs were unpacked, were they properly checked to ensure that none were stuck together? What was the accepted approved practice that the doctor and the nurse should have followed? Were there any justifiable reasons why this need not have been followed? In addition, there might be some liability on the part of the manufacturer as well. Since 1 January 1990, health authorities have accepted responsibility for the negligence of doctors and dentists while acting in the course of employment. This also applies to NHS trusts. It is, therefore, less important how liability between nurse and doctor is shared, since the compensation will be paid to the patient by the employer, because of its vicarious liability for the negligence of its employees. It is important, however, to allocate responsibilities through procedures and policies to ensure that similar harm does not occur again. It is essential that procedures are in place to prevent such incidents arising.

There have been some very rare cases where, although the scrub nurse points out that a swab is unaccounted for, the surgeon still proceeds with stitching up the patient. This may be justifiable in particular cases if the patient's condition is deteriorating and there is a greater risk in keeping him under the anaesthetic than in taking the risk of the swab still being inside him. It would be very

different if the surgeon were simply ignoring the nurse's count without any justification. The proportion of liability between nurse and surgeon thus depends entirely on the individual facts of the case.

Policies and practices

Practical Dilemma 16.1 illustrates the importance of having clear policies and codes of practice as to the responsibility of each person in theatre, so that there is no overlap. In a situation where the patient is unable to correct any wrong assumptions, it is essential that these codes cover every possible danger. The responsibility for the identification of the patient, the nature of the operation to be performed, including the identification of the part of the body or limb to be operated on, must all be clearly allocated so that there can be no errors. Many of these procedures may be repeats of checks already made at ward level, but they cannot be omitted on that account in theatre. If any such cases came to court, the judge would expect evidence on what the procedure should have been and what in fact took place.

There are many implications for theatre nurses: they should clearly be familiar with the procedures and implement them, resisting any unjustifiable shortcuts whatever the pressure. In addition, their records should be detailed and meaningful so that if there is a query about the care in the theatre, then they are able to refer to a comprehensive account of what took place. Booklets produced by organisations such as the Medical Defence Union and the Medical Protection Society and professional associations, such as the Royal College of Nursing[2], the British Association of Critical Care Nurses[3] and the Association for Perioperative Practice[4] (formerly the National Association of Theatre Nurses), cover procedures for admission, labelling and ward procedure, lost swabs and instruments and other causes of potential hazards (see Figure 16.1). 'A Step Guide to Improving Operating Theatre Performance',[5] prepared by the NHS Modernisation Agency, was sent to all NHS trusts in 2006 to reduce cancelled operations and to optimise theatre use. It drew on best practice across the country.

In 2003 the National Institute for Health and Care Excellence (NICE) published interventional procedures guidance covering eight clinical areas to protect patients and to support health professionals when performing innovative surgical procedures. For four of the procedures, NICE advised that the data appear adequate to support their use; in the other four, there was uncertainty and in such cases NICE advised that patients are kept fully informed and that clinicians monitor and audit the results of the procedures they undertake carefully. Guidelines issued by NICE in respect of specific surgical procedures are available from its website[6] (see chapter 5).

In 2000 the wrong kidney was removed from a patient in Prince Philip Hospital, Llanelli. In the subsequent report of the inquiry by the Commission for Health Improvement[7] into that incident, it was found that there were serious faults in the marking of X-rays and significant recommendations were made. A trial of the two surgeons involved began at Cardiff Crown Court, but the prosecution failed to establish that the removal of the wrong kidney caused the death of the patient and the jury was ordered by the judge to acquit the defendants. Subsequently, professional conduct proceedings were held by the General Medical Council.

The Action Against Medical Accidents[8] reported that since 2004 there had been 283 claims against NHS trusts after surgical instruments or other foreign bodies had been left inside patients following surgery. Four million pounds was paid in compensation for such incidents.[9] The National Patient Safety Agency issued a patient safety alert on correct site surgery with recommended action to be taken by the NHS in March 2005[10] and a fact sheet on patient safety in anaesthetics and theatres is available on its website. In June 2012 the functions of the NPSA were transferred to the NHS Commissioning Board (NHS England).

In May 2013 a Freedom of Information request by *The Times* revealed that over 750 patients over the past four years had suffered from serious mistakes in surgery in England. These included 322 of foreign objects left inside patients, 214 cases of surgery on the wrong side of the body, 73 cases of tubes being inserted in the lungs instead of the stomach or veins and 58 cases of wrong implants or prostheses being fitted. These cases are known as 'never events' and according to Mike Durkin, Director of Patient Safety for NHS England 'even one is too many in any week, in any day in any hospital'.[11] The

Potential hazards in operating theatres

- Allergies not marked on notes
- Units of blood not checked
- Nerves over bony surfaces damaged
- Eyes exposed to harm
- Sharp and powered tools used dangerously
- Faulty gauges on pneumatic cuffs, faulty monitors
- Tourniquets left on too long and skin necrosis beneath tourniquet cuffs
- Spirit solutions used with cautery
- Hot instruments and hot water in tubing
- Water mattresses overheating
- Diathermy burns
- Uninsulated electrodes
- Misplaced footswitch
- Faulty alarms and faulty equipment

Figure 16.1 Potential hazards in the operating theatre

Department of Health produces an annual list of 'never events', i.e. incidents which are considered unacceptable and eminently preventable. The list for 2013/14 obtainable on the government website[12] contains 25 such events, many of which relate to surgery such as wrong site surgery, wrong implant/prosthesis and retained foreign object post-operation, each of which is accompanied by guidance on safer practice.

A surgeon, Dr Siddiqui, was struck off after the GMC found that he had failed to address concerns over the past four years. He had made a series of errors leaving patients worse off: seven patients suffered care below the standard expected and six cases were seriously below the expected standard.[13]

Two surgeons at Imperial College and the Royal Brompton Hospital are under investigation by the GMC over alleged poor care of a patient with a rare life-threatening condition.[14]

Further information and guidance on anaesthetic, theatre and recovery room procedures can be obtained from the British Anaesthetic and Recover Nurses Association (BARNA)[15] and from the Association for Perioperative Practice.[16]

The theatre nurse and the scope of professional practice

There is little uniformity in the tasks that nurses are expected to perform in theatre. The duties of a scrub nurse can depend on the personal preferences of an individual surgeon, the employment of ODPs and on whether the hospital is a teaching hospital. Anaesthetic nurses may also have a variety of duties: for example, in some theatres they may be expected to draw up the drugs in syringes for the anaesthetist to check; in others, the anaesthetist might do this him or herself. The nurse's role will also depend on the existence of and the duties performed by the operating department practitioner (ODP). Some of the tasks she performs will be regarded as expanded-role duties in which she might have been trained on a post-registration training course. In its report *Anaesthesia under Examination*,[17] the Audit Commission made significant recommendations on anaesthetic and pain management services, and suggested that there was considerable scope for the role expansion of many of the different professional groups who work in theatres. The report illustrates how problems can arise when interdisciplinary team working breaks down. It puts forward practical suggestions on how trusts can improve anaesthetic

and pain relief services. (See chapter 24 and page 659 on the scope of professional practice and the theatre nurse.) ODPs are now a registered profession under the aegis of the Health and Care Professions Council. In chapter 28 their role in relation to medication is discussed. The scope of professional practice of the theatre nurse should take into account the role of the ODP (see chapter 24). In 2014 the HCPC published new standards of proficiency for ODPs.[18] The NPSA has published a safety leaflet on teamwork, including teamwork in surgery, which is available on its website.[19] While expanded roles are of increasing significance it is essential that basic skills are not neglected. In 2013 the National Confidential Enquiry into Patient Outcome and Death found that one in five patients had a problem caused by an IV drip being administered wrongly and many have died. As a consequence of this finding NICE produced draft clinical guidelines on intravenous fluid therapy in hospitals.[20] In July 2013 following the death of a patient during an operation in the cardiac department at Croydon University Hospital an argument broke out between the consultant and the hospital management: the former alleging that no-one had told the doctors performing surgery that a specialist nurse had been suspended and was not available; the NHS trust saying it did not accept claims of bad management.[21]

Accidents in the theatre

An incident book should be kept to record accidents and other mishaps in theatre and the recovery room, and accidents and other untoward incidents should be reported to the chief executive or his/her assigned officer. There may be opposition from some medical staff over the necessity to record untoward incidents, but the nurse has a duty to ensure that records are maintained on incidents that cause harm: diathermy burns, an unintentional cut and the more serious incidents such as operating on the wrong side of the patient or even on the wrong patient. A policy of disclosure to the patient should be encouraged. However, it is not for the nurse to notify the patient; this is the consultant's or manager's duty. The National Patient Safety Agency (NPSA) was established in 2001 to set up a national reporting system of adverse healthcare incidents so that lessons could be learnt and accidents prevented. The NPSA is discussed in chapter 12. In October 2010 the NPSA reported that in 2009–2010 there were 57 reports of wrong-site surgery. There were 111 'never' events, i.e. incidents which should never happen, including leaving swabs and instruments in patient's bodies. Proposals for a new NHS redress scheme recommended the introduction of a duty of candour but this was not included in the NHS Redress Act (see chapter 6). However, the need for openness and candour has been emphasised in the Francis Report on Mid Staffs which is discussed in chapter 5, and section 81 of the Care Act enables regulations to be drawn up to impose such a duty on health organisations. The Kennedy Report[22] following the inquiry into children's heart surgery at Bristol also emphasised the need for openness and honesty between health professionals and patients (see chapter 4). An association has been established for assistants in surgical practice (National Association of Assistants in Surgical Practice), which has set up a website to support members.[23] It also runs workshops and conferences to provide professional development to assistants in surgical practice, including non-medically qualified practitioners. Its code of practice and clinical milestones for the surgical care practitioner can be seen on its website. See also the website for the Association of Perioperative Practitioners for guidance on standards.[24] Recent examples of negligence in surgery include a surgeon who lied to a patient telling her that he had removed a brain tumour and then lied frequently to cover it up.[25] Another surgeon, Ian Paterson, performed four unnecessary breast operations on a woman and an inquiry found that he had performed more than a thousand inappropriate or unnecessary surgeries on women over a 17-year period. The slowness of the managers to take action against him was criticised in a review led by Sir Ian Kennedy which reported in December 2013.[26]

A surgeon who engraved a patient's liver with his initials was suspended by the University Hospitals Birmingham NHS Foundation Trust.[27] The patient has subsequently asked for the surgeon to be reinstated.[28]

In June 2008 a new safety checklist for surgical teams was launched by the World Health Organization. Several studies had shown that in industrial countries major complications occur in 3–16 per cent of inpatient surgical procedures, and permanent disability or death rates are about 0.4–0.8 per cent,

according to the WHO. The checklist, which is being backed by the NPSA and junior Health Minister Lord Darzi, was drawn up using evidence from eight pilot sites, including one based at St Mary's Hospital in London. Use of the checklist in pilot sites has increased the rate of adherence to receive proven standards of surgical care from 36 to 68 per cent and in some hospitals to almost 100 per cent. Final results on the impact of the checklist are expected in the next few months. Further information and the checklist are available on the WHO website.[29]

In May 2013 a report from Imperial College London showed that patients who have operations on a Friday are almost 50 per cent more likely to die than those who have operations on a Monday.[30] The authors suggested that the root cause was that over the weekend when patients were recuperating senior doctors were often unavailable, nursing staff were fewer and testing services reduced. The *Sunday Times* initiated a campaign in 2013 to ensure that hospitals were properly staffed 24 hours seven days a week.

As part of the initiative to improve NHS standards the NHS England Medical Director Sir Bruce Keogh recommended that all consultants should devise ways of publicly measuring their performance. The press has tended to focus on death rates, but these are not necessarily an effective measure since low numbers of operations means that chance factors overwhelm the influence of surgeon performance on the number of deaths.[31] He set up a Forum in February 2013 to look at NHS Services Seven Days a Week. The findings were published in December 2013 which showed that the increased risk of mortality at the weekend could be as high as 11 per cent on a Saturday and 16 per cent on a Sunday. He set out 10 new clinical standards describing the standard of urgent and emergency care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges. He recommended that they should be adopted by the end of the 2016/17 financial year. The NHSIQ's Report *NHS Services Open Seven Days a Week: Every Day Counts*, the forum summary report and the Board paper are accessible on the website of NHS England.[32]

The Director of Patient Experience at NHS England, Neil Churchill has recommended that doctors should take more responsibility for hospital food and drink, since hospital meals are absolutely crucial to patient care.[33]

Consent in the theatre

Some particular problems arise in relation to consent in the theatre. One is the failure of ward staff to ensure that the appropriate forms have been filled in before the patient is sent to theatre. Consider Practical Dilemma 16.2.

Practical Dilemma 16.2 Validity of consent

Paula Green was admitted to hospital for a biopsy of the breast. It was intended that, should there be any malignancy, a mastectomy would be carried out immediately. Paula was given the pre-medication by the ward staff and brought to theatre. When the theatre sister was checking through the records, she noticed that there was no consent form. The anaesthetist, who had begun to prepare Paula for the operation, said that he had seen Paula on the ward the previous day and knew there was no doubt that she wanted this to be carried out and that she might still be able to put her signature to a form. The theatre sister was very concerned about this. The surgical registrar then apologised and said that he had spoken to Paula about the operation and that she knew the implications of it. However, when he had visited the ward, he had run out of consent forms. He had intended returning to the ward to get Paula's signature but had been distracted and had completely forgotten about it. He saw no reason not to proceed with the operation and argued that Paula would be far more upset if the operation did not proceed and she returned to the ward without it than for the operation to go ahead without her signature. What should the theatre sister do?

Consent after pre-medication

In chapter 7, it was pointed out that consent can be given in a variety of forms: in writing, by word of mouth, by implication. These are all equally valid in law. It could be argued, therefore, that the fact that Paula had given her consent to the registrar means that that can be relied on and therefore the operation can proceed. However, consent in writing is infinitely superior as a form of evidence. Imagine that Paula's operation proceeded. When the biopsy was analysed, a malignancy was discovered and the surgeon therefore proceeded with a mastectomy. On recovery, however, Paula denied that she had any idea that this was a likely possibility and had she known she would have preferred to have had radiotherapy. This possibility cannot be discounted and in such a situation it would be far better for Paula to return to the ward and, when the pre-medication has worn off, to agree in writing that the operation can proceed. One can imagine certain circumstances where there would be such considerable risks in postponing the operation that, on balance, the advantages to the patient are in favour of proceeding rather than returning the patient to the ward. In such cases, there could be an action for negligence if harm were caused by this delay. However, these would be unusual circumstances. In general, it would be wiser to ensure that the patient has signed a consent form and has had all the risks and implications explained to her. Sending the patient back to the ward, although undoubtedly leading to a furious complaint from a rightly indignant patient, has several long-term advantages: the ward staff will be less likely to give the patient a pre-medication before checking whether the consent forms have been signed and the doctors will know that they cannot get by with a casual approach to patients' rights.

A more difficult situation which occasionally occurs is where the patient himself, after pre-medication and prior to the general anaesthetic, asks the surgeon if something else could be 'sorted out', e.g. an in-growing toe nail, a cyst, etc. What is the surgeon to do? It would seem churlish for him to say, 'No. I must have your consent in writing for that and since you have been pre-medicated you are incapable of giving a valid consent.' Contrariwise, if he agrees to proceed and undertakes the additional task and there are some unforeseen or unmentioned side effects, then litigation may result. Compensation was paid to a patient when she changed her mind about an abortion, but this was ignored and the termination was carried out[34] (see chapter 15).

Consent refused

Practical Dilemma 16.3 What the eyes don't see . . .

An adult Jehovah's Witness patient makes it clear that he will agree to a particular operation only on the understanding that he will not be given blood (see Figure 7.1). The surgeon agrees to operate on that basis, but does intend that, if blood is needed, the patient will be given it anyway and will be none the wiser. The operation proceeds. The patient begins to haemorrhage and the surgeon instructs that blood should be given. Somehow the patient discovers what has happened and sues the NHS trust for trespass to the person.

In this case, it is clear that there has been a trespass to the person since the patient was given blood contrary to his express instructions and any deliberate intention to mislead the patient by the surgeon was a breach of professional conduct. The patient should, therefore, be entitled to substantial damages. Only if there were any doubt about the mental capacity of the patient and therefore the possibility that he was incapable of making a decision, could the judge consider that the actions were justified in the best interests of the patient under the Mental Capacity Act 2005. (See the case of *Re MB*, which is considered in chapter 7 and chapter 14.) To avoid the possibility of court action, a surgeon could advise that he is not prepared to operate with restrictions on his discretion and if the patient refused to give

an unrestricted consent, then he would not be operated on. (Note the case of *Malette* v. *Shulman*, where blood was given to an unconscious card-carrying patient (see Case 7.6 in chapter 7).)

Other restrictions that the patient may also wish to impose on the surgeons are often refused; thus it should be made clear that the operation will not be performed by a particular surgeon or that there will be a specified anaesthetist or that any particular procedure will be followed. It is now recommended that the forms contained in the Department of Health's guidance on consent to examination and treatment[35] should be used prior to any operation. (These are discussed in chapter 7.)

Even though the patient has consented to a particular operation and is therefore prevented from bringing an action for trespass to the person, it might well be that if harm occurs, the patient will complain that he has not been informed of this possibility and side effects and that, had he known, he would not have gone ahead with it. This possibility is discussed in connection with the Sidaway case (see chapter 7).

One important point must be emphasised, however. The patient, in signing the consent form, is consenting to an action that without his consent would count as a trespass to his person. He is also consenting to undergo the risks of those unforeseen chances that, no matter how much care is taken, can still occur. He is not consenting to negligence or to the possibility that harm could occur to him because a nurse or doctor is careless or because the procedures are not followed correctly or inadequate precautions are taken to ensure that he will be safe.

Sometimes it might be pointed out to the patient that a particular operation is experimental and he might expressly agree to undergo the additional risk of this unknown procedure, but he still does not consent to the possibility of a failure to follow approved accepted practice.

Other difficulties in relation to consent to treatment are considered in the chapters relating to consent generally (chapter 7), children's nursing (chapter 13), gynaecology (abortion and sterilisations) (chapter 15), learning disabilities (chapter 17), the older person (chapter 19), psychiatric nursing (chapter 20) and A&E departments (chapter 21).

There have been successful claims by patients who have brought action on the grounds that, while under the anaesthetic, they were conscious of activities around them and suffered agonising pain, but were unable to move. Research published in 2007 suggested that about 1 in 14,000 patients had a general anaesthetic experience awareness if certain risk factors were present. If these risk factors were not present the rate reduced to 1 in 42,000 anaesthetics.[36] The Royal College of Anaesthetists has published risk information leaflets. Section 8 of these covers awareness during general anaesthesia. The fifth edition was published in 2014 and showed that 51 per cent of incidents led to distress and 41 per cent to long-term psychological harm. In 1985, £15,000 was awarded to Margaret Acters by Wigan. Clearly, nurses should be vigilant for any sign that the patient is not properly anaesthetised. The role of the ODP in relation to medicines is considered in chapter 28.

Recovery room nursing

This is often under the control of the consultant anaesthetist. Recovery nurses will usually have post-registration training in recovery nursing. The training includes developing the skills, expertise and knowledge to detect possible adverse side effects resulting from the anaesthetic drugs. They must be trained to act speedily in an emergency, and staffing ratios assume even greater importance than in some other areas. It is essential that they are clear as to their competence in a wide area.

Another interesting facet of the law in this area is the fact that nurses may hear confidential information from the semi-conscious patient that would come under the principles discussed in chapter 8. Similarly, it is essential that nurses do not discuss the patient or any other patient in front of any of the semi-conscious patients in the recovery room since there are many accounts of patients who have overheard what staff have said and have been very upset by this. The nurse's duty of care obviously includes the duty of foreseeing what could harm a patient in this context and taking reasonable precautions to prevent that occurring.

Transfusions and blood contamination

In an attempt to reduce transfusion errors, the British Committee for Standards in Haematology, Blood Transfusion Task Force, RCN and the Royal College of Surgeons of England[37] produced the first clinical guidelines on blood transfusion. If hospitals implement them and provide the necessary resources and training, transfusion errors should be reduced. Guidance has also been provided by the NPSA.[38] An NHS Blood and Transplant (NHSBT) organisation was set up in 2005 as a special health authority. It combines the roles of the National Blood Authority and UK Transplant with a remit of increasing the quality, safety and supply of donated blood, organs and tissues and increasing the effectiveness of blood and transplant services. New regulations on blood safety require annual reports on serious adverse events and reactions to be made by blood establishments, hospital blood banks and facilities where blood transfusions take place.[39] Following the review of arm's-length bodies, the NHSBT remained an independent arm's-length body, but its Bio Products Laboratory was transferred into a Department of Health-owned limited company.[40] Further information on the NHSBT including its strategic plan for 2013–2018 can be found on its website.[41] The Serious Hazards of Transfusion Report for 2013 showed that errors were the largest cause of adverse transfusion incidents and urged a redesign of the transfusion process by mapping and audit, locally and nationally.

Criticisms were made of the waiting times and inefficiencies of the blood donor clinics with 1 in every 80 persons being sent away for non-medical reasons, an increase of 40 per cent compared with two years ago.[42] The criticism has led to the suggestion that the NHS Blood and Transfusion Service should become a charity.[43]

Compensation for being infected with contaminated blood

Before the disease of AIDS was recognised in this country as a possible killer, many haemophiliacs were given contaminated blood and have since become HIV positive. To succeed in an action for compensation in respect of the harm caused by being given contaminated blood, they would need to be able to show that those professionals providing the blood should have tested it for AIDS and were in breach of their duty of care in failing to do so and that this failure was contrary to the standard accepted practices of the time. It is unlikely that those who were originally infected could show this and therefore they have been dependent on government ex gratia payments and charity to assist them. The government paid compensation to them, but the agreement included a waiver to prevent them from taking action over other blood-borne viruses that they might contract in the future. This waiver was challenged by a haemophiliac who claimed that he was infected with hepatitis C virus from a blood transfusion. Any person receiving contaminated blood now, which has not been properly tested, would have a *prima facie* case of negligence and might also be able to obtain compensation under the Consumer Protection Act[44] (see chapter 12). In August 2003 the Secretary of State announced that £100 million was being made available to compensate people who had been infected with hepatitis C from contaminated blood products. The numbers include 2,800 haemophiliacs who were infected through contaminated clotting agents they were given during the 1970s and 1980s. The details of the scheme were announced in January 2004:[45] from April 2004 patients who were alive on 29 August 2003 and who had been infected with hepatitis C after being given blood by the NHS before September 1999 were to receive an initial lump sum of £20,000. This included those who had contracted hepatitis C through someone infected with the disease. Those with more advanced stages of illness were to receive a further £45,000. However, the widows of haemophiliacs who had died from the disease were excluded from the compensation. A Private Members' Bill was introduced into the House of Lords in October 2010 to provide compensation for those who have been infected by contaminated blood: Contaminated Blood (Support for Infected and Bereaved Persons) Bill 2012–13 (it received a first reading on 16 May 2012 but a second reading was not scheduled and it failed to progress).

Skipton Fund

The government set up a scheme for haemophiliacs to be compensated for being given contaminated blood. The Skipton Fund handles claims.[46] An inquiry into the circumstances surrounding the supply to patients of contaminated blood and blood products was established under the chairmanship of Lord Archer of Sandwell to look at the consequences to the haemophilia community and others afflicted and to suggest further steps to address their needs. Lord Archer's report was published in February 2009 and the government published its response in May 2009.[47] The government did not support the recommendation to set up a statutory committee to advise on the management of haemophilia, preferring to build on the existing UK-wide partnership of the Haemophilia Alliance. A commitment was made to provide £100,000 per annum funding to the Haemophilia Society for five years.

The Caxton Foundation, a government-funded charity set up in 2011 provides financial assistance to individuals in England who have been infected with the hepatitis C virus as a consequence of receiving NHS treatment using contaminated blood. Further information can be found on its website.[48] To be eligible for support a person must be or have been registered with the Skipton Fund. Criticisms were made of the Caxton Foundation about its breaches of confidentiality and inadequate care of claimants.[49]

Organ transplantation

Transplants from deceased persons

The Human Tissue Act 2004 covers the use of organs from living or dead donors.

Practical Dilemma 16.4 A transplant opportunity?

A youth of 23 years is knocked down in a road traffic accident. He has no identification on him and appears to be unaccompanied. He is brought into hospital by the ambulance crew and is resuscitated. He is maintained on the ventilator, but the prognosis is poor. Transplant teams are anxious to remove his lungs, heart, kidneys and liver and an ophthalmologist would like to make use of his eyes. The police are asked to notify the relatives as soon as possible. They are advised by the surgeon that the organs should be removed within half an hour of death. The youth is kept on a positive pressure ventilator. Can his organs be used for transplant on diagnosis of death before the relatives are contacted? What difference would it make if he were found to be carrying a donor card?

The Human Tissue Act 2004 now applies to the situation in Practical Dilemma 16.4. The procedure relating to the diagnosis and certification of death (see chapter 29) must be followed. Death must be certified by registered medical practitioners who are not connected with the transplant team. Where the dying person has not indicated his wishes, then any person whom he has nominated to act on his behalf can give consent to the organ donation. The nomination can be oral or in writing, with stipulations about witnesses and only adults can be nominees. Where there has been no such nomination, then a person in a qualifying relationship such as a partner or other relative or friend can give consent. Section 27(4) of the Act sets out a hierarchy of persons who are defined as in a qualifying relationship, beginning with spouse or partner and ending with friend of long standing. If there is no donor card or if the dying person has not registered as an organ donor nor made a nomination, then the person in a qualifying relationship must be contacted. If, however, the dying person has been registered as an organ donor with the NHS organ donor register[50] or is carrying a donor card, then that would count as a valid consent for the removal of the organs.

Keeping the patient ventilated

Section 43 of the Human Tissue Act 2004 states that where part of a body (i.e. of a deceased person) lying in a hospital, nursing home or other institution is or may be suitable for use for transplantation, it shall be lawful for the person having the control and management of the institution:

(a) to take steps for the purpose of preserving the part for use for transplantation, and
(b) to retain the body for that purpose.

However, the authority given under this section only extends to the taking of the minimum steps necessary for the purpose mentioned in that provision, and to the use of the least invasive procedure. The authority can include that of the coroner.[51] Once it has been established that consent making removal of the part for transplantation lawful has not been, and will not be, given, then the authority under this section ceases to apply.

Transplants from living donors

Special provisions apply to a situation where a potential donor is alive, as Practical Dilemma 16.5 illustrates.

Practical Dilemma 16.5 Live donation

A nurse cares for a renal patient aged 23. She has been on dialysis for a number of years, but has been advised that a kidney transplant is urgently required. Her mother has offered to be a donor and seeks the advice of the nurse over whether such an offer would be accepted.

Under section 33 of the Human Tissue Act 2004 it is a criminal offence to remove any transplantable material from the body of a living person intending that the material be used for the purpose of transplantation. However, in certain circumstances approval can be given by the Human Tissue Authority to the transplantation of organs (or part of organs), bone marrow and peripheral blood stem cells from living persons. Regulations drawn up under the Human Tissue Act specify the strict conditions which must be satisfied.[52] The prohibition on transplants from a live donor is lifted under Regulation 11 if specific conditions are satisfied. The conditions which must be satisfied include the following.

1 A registered medical practitioner who has clinical responsibility for the donor must have caused the matter to be referred to the Human Tissue Authority.
2 The Authority must be satisfied that no reward has been or is to be given and consent has been given for the removal of the transplantable material or it is otherwise lawful.
3 The Authority must take into account the report of the interviews with the donor (or person who gave consent) and the recipient when making its decision.
4 The authority must give notice of its decision to:
   (a) the donor (or any person acting on his behalf);
   (b) the recipient (or any person acting on his behalf); and
   (c) the registered medical practitioner who referred the matter to the Authority.
5 One or more qualified persons must have conducted separate interviews with each of the following:
   (a) the donor;
   (b) if different from the donor, the person giving consent; and
   (c) the recipient;

and (unless the transplant is the result of a court order) reported to the Authority on the following matters:

(a) any evidence of duress or coercion affecting the decision to give consent;
(b) any evidence of an offer of a reward; and
(c) any difficulties of communication with the person interviewed and an explanation of how those difficulties were overcome.

6 The following matters must be covered in the report of the interview with the donor and, where relevant, the other person giving consent:

(a) the information given to the person interviewed as to the nature of the medical procedure for, and the risk involved in, the removal of the transplantable material;
(b) the full name of the person who gave that information and his qualification to give it; and
(c) the capacity of the person interviewed to understand:
  (i) the nature of the medical procedure and the risk involved, and
  (ii) that the consent may be withdrawn at any time before the removal of the transplantable material.

7 A person is qualified to conduct an interview if:

(a) he appears to the Authority to be suitably qualified to conduct the interview;
(b) he does not have any connection with any of the persons to be interviewed, or with a person who stands in a qualifying relationship to any of those persons, which the Authority considers to be of a kind that might raise doubts about his ability to act impartially; and
(c) in the case of an interview with the donor or other person giving consent, he is not the person who gave the information to those people.

In Practical Dilemma 16.5 the mother of the renal patient should make known her intention to the doctor in charge of the patient, who can ensure that the appropriate referral is made to the Human Tissue Authority and the procedure would then be set in place. She may of course not prove to be a match. However, it is possible for her to take part in a paired or pooled donation. In October 2007 there was a report of a paired donation, i.e. twinned kidney transplant between couples, where a potential donor from couple A was matched with a recipient from couple B and the partner of the recipient was matched with the partner of the donor A. It is therefore possible for the mother to be matched with another recipient whose relative was a potential donor and match for her child. Regulation 13 requires that where the donor is a child, an adult who lacks the capacity to give consent or the case involves a paired donation, pooled donation or non-directed altruistic donation, then a panel of no fewer than three members of the Human Tissue Authority must make the decision on whether approval should be given. Procedures are in place for requiring the HTA to review its decision over a transplant (Regulations 13 and 14). Transitional provisions covered organ transplants between genetically related persons.[53]

It was reported in November 2013 that a hospital in Colombo, Sri Lanka was offering kidney transplants to UK patients despite the law banning the sale of human organs.[54]

Dispute over resources is holding back the possibility of hand transplants. Clinical Commissioning Groups are refusing to finance the operations, claiming that it is the responsibility of NHS England which pays for specialist care.[55]

Transplant and consent by the recipient provisions

Transplants and children

The principles of consent (considered in chapter 7) apply to the recipient of the transplant. If the person is mentally competent and over 18 years, then they can give consent or refuse. If the person is under 18 years, then the principles that are discussed in chapter 13 on children apply. In the following case, the mother consented to the child's transplant, but the child refused.

Case 16.1 *Re M (Medical Treatment: consent)* (1999)

Child refusing a transplant[56]

A 15-year-old girl refused to consent to a transplant that was needed to save her life. She stated that she did not wish to have anyone else's heart and she did not wish to take medication for the rest of her life. The hospital, which had obtained her mother's consent to the transplant, sought leave from the court to carry out the transplant.

The court held that the hospital could give treatment according to the doctor's clinical judgement, including a heart transplant. The girl was an intelligent person whose wishes carried considerable weight, but she had been overwhelmed by her circumstances and the decision she was being asked to make. Her severe condition had developed only recently and she had had only a few days to consider her situation. While recognising the risk that for the rest of her life she would carry resentment about what had been done to her, the court weighed that risk against the certainty of death if the order were not made.

In contrast to Case 16.1 when Hannah Jones, who was terminally ill with leukaemia, refused a heart transplant on the grounds that she would prefer to die with dignity, her parents respected her wishes and, despite doctors reporting the case to the child protection officers, no application was made to court to enforce a transplant. After interviewing the child, the child protection officer accepted that her wishes should prevail.[57] It was subsequently reported that she had changed her mind and agreed to go on to the waiting list.[58] Similarly, Liam Gawthorpe who was born with a heart defect and pulmonary hypertension, refused a heart and lung transplant when he was 11 years old and again when he was 18 because he wanted to enjoy the time he had left. His parents accepted his wishes.[59]

Transplants from mentally incapacitated persons

Where a transplant from a mentally incompetent person is being considered and the person is unable to give consent, the sole question for the courts is what is in the interests of the donor. This situation arose in the American case of *Hart* v. *Brown* where the donor and recipient were identical twin girls. The court approved the parental request to transfer a kidney from one to the other. One of the main justifications was that, medically, such a graft was more likely to be successful and another justification was that, if they refused to allow the donation, the donor might, in later life, feel guilty at not being allowed to be a donor.[60] In another American case (*Strunk* v. *Strunk*),[61] a kidney transplant was authorised to proceed from an institutionalised adult with the mental capacity of a 6-year-old to his brother who was terminally ill with kidney trouble. The court accepted the medical evidence that there was a strong emotional bond between the brothers and the mentally incompetent person would suffer a severe traumatic experience if the brother died.

In England, the courts have discussed whether a mentally and physically impaired younger sister could give bone marrow to her older sister who was suffering from a serious blood condition.[62] The court held that it was in the younger sister's best interest for her to give bone marrow to her older sister and the risks to her were minimal. The important issue was that it is the interests of the donor that have to be considered, not the interests of the recipient. It can be a criminal offence for parents to fail to take appropriate action for the care of their children.

The situation of transplants from a person lacking the requisite mental capacity is now covered by the Human Tissue Act 2004 and the Regulations made under that Act.[63] The transplant could only take place if it were clearly in the best interests of the proposed donor and if it were approved by a panel of at least three members of the Human Tissue Authority.

Liability arising from transplants

Practical Dilemma 16.6 Diseased organs

A patient received a kidney transplant and was subsequently told that it was HIV-infected. It was discovered that this was unknown to the doctors and family of the deceased patient. Does the patient who received the kidney have any rights of action?

In the above situation, there is a duty of care, according to the reasonable professional standard for the transplant team, to ensure that the kidney is reasonably safe for transplant. In determining whether this duty of care had been fulfilled, note would be taken of the timescale within which any tests would have to take place. The possibility of the patient being able to sue under the Consumer Protection Act 1987 depends on whether the organ could be defined as 'goods' under that Act and whether the transaction could be seen as in the course of business. Since the Human Organ Transplant Act 1989 (now consolidated in the Human Tissue Act 2004) prohibits commercial dealings, it could be argued that organ transplantation is not in the course of business. However, the activities of hospitals and health organisations would be defined as in 'the course of business'. National heart and lung transplant standards have been published by the National Specialist Commissioning Advisory Group[64] in 2006 to ensure that patients receive services that match the evidence on best care available. These standards replace those issued in September 2002. A businessman claimed £14 million compensation from an NHS trust when an operation for him to donate a kidney to his father went wrong, causing catastrophic damage to his remaining kidney. The NHS trust accepted liability, but disputed the damages claimed which the victim said were loss of earnings because he was unable to set up a pharmaceutical market research company.[65] He was awarded £6.7 million in damages.

Other concerns which are considered in chapter 29 include the decision not to resuscitate a patient and consent for the use of organs and tissues and in what circumstances machines can be switched off.

The EU Organ Donation Directive has been written into UK law through the Quality and Safety of Organs intended for Transplantation Regulations 2012[66] which were amended in 2014.[67] Each transplant unit and the NHSBT are required to have a licence to perform any of the activities regulated under the 2012 regulations which cover procurement activities and transplantation activities. For further details see the Organ Donation and Transplantation website.[68] Under the regulations it is a statutory duty to report a serious adverse event and adverse reaction (SAEAR) to the NHSBT. Further information can be found on the organ donation website.[69]

Encouraging donors

The government launched *Saving Lives, Valuing Donors* in July 2003 which was a 10-year framework to encourage people to donate organs and tissues. The progress was reviewed in 2004.[70] This was followed by many initiatives governmental as well as personal to increase the number of organs available for donation, including the appointment of a task force by the Department of Health to investigate improvements to the transplant services reported in January 2008.[71] It made recommendations on increasing the number of transplant coordinators, strengthening the network of retrieval teams, identifying potential donors sooner and mandatory training of critical care staff. The taskforce rejected the option of presumed consent for organ donation. The Nuffield Council on Bioethics published a consultation paper in April 2010 which explored ways of encouraging organ and tissue donation. Other suggestions came from research at the John Radcliffe Hospital in Oxford which suggested that requests for donations were more likely to be successful when the request was separated from the announcement of death and when a transplant coordinator accompanied the doctor.

The Welsh Assembly government took the decision in 2010 to introduce 'presumed consent' to organ donation[72] and in 2013 Wales became the first country in the UK to introduce a system of presumed consent for organ donation.[73] The Act imposes upon Ministers in Wales the duty to promote transplantation, and it provides that in the absence of express provision in relation to consent, consent will be deemed to have been given in most cases. Deemed consent does not apply to those under 18 years, those who have lived in Wales for less than one year, and people who lacked capacity to understand that consent could be deemed in the absence of express consent. Doctors will therefore have the right to remove people's organs when they die unless they have registered an objection. Its introduction will be studied carefully in the rest of the UK to analyse its effect on the numbers of organs available for transplant and upon public opinion.

Waiting lists for kidney donors may be reduced as a result of recent research which suggests that kidneys from dead donors may be viable.[74] Provided that kidneys can be transplanted within 12 hours from non-heart-beating donors, they are as safe and as effective as those from someone whose heart is still beating but is brain-dead.

In 2013 a Facebook campaign led to a 21-fold rise in those signing up as organ donors.[75] Since its launch in May 2013 almost 1 million more people have joined the donor register. Facebook users are encouraged to describe themselves as organ donors. A suggestion that people should be able to jump the queue for a transplant if they are on the organ donor register to boost donation rates among ethnic minorities was made by Dr Sharif, a kidney consultant at Queen Elizabeth Hospital Birmingham.[76]

Retention of organs

Considerable public concern was raised when it was learnt that human organs from children who had died had been retained at Bristol Royal Infirmary. New guidance was considered necessary when, during the inquiry into allegations of professional misconduct in carrying out paediatric heart surgery, it was learnt that more than 11,000 children who had died in the past 40 years had had their organs used for research in British hospitals without the explicit consent of their parents.

At the same time, concerns were raised about the retention of human brains and spinal cords at the Walton Centre, Liverpool, and of children's organs at Alder Hey Hospital. The Report of the Royal Liverpool's Children's Inquiry (chaired by Michael Redfern QC)[77] on the retention of organs and body parts was published on 30 January 2001. Its publication coincided with three other publications:

1. A report of a census of organs and tissues retained by pathology services in England carried out by the Chief Medical Officer.[78]
2. The removal, retention and use of human organs and tissue from post-mortem examination: advice from the Chief Medical Officer.[79]
3. Consent to organ and tissue retention at post-mortem examination and disposal of human materials.[80]

The inquiry found that thousands of children's body parts had been collected at the hospital, some going back to before 1973. Most, however, were retained after 1988 when Professor Richard Van Velzen was appointed to the Department of Pathology and there was a huge increase in the number of organs removed and retained.

In response to the Redfern Report, the Secretary of State set up a Retained Organs Commission under the chairmanship of Professor Margaret Brazier. It was a special health authority which had the responsibility of overseeing the return of tissues and organs from collections around the country, ensuring that collections were accurately catalogued, providing information on collections throughout the country, ensuring that suitable counselling was available, acting as an advocate for parents if problems arose, advising on good practice in this area and handling enquiries from families and the public. On completion of its work it ceased to exist in March 2004.

Legal action by parents who had suffered as a result of the removal and retention of organs from their dead children in a group litigation action was initiated and the court agreed that the legal costs would be capped at £506,500.[81] On 26 March 2004 the High Court ruled, in respect of three test cases, that where hospitals had illegally removed the organs in post-mortem examinations without the parents'

consent, parents could claim damages if they had suffered psychological injury.[82] Damages of £2,750 were awarded in one of the test cases; the other two lost.

As a consequence of these developments the Human Tissue Act 2004 was passed which made it an explicit requirement that the informed consent of the parents or relatives must be obtained for the post mortem to be carried out (unless required by a coroner) and for the removal and retention of organs or tissues and the introduction of criminal offences for failure to obey the laws. These are discussed below.

'Human Bodies, Human Choices'

A consultation paper, 'Human Bodies, Human Choices', was published in July 2002,[83] which invited feedback on the principles to apply to the removal, retention and storage and use of organs. It was followed by proposals for new legislation on human organs and tissue, which were published in September 2003.[84]

Human Tissue Act 2004

The Human Tissue Act 2004 gave legal effect to the recommendations of the consultation paper and to the European Tissue Directive,[85] which was implemented in 2007.[86] The Act regulates the removal, storage and use of human organs and other tissues for specified purposes, specifies the appropriate consent for children and adults; creates a criminal offence in relation to the removal without appropriate consent; establishes a Human Tissue Authority and a licensing regime, arranges for the publication of codes of practice and sets up inspectorates for anatomy and pathology and of organ and tissue for human use. In addition, it makes provision for the use of DNA and creates an offence relating to non-consensual analysis of DNA, with specified exceptions. The government did not support any legal change to allow a person's organs to be donated automatically on their death unless they or their family had specifically asked otherwise, i.e. presumed consent for organ donation was not included in the Act. However, the Chief Medical Officer of the DH called in July 2007 for the introduction of an 'opt-out' system and a review was carried out. Further information is available from the website[87] of the Human Tissue Authority on which the codes of practice can be found.

In May 2007 a man became the first person to be convicted under the Human Tissue Act for trying to sell his kidney on line for £24,000 in order to pay for his gambling debts.[88]

Intensive care units: resource pressures

There is national concern over the pressure placed on intensive care beds, often highlighted during flu epidemics. Thus in the winter of 2003/4 a warning was given by the Intensive Care Society in its report *Critical Insight* that critical care units across the country would face an inevitable bed shortage as the flu season began.[89]

An Audit Commission report[90] on intensive care units pointed out: 'It does not make sense to respond to pressures created in cheaper areas of the hospital by increasing the number of the most expensive beds.' The report found that critical care beds were not always used appropriately and 'critical care units can become the backstop of a poorly performing hospital'. It gave as an example of inappropriate use the fact that almost one-third of hospitals place extra strain on critical care beds, and bear unnecessary extra costs, by nursing patients with epidurals for pain relief after major surgery within critical care units. The Audit Commission report found that there were great variations in the resources deployed: 'Some units employ twice as many nurses as others have in order to have, for example, five direct care "bedside" nurses on duty at any time . . . Yet the cost of neither nurses nor doctors is related to mortality differences between units.' It suggests that there should be national research to record more scientifically the benefits offered by one-to-one nursing. The Intensive Care Foundation was founded in 2003 by the Intensive Care Society to facilitate and support the highest quality collaborative care

research in the UK. Further information on its activities and also of the role of the Intensive Care Society can be found on the latter's website.[91]

Practical Dilemma 16.7 Inadequate staffing

During a flu epidemic, there was considerable pressure on ITU beds and operations were being postponed because of the inability to offer patients follow-up in ITU. During this crisis, an extra bed was used in ITU, although the staffing numbers were not increased. Sarah Roberts was attempting to look after her own patient as well as cover for another patient, when the nurse was on break. Unfortunately, she administered the wrong dose of a drug and the patient died.

Sarah could face criminal proceedings for acting with a lack of professional care. If it can be shown that she is guilty of such gross professional recklessness and negligence that it amounts to a criminal offence, she could be found guilty of the manslaughter of the patient. Account would be taken of the pressure she had been placed under and the extent to which she had fulfilled her professional duty to the NMC under its Code of Professional Conduct by drawing the crisis situation to the notice of senior management and taking other appropriate action. (The legal issues relating to resources are considered in chapter 4.)

Review of critical care services

Following the Audit Report, an expert group was set up to review critical care services. Its report,[92] *Comprehensive Critical Care*, was published in 2000 along with a review of adult critical care nursing.[93] The Comprehensive Critical Care Report recommended a modernisation programme to develop consistent and comprehensive critical care services. Four levels of care were identified:

Level 0 normal acute ward care
Level 1 acute ward care, with additional advice and support from critical care team
Level 2 more detailed observation or interventions, e.g. patients with a single failing organ system
Level 3 advanced respiratory support alone or basic respiratory support together with support of at least two organ systems.

The report highlighted the need for action in four areas:

1. a hospital-wide approach to critical care
2. a networked service
3. workforce development
4. better information with all critical care services, collecting reliable management information and participating in outcome-focused clinical audit.

In 2013 NHS England published detailed plans to meet increases in demand for critical care service. It aimed to coordinate a strategic response to increasing demand and capacity pressures in critical care during winter months. It is available on its website.[94]

Other major concerns of relevance to the intensive care nurse include definition of the scope of her professional practice. The DH launched a document called the *Recruitment and Retention of Staff in Critical Care* on 4 June 2004. This is considered in chapter 24 and the same basic principles that are discussed there apply to the intensive care nurse. Other aspects relating to death are considered in chapter 29. A telephone survey was conducted by the RCN[95] that provided an analysis of the role of the nurse in intensive care and illustrated considerable differences in the functioning of nurses in ICUs and considerable flexibility of roles between doctors and nurses. These findings were confirmed by the report of the Audit Commission, which is considered above. In 2003 RCN published guidance on nurse

staffing in critical care which includes consideration of the measuring of patient dependency, the role of critical care nurses, supervisory shift leaders, flexible working and other significant issues.[96] It has also published information on staffing levels for children's services, including paediatric intensive care[97] and in 2007 provided guidance on safe nurse staffing levels in critical care.[98]

In 2008 the DH (in conjunction with representatives from the British Association of Critical Care Nurses, the Intensive Care Society, the Intercollegiate Board for Training in Intensive Care Medicine and the Royal College of Nursing Critical Care Forum) published guidance on the role of an advanced critical care practitioner. It covers: how the role should function within the critical care team; the benefits of introducing the role in clinical practice; and a national framework of education and competence for the role within recognised standards of practice. It also published a National Education and Competence Framework for assistant critical care practitioners. Both documents are available on the DH website. Several universities offer a Masters Course in Advanced Critical Care Practice. Information on the national association of critical care practitioners is available on the website for the Faculty of Intensive Care Medicine.[99]

Conclusions

It is inevitable that standards in acute care will be one of the main areas of litigation. In addition, the work within operating theatres and the efficiency of surgical wards are central to any major success in the reduction of waiting lists and the decrease of litigation. Standards across all health service areas are subject to inspection by the Care Quality Commission (CQC) and all staff must be aware of recommendations from the National Institute for Health and Care Excellence. Significant changes have resulted from developments in the scope of professional practice of the nurse and from the recognition of the operating practitioner as a health professional registered under the Health Professions Council. The Human Tissue Act 2004 has made significant changes to the laws relating to many of the issues covered in this chapter. The shortage of organs for transplant continues to be of major concern and the effect of the law in Wales which presume consent to donation will be closely watched. The proposal that the HTA should be amalgamated with the Human Fertilisation and Embryology Authority (HFEA) into the Regulatory Authority for Tissue and Embryos (RATE) was dropped by the Government following criticism by the Joint Parliamentary Scrutiny Committee reviewing the Human Fertilisation and Embryology (Draft) Bill (see chapter 22). However, the review of arm's-length bodies has recommended that eventually both the HFEA and the HTA should be reorganised, with their functions being transferred to the CQC or the Health and Social Care Information Centre.[100] For the present they remain as separate organisations.[101]

Reflection questions

1 How do the provisions of the Health and Safety at Work Act (see chapter 12) affect the theatre manager?

2 Procedures do not provide the solution to every eventuality. In what circumstances do you consider a nurse would be justified in deviating from a specified procedure (see chapter 3)?

3 How do the basic principles of consent to treatment affect the work of the surgical ward and theatre nurse (see chapter 7)?

4 What are the main provisions of the Human Tissue Act on the law on consent to donate organs? What are the advantages and disadvantages of introducing an opt-out system?

5 Examine the role of the consultant nurse in ITU. What safeguards should exist to protect the patient?

Further exercises

1. Look back over the records that you have made on a patient who was in hospital several weeks before. If you were now to be challenged on any aspect of your care in that case, how useful and comprehensive would your notes be? Are there any obvious gaps on which you should have kept a record and are there any faults in the record keeping? (Refer to chapter 9.)
2. How do the principles relating to the scope of professional practice affect the nurse working in the areas considered in this chapter (see chapter 24)?
3. Obtain a copy of the incident book that is kept in the theatre in which you work and consider how some of these incidents could have been avoided.
4. Access the NPSA website[102] and study their hazard reports on incidents in operating theatres. To what extent is your department taking all appropriate steps to prevent such occurrences?
5. Over a period of 2 weeks, list the legal problems that you have encountered in your work in an intensive care unit or transplant unit and refresh your memory of the basic principles of accountability.
6. Relatives often have very fixed views on the outcome they wish for the seriously ill patient. Prepare a short paper outlining the basic principles of consent that apply in order to clarify the situation for relatives. Refer to the Mental Capacity Act 2005 (see chapters 7 and 29).

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Chapter 17
Learning disabilities

This chapter discusses

- Acting in the best interests of a mentally incapacitated adult
- Deprivation of Liberty Safeguards (DoLS) (Bournewood)
- Carers
- Court of Protection and Code of Practice
- White Paper *Valuing People*
- Safeguarding vulnerable adults
- Sexual relations and related issues
- Property
- Direct payments
- Registration and inspections

Introduction

While some persons with learning disabilities may also suffer from a mental disorder (just as they might have physical disabilities and illnesses and come under the chapters on gynaecology (chapter 15) or acute care (chapter 16)), the definition of mental disorder in the Mental Health Act 1983 (as amended by the 2007 Act) excludes learning disabilities on its own. Only if the learning disability is associated with abnormally aggressive or seriously irresponsible conduct on the person's part will it come within the statutory definition of mental disorder and could lead to detention under the Mental Health legislation. Mental Disorder is considered in chapter 20. The NMC has published guidelines for learning disabilities nursing.[1] Those with learning disabilities have exactly the same rights as others. If they are assessed as having the requisite mental capacity to make a specific decision, then they have the right of

autonomy or self-determination. Where a person with learning disabilities also has a mental illness, then he or she may come within the provisions of the Mental Health Act 1983. Where a person with learning disabilities lacks the requisite mental capacity to make a specific decision, then he or she would come under the provisions of the Mental Capacity Act 2005. People with learning disabilities can also rely upon the rights set out in the European Convention on Human Rights (see the website of this book). The Equality Act 2010 is discussed in chapter 10 and recognises many of the rights set out in the United Nations Convention on the rights of persons with disabilities (signed in 2006) which is available on the internet.[2] The topics discussed in this chapter are shown above.

Acting in the best interests of a mentally incapacitated adult

Case 17.1 *In re F (Adult: Court's jurisdiction)* (2000)

Care of incapable adults at risk of harm[3]

T, an 18-year-old girl with an intellectual age of 5–8 years, lacked the capacity to make decisions about her future. The local authority sought to invoke the inherent jurisdiction of the court under the doctrine of necessity to obtain directions as to where T should live and to supervise her contact with her natural family, principally her mother. The mother challenged the power of the court to make such a ruling, on the grounds that its former *parens patriae* jurisdiction had lapsed in 1959. The Court of Appeal held that in the present conflict, where serious questions hung over the future care of T if returned to her mother, there was no practicable alternative to intervention by the court.

In Case 17.1 it was held that it was essential that T's best interests should be considered by the High Court and there was no impediment to the judge hearing the substantive issues involved in the case. Lord Justice Sedley specifically stated that this conclusion did not conflict with the European Convention for the Protection of Human Rights and Fundamental Freedoms[4] (see the website of this book). The House of Lords in the *Re F* (1989)[5] case recognised the powers that existed at common law which enabled professionals and carers to make decisions on behalf of those lacking the mental capacity to make decisions in their best interests. In a third case,[6] a young man (S), born in 1984 with velo-cardio-facial syndrome with severe global developmental delay and bilateral renal dysplasia, was assessed as having a cognitive functioning age of about 5–6 years. His dialysis catheter became infected and there was concern over what treatment would be in his best interests. The President of the Family Division, Dame Elizabeth Butler-Sloss, held that:

- The fundamental principle of the sanctity of life was of particular relevance in this case where the existing and proposed treatment options were crucial to sustain S's life.
- As S lacked capacity to make decisions about his medical treatment and there was disagreement between S's family and the treating clinicians, it was the duty of the court to decide, in an exercise addressing medical, emotional and all other welfare issues, what was in his best interests.
- Just because a person could not understand treatment it was wrong to say that he could not have it: it was crucial that S, who suffered from serious mental in addition to physical problems, should not be given less satisfactory treatment than a person who had full capacity to understand the risk, pain and discomfort inseparable from major surgery.
- It was in S's best interests that he should continue to receive dialysis as long as some form of that treatment was working and providing him with a reasonable quality of life; when haemodialysis was no longer effective, he should move to peritoneal dialysis; dialysis via an arteriovenous fistula should

not be ruled out but should be considered in consultation with learning disability experts once S had settled into the adult renal unit and an adult way of life; a kidney transplant should not now be carried out as it was not clear that he would enjoy a longer lifespan with a transplant; but if, in future, medical reasons were in favour of a transplant, it should not be rejected on the grounds of S's inability to understand the purpose and consequences of the operation or concerns about his management.

These three cases preceded the implementation of the Mental Capacity Act 2005 which replaced the common law by statutory provisions for decision making on behalf of those mentally incapacitated adults who were unable to make their own decisions.

Mental Capacity Act 2005

This Act, which came fully into force in October 2007, provides a statutory definition of capacity and sets out the steps to be taken in determining the best interests of a person who lacks the requisite mental capacity (see chapter 7). It requires, in the absence of informal carers or others who can be consulted about a person's best interests, an independent mental capacity advocate (IMCA) to be appointed where decisions relating to serious medical treatment, accommodation or protection measures are being considered. (In the latter case, an IMCA must be appointed even if there are informal carers.) In 2014 the Court of Protection ruled that a woman suffering from autistic spectrum disorder and borderline learning difficulties lacked the capacity to make her own decisions and that physically invasive medical procedures, i.e. a Caesarean, were in her best interests. She had already had five children who were in care and her third child who was born secretly at home was believed to have been fed on packet soup for his first week and was in a dehydrated and malnourished state when taken into care.[7]

In determining the capacity of a person with learning disabilities it must be emphasised that the capacity to consent must be related to the actual decision being made, that acquiescence does not necessarily mean consent and that if capacity is considered to be lacking then the decision must be made in the best interests of the person.

Restraint

Under the Mental Capacity Act 2005 restraint can only be used where a person reasonably believes that it is necessary to do so in order to prevent harm to the person who lacks the requisite mental capacity and where the act of restraint is a proportionate response to (a) the likelihood of P's suffering harm, and (b) the seriousness of that harm. As a consequence of amendments to the Mental Capacity Act 2005 introduced by the Mental Health Act 2007, safeguards have been introduced where a person lacking the requisite mental capacity is deprived of his or her liberty. These were introduced as a result of the decision of the European Court of Human Rights in the Bournewood case (see page 464). (See also the discussion on restraint in chapter 19 in relation to the elderly and in chapter 20 in relation to the mentally disordered.)

In a case (*LA* v. *A* page 477 ref 81) concerning a married couple, both with learning disabilities, who were opposed to contraception, the local authority sought a declaration that Mrs A lacked capacity to decide whether to use contraception and that it would be in her interests to be required to receive it. The judge ruled that she lacked the capacity to make a decision about contraception, that her refusal was not the product of her own free mind and that she lacked the ability to use or weigh the information given to her. He refused, however, to make a declaration that it was in her best interests for contraception to be given to by force, and quoted from Lady Hale in the case of *R* v. *Broadmoor Special Hospital Authority*[8] where she had stated that where an incapacitated person was actively opposed to a course of action, 'the benefits which it holds for him will have to be carefully weighed against the disadvantage of going against his wishes, especially if force is required to do this'.

Case 17.2 *ZH (A protected party) v. Commissioner of Police of the Metropolis, Liberty and another intervening* (2013)

Restraint of an autistic boy was inhuman[9]

The Court of Appeal held that physical restraint of a vulnerable teenage boy who was autistic, epileptic and lacked understanding of what was happening to him, carried out by police officers with handcuffs and leg restraints, and his detention in a cage in a police van, were capable of constituting inhuman or degrading treatment contrary to Article 3 and a deprivation of liberty in breach of Article 5 of the European Convention on Human Rights. The boy had been taken by carers to the local swimming baths. He became fixated by the water and did not move. The manager called the police. The boy was still standing beside the pool, but jumped in fully clothed when the police arrived. He was removed from the water by lifeguards and the police took him into custody as described above. The restraint and detention lasted about 45 minutes.

The Bournewood case

The House of Lords in the Bournewood[10] case considered the question of whether a mentally incapacitated person, incapable of giving consent to admission, could be held at common law in a psychiatric hospital and not placed under the Mental Health Act 1983 (see Case 17.3). It decided that section 131 of the Mental Health Act 1983 did not require a mentally disordered person to have the capacity to consent to admission as an informal patient. However, the application against this decision to the ECHR succeeded and the UK government was required to introduce changes. The result was that the Mental Capacity Act 2005 was amended to make provision for the restriction of liberty of such persons (which are known as the Deprivation of Liberty Safeguards (DoLS)).

Case 17.3 *L v. United Kingdom* (2004) (The Bournewood case)

Lack of capacity to consent to admission[11]

L, an adult with learning disabilities, was informally admitted to a mental health unit. He was not detained under the Mental Health Act 1983. His carers asked for his discharge, but his psychiatrist considered that it was not in his best interests to be discharged and that he should remain in hospital. The carers challenged the legality of this decision. They lost in the High Court, but the Court of Appeal held that section 131 of the Mental Health Act required a person to have the mental capacity to agree to admission; a person lacking the requisite capacity should be examined for compulsory admission under the Act. The House of Lords upheld the appeal of the NHS trust, holding that an adult lacking mental capacity could be cared for and detained in a psychiatric hospital, using common law powers. Subsequently, an application was made to the ECHR, which held that there was a breach of his Article 5 right to liberty.

As a consequence of the Bournewood case, changes to the law were necessary to ensure compliance with the Human Rights Act 1998 (see chapter 1). Article 5 of the European Convention on Human Rights, which is set out in Schedule 1 in the Human Rights Act 1998, states:

> **Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.**

Included in the 'following cases' under (e) are 'persons of unsound mind'. However, the fact that mentally incapacitated adults could under the House of Lords' Bournewood ruling be detained without being placed under the Mental Health Act 1983 was not a procedure prescribed by law. The Bournewood amendments to the Mental Capacity Act 2005 were therefore necessary to provide protection for such persons when a restriction of liberty was required in their best interests.

Deprivation of Liberty Safeguards (DoLS) (Bournewood)

The Mental Health Act 2007 amended the Mental Capacity Act 2005 to introduce the safeguards necessary to justify loss of liberty of residents in hospitals and care homes. These are known as the Deprivation of Liberty Safeguards (DoLS). The DoLS regulations came into force on 3 November 2008[12] together with the regulations relating to the appointment of the relevant person's representative.[13] The DoLS safeguards are set out in the new Schedule A1 to the Mental Capacity Act as introduced by the Mental Health Act 2007 and can be found in a briefing paper available from the Department of Health.[14] The following situations should be kept distinct:

(a) Where a patient requires treatment for mental disorder, an application should be made under the Mental Health Act 1983 as amended by the 2007 Act.
(b) Where a patient is suffering from mental disorder and requires restriction of his or her liberty for which detention under the Mental Health Act is inappropriate, then DoLS applies.
(c) Where a person lacks the mental capacity to make his or her own decisions, the Mental Capacity Act applies and limited restraint may be used (see chapter 19).

Who is covered by the Deprivation of Liberty Safeguards?

- Those over 18 years
- Those who suffer from a disorder or disability of mind (as defined in the Mental Health Act 1983) (see chapter 20)
- Those who lack the capacity to give consent to the arrangements made for their care and
- Those for whom such care (in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights) is considered after an independent assessment to be a necessary and proportionate response in their best interests to protect them from harm.

The DoLS Code of Practice published by the Ministry of Justice[15] sets out the circumstances where the use of the Deprivation of Liberty Safeguards may be indicated in the following circumstances:

- Where restraint is used to admit a person or to prevent their leaving
- Where movement is controlled for a significant period
- Where a request for discharge by relatives is refused
- Where an individual is prevented from having social contact because of restrictions placed on access by others
- Where continuous supervision and control has led to a loss of autonomy by an individual.[16]

What procedures are required?

1 Application for authorisation

The care home, i.e. the managing authority, must identify a client/patient as lacking capacity and who risks being deprived of his/her liberty. It must apply to the supervisory body, i.e. the local authority in which the client/patient was ordinarily resident or the clinical commissioning group, for the authorisation of deprivation of liberty.

2 Assessments required

1 Age assessment – client/patient must be over 18 years.
2 Mental health assessment – client/patient must be suffering a mental disorder.
3 Mental capacity assessment – client/patient must lack the capacity to decide whether to be admitted to or remain in the hospital or care home.
4 Eligibility assessment – the client/patient must:
   (a) Not be detained under the Mental Health Act
   (b) Not be subject to a conflicting requirement under the Mental Health Act
   (c) Not be subject to powers of recall under the Mental Health Act
   (d) Not be subject to a treatment order in hospital to which the client/patient objects.
5 Best interests assessment – the authorisation would be in the client/patient's best interests and is a proportionate response to the likelihood of suffering harm and the seriousness of that harm.
6 There is no conflict between the authorisation sought and a valid decision by a donee of a lasting power of attorney or a deputy, nor with a valid and applicable advance decision made by the client/patient.

3 Appointment of representative for the client/patient

If the best interests assessor concludes that the client/patient has the capacity to appoint his/her own representative, then he/she can do this. Otherwise the best interests assessor can appoint a representative. If the assessor notifies the supervisory body that a representative has not been appointed for him/her then it can appoint a representative who can be paid to act as the client's/patient's representative.

4 Authorisation granted

If all the assessments are satisfactory then authorisation by the supervisory body can be granted for the deprivation of the client's/patient's liberty for up to 12 months. An urgent authorisation can be issued for a maximum of 7 days where the standard authorisation cannot be made and it is necessary in the best interests of the person to be deprived of his or her liberty.

5 Review and monitoring

The supervisory authority should keep under review the client's/patient's deprivation of liberty and the whole process of the assessments and authorisation will be monitored to ensure that all the required procedures were followed.

The DoLS were first considered by the court in the case of *GJ* v. *the Foundation Trust*.[17] In this case the court had to consider whether GJ was 'ineligible to be deprived of liberty by the MCA'. The judge considered the historical background to DoLS and the relationship between the Mental Health Act and the Mental Capacity Act and DoLS. He concluded that in the case before him the deprivation of liberty of GJ, who suffered from mental disorder and also diabetes, was justified under DoLS. He considered that if the nature of the treatment for which deprivation of liberty was required was essentially for physical health problems then it would not be appropriate for the patient to be detained under the Mental Health Act (which can only authorise treatment for mental disorder). In the case of *A Local Authority* v. *A (A Child) & Anor*,[18] the judge decided in two separate cases that there was no deprivation of liberty of a person lacking mental capacity when in the first case – an adult – and in the second case – a child – was locked in a bedroom at night.

In May 2014 the Court of Appeal held that a man who lacked mental capacity as a result of serious brain injury which led to his leading a chaotic life as an alcoholic could be detained in his best interests in a care home for the purpose of receiving care and treatment.[19] His appeal against the decision not to

terminate the standard authorisation to deprive him of his liberty was turned down. See also the case where a judge upheld a woman's application to return home and overruled the DoLS authorisation (see chapter 29).[20]

The case of *G v. E & Ors*[21] (see Case 17.7, page 471) under the Court of Protection is an example of the complexity which can arise in such situations. In this case the local authority was held to be at fault in moving a person to different accommodation without carrying out a DoLS assessment. Ben Troke and Neil Ward explore the complexities and as yet unanswered questions relating to DoLS.[22] Further information on DoLS can be found on the Alzheimer's Society's website[23] which provides a PDF fact sheet.

The CQC undertakes an annual report on Deprivation of Liberty Safeguards which can be accessed on its website.[24] The conclusions in its report for 2011/12 were that there was still confusion around the precise definition and thresholds for deprivation (as opposed to restriction) of liberty. Recent court decisions have ruled that there is no universal definition. Decisions can only be made on individual circumstances. The relationship between care, appropriate restrictions of liberty, the Deprivation of Liberty Safeguards and the wider Mental Capacity Act has become complex and potentially confusing. It recommended that health and social care providers operating the DoLS system should give the highest priority to improve understanding and practice of the MCA.

Fundamental flaws in the protection provided by the Mental Capacity Act and DoLS were found by the House of Lords in its report published in March 2014[25] on the post-legislative scrutiny of the Mental Capacity Act 2005.

See also the case of *An NHS Trust v. Dr A* [2013][26] on DoLs and deprivation of liberty in a hunger strike which is considered in chapter 7. In March 2014 the Supreme Court ruled on the test of mental capacity for the purpose of bringing an action and ruled that a settlement agreed without a litigation friend being appointed was invalid[27] (see chapter 7).

Case 17.4

P (by his litigation friend the Official Solicitor) v. Cheshire West and Cheshire Council and Anor [2014][28]

Two sisters with learning disabilities and a man with cerebral palsy brought an action stating that the Deprivation of Liberty Safeguards had not been applied to them. The Court of Appeal ruled that they were not deprived of their liberty, because their freedom was inherently restricted because of their disabilities and their lives in their homes were not significantly different from their previous circumstances. The Supreme Court held that vulnerable people with dementia and other disabilities have the same human right to physical liberty as the rest of the human race as guaranteed by Article 5 of the European Convention on Human Rights. It considered how a deprivation of liberty should be defined, seeing the acid test as being whether a person is under the complete supervision and control of those caring for her and is not free to leave the place where she lives. The following are not relevant: the person's compliance or lack of objection, the relative normality of the placement, and the reason or purpose behind a particular placement. There should be no confusion between the question of the quality of the arrangements which have been made and the question of whether these arrangements constitute a deprivation of liberty. Lady Hale stated that a gilded cage is still a cage and suggested that there must be a regular review to ensure that the restrictions on their liberty are justified. The Supreme Court also heard the case of *P and Q v. Surrey County Council (subnom Re MIG and MEG)* and in a majority verdict held that there was a deprivation of liberty. P and Q were sisters with substantial learning disabilities and lacked the capacity to make decisions about their care and where they lived. They were moved from the family home in 2007 to a family home with a devoted foster mother and Q to a specialist residential home. The Court of Appeal had held that neither was deprived of her liberty.[29]

The Department of Health issued a note on the implications of both the Cheshire and Surrey County Council judgments for those responsible for the assessment and authorisation of deprivation of liberty, the care of individuals and those responsible for policies and procedures.[30]

The note recommended that the revised test of deprivation of liberty be applied (i.e the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements). It stated that deprivation of liberty can still occur in domestic settings. Suggested action included relevant staff familiarising themselves with the provisions of the Mental Capacity Act 2005, particularly the five principles and specifically the least restrictive principle (see chapter 7); being alert to any restrictions and restraint; reviewing existing care and treatment plans; exploring alternative ways of providing care and treatment to identify less restrictive means; and ensuring that, if unavoidable, any deprivation of liberty is authorised. Local Authorities are advised to review their allocation of resources to ensure they meet their legal obligations in the light of the Supreme Court judgment. As a consequence of this decision the Vice-President of the Court of Protection estimated that many thousands more cases will come to the Court of Protection to have their detention authorised.[31]

The Steven Neary case illustrates the difficulties of local authorities in using DoL safeguards.[32]

Case 17.5 *London Borough of Hillingon v. Neary* (2011)

Steven Neary, who suffered from autism and severe learning disabilities was taken into respite at the request of his father for a few days in December 2009. He remained there until December 2010 against both his and his father's wishes. The father and son contended that the LA's actions were unlawful. The LA claimed that initially the father had consented to the stay and thereafter Steven was kept in the home lawfully as a result of using Deprivation of Liberty Safeguards. Mr Justice Jackson held that the DoL authorisations relied upon flawed assessments. The LA had failed to accept the principle that all other things being equal Steven should have been cared for by his family, they had failed to appoint an independent mental capacity advocate speedily and had delayed in referring the matter to the Court of Protection. The LA therefore had breached Steven's rights under Articles 8, Article 5(1) and 5(4). The judge held that 'there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court'.

See also the case of *MH* v. *United Kingdom*[33] where the European Court of Human Rights suggested that DoLs may not be a sufficient defence against an alleged breach of Article 5(4) if the person lacks capacity and is not represented. (See chapter 20 for a consideration of the case.)

In 2012 a local authority sought a declaration relating to restrictions which had been put in place on the liberty of G, a 57-year-old man who resided in a private care home. He suffered from a number of mental disorders, including childhood autism, dissocial personality disorder and paedophilia and lacked the capacity to make decisions concerning his care needs. Restrictions included strip searching, and monitoring of correspondence and telephone conversations. The Court of Protection granted the declaration and stated that the restrictions were sufficiently detailed in the scope of their safeguards and complied with Article 8.[34]

Carers

The implementation of the Mental Capacity Act 2005 has major implications for carers of those with learning disabilities. Their role in the decision-making process where a person lacks the mental

capacity to make a specific decision has been clarified. Information which they can give about the mentally incapacitated person's past wishes and feelings, views, beliefs and any other relevant information must be passed to the decision maker to determine the best interests of the mentally incapacitated person. While the Act does not stipulate that informal (i.e. unpaid) carers are required to follow the guidance in the Code of Practice, it suggests they would find the advice of considerable help.[35] The Care Act 2014 recognises the right of the carer to be assessed and supported (see chapter 23).

Independent mental capacity advocates (IMCA)

Where a relative or friend is not available to be consulted in the process of determining the best interests of a person lacking the requisite mental capacity, the Mental Capacity Act 2005 requires the appointment of an IMCA in specified circumstances. These include where serious medical treatment is being considered and where accommodation is being arranged by the NHS or social services. Under the regulations[36] drawn up under the Mental Capacity Act 2005 an IMCA should be appointed in an adult protection case even though relatives or informal carers are available. Further information on the IMCA can be found in the author's work.[37]

Refusal to grant accommodation

The rights of relatives to refuse to take back a client who has been in respite care also need to be considered. In the case of an adult person suffering from mental impairment, if the relatives refuse to take the person back home this is their right and they cannot be compelled to look after him or her. Health and social services professionals would have to look for other accommodation for the client. (Reference should be made to the discussion in chapter 19.)

Protection of the autonomy of the client

Conversely it may happen that an extremely diligent parent/carer is unwilling to allow a son or daughter with learning disabilities to leave home and enter sheltered accommodation. In one case a mother had been placed under an **injunction** not to visit her son who had been moved to alternative accommodation. The Court of Appeal ruled that the injunction should be lifted as it was not appropriate to threaten her with imprisonment, but the case illustrates the difficulties of 'letting go'.

Case 17.6 *Local Authority X v. MM* (2007)[38]

The local authority (LA) brought the case seeking orders that M lacked capacity to conduct litigation, make decisions as to where she should reside, determine with whom she should have contact, manage her own affairs or enter into marriage. It also wanted a declaration that it was in M's best interests to reside in supported accommodation and to have limited contact with K, her partner. M was a vulnerable adult who suffered paranoid schizophrenia and learning disabilities. She had been with K for 15 years. The LA received information that K was intending to move M from her supported accommodation and disengage from psychiatric services. They therefore applied for an interim injunction to prevent M being moved from her supported accommodation or to have unsupervised contact with K.

The judge held that the test of mental capacity to consent to medical treatment was also applicable to decisions over residency and with whom the person was to have contact. There was no relevant

distinction between the test in *Re MB*[39] and the statutory definition in the Mental Capacity Act 2005 (see chapter 7). The capacity to consent to sexual intercourse depended on a person having sufficient knowledge and understanding of the sexual nature and character of the act of sexual intercourse and of the reasonably foreseeable consequences of sexual intercourse, to have the capacity to choose whether or not to engage in it. It was issue-specific, not partner-specific. M had the capacity to consent to sexual intercourse, but lacked the capacity to litigate, to manage her finances, to decide where and with whom she should live, to marry and to decide with whom she should have contact. M's human rights had to be taken into account and her wishes and feelings should be considered and the court had to pay regard to M's wishes to have an ongoing sexual relationship with K. The judge made the order required by the LA subject to the qualification that her contact with K did not have to be supervised. The LA was directed to file a care plan setting out its final proposals which was considered by the same judge a few months later.[40]

In another case the Court of Appeal upheld the decision of the Court of Protection which had held that a woman who had suffered brain damage had the capacity to give consent to sex with her former lover. Her mother had challenged the CoP decision.[41]

Court of Protection and Code of Practice

In October 2007 the new Court of Protection was established.[42] It has the power to make decisions about both personal welfare and property and affairs for a person who lacks the requisite mental capacity and can make declarations about advance decisions (see chapter 29). It also has ultimate control over those appointed under a lasting power of attorney (see chapter 19). Court-appointed deputies replace the previous system of receiverships and have extended powers to include welfare and healthcare matters as well as financial and property affairs. The significant new feature is that there is now a single integrated framework for making personal welfare decisions, healthcare decisions and financial decisions on behalf of those lacking the requisite mental capacity, as recommended by the Law Commission in 1995.[43] The Court can make both one-off orders and also appoint a deputy with continuing powers. Under section 15 of the Mental Capacity Act it can make declarations on:

(a) Whether a person has or lacks capacity to make a decision specified in the declaration.
(b) Whether a person has or lacks capacity to make decisions on such matters as are described in the declaration.
(c) The lawfulness or otherwise of any act (which includes an omission and course of conduct) done, or yet to be done, in relation to that person.

Examples of (c) might include deciding whether the withholding or withdrawing of medical treatment is in the best interests of P.

In 2014 the Court of Protection exercised its supervisory powers when it heard an application by a local authority for breach of an order made by the court. The partner (Lindsey M who had a drink problem) of a mentally incapacitated man PW broke an order that she should not have contact or seek to go into the property of PW. The judge deferred sentence to give Lindsey M a chance to show that she could comply with the order.[44]

Significant changes in the way the Court of Protection works are likely to follow the increase in workload following the decision of the Supreme Court in the Chester case (see Case 17.4). A clearer regional structure rather than ad hoc regional sittings is planned together with greater openness in its hearings. Even before the Chester decision, its workload had increased by 30 per cent over the past four years. Guidance on the publication of judgments was issued in 2014.[45]

A Code of Practice providing guidance on the Mental Capacity Act 2005 was prepared by the Department of Constitutional Affairs (now the Ministry of Justice) and is available online.[46] A supplementary code was published to provide guidance on the Deprivation of Liberty Safeguards.[47]

Case 17.7 *G v. E & Ors* [2010]

Decision making by the Court of Protection[48]

E (aged 19) suffered from a rare and very complex genetic condition known as tuberous sclerosis and as a result had a severe learning disability. An application was brought by E's sister, G. The respondents to the application were E himself by his litigation friend, the Official Solicitor; the local authority in whose area E resides; and F, a woman with whom E resided for over 10 years, initially as a foster carer under section 20 of the Children Act 1989 and subsequently under an adult placement until he was removed by the local authority in April 2009. G asked for the following issues to be determined:

(i) whether E has capacity to make decisions;
(ii) whether it is in his best interests to return to live with F or whether he should be cared for in a residential care home and, if so, which care home;
(iii) what contact provision should be made for G and/or F if E does not return home;
(iv) whether the local authority has unlawfully detained E in breach of Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms and/or the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005 and/or Article 6 of the convention;
(v) whether the local authority has interfered with E's right to a home and/or to family life under Article 8 of the convention;
(vi) whether E should receive damages from the local authority and the amount of such damages for breach of Articles 5, 6 and/or 8;
(vii) whether the local authority should bear the costs of this claim.

In an interim hearing in March 2010 the judge had to determine the following issues:

1 whether E is currently deprived of his liberty, and
2 what is in E's best interest with regard to residence and contact pending the final hearing, listed for July 2010.

He held that E lacked the mental capacity to make his own decisions; that the local authority had unlawfully deprived E of his liberty and infringed his Article 5 rights by placing him in accommodation without seeking authorisation under the Deprivation of Liberty Safeguards or seeking an order of the Court of Protection. It was also in breach of his Article 8 rights by removing him from the protection of F's care without proper authorisation. E was to stay in his present accommodation until the full hearing in July 2010. An appeal against the Court of Protection ruling failed.[49]

Appointment of deputy

The Court of Protection can make a single order or appoint a deputy in relation to a matter within its jurisdiction, which includes personal welfare as well as finance and property. Section 16 makes provisions for the Court of Protection to make decisions and for the appointment of deputies. The deputy must act on behalf of the patient in accordance with the principles set out in the Mental Capacity Act 2005, in the best interests of the patient (see chapter 7) and within the powers granted him or her by the Court of Protection. The deputies can be given powers (with specified limitations) over matters of personal welfare which extend in particular to:

- deciding where P is to live (where a deputy makes a decision on this, it is subject to the restrictions on deputies)

- deciding what contact, if any, P is to have with any specified persons (the deputy has no power to make an order prohibiting a named person from having contact with P)
- giving or refusing consent to the carrying out or continuation of a treatment by a person providing healthcare for P.

A deputy cannot give a direction that a person responsible for P's healthcare allows a different person to take over that responsibility: only the Court of Protection has that power. Where the deputy is given powers over a person's property and affairs, they could include the following:

- the control and management of P's property;
- the sale, exchange, charging gift or other disposition of P's property;
- the acquisition of property in P's name or on P's behalf;
- the carrying on, on P's behalf, of any profession, trade or business;
- the taking of a decision which will have the effect of dissolving a partnership of which P is a member;
- the carrying out of any contract entered into by P;
- the discharge of P's debts and of any of P's obligations, whether legally enforceable or not;
- the settlement of any of P's property, whether for P's benefit or for the benefit of others;
- the execution for P of a will (unless P is under 18 years old) (subject to restriction on deputies);
- the exercise of any power (including a power to consent) vested in P whether beneficially or as trustee or otherwise;
- the conduct of legal proceedings in P's name or on P's behalf.

The Code of Practice identifies the following list as duties to be followed by the court-appointed deputy.[50] It notes that when agreeing to act as deputy whether in relation to welfare or financial affairs, the deputy is taking on a role which carries powers that s/he must use carefully and responsibly. The standard of conduct expected of deputies involves compliance with the following duties as an agent and with the statutory requirements:

- To comply with the principles of the Act
- To act in the best interests of the client
- To follow the Code of Practice
- To act within the scope of their authority given by the Court of Protection
- To act with due care and skill (duty of care)
- Not to take advantage of their situation (fiduciary duty)
- To indemnify the person against liability to third parties caused by the deputy's negligence
- Not to delegate duties unless authorised to do so
- To act in good faith
- To respect the person's confidentiality
- To comply with the directions of the Court of Protection.

To be appointed as a deputy an individual must be 18 years or over. An individual of at least 18 years or a trust corporation can be appointed as a deputy in respect of powers relating to property and affairs. The deputy must give consent to the appointment. The holder of a specified office or position may be appointed as deputy. Two or more deputies could be appointed to act jointly or jointly and severally. (Jointly means that they act together in making decisions and exercising the powers; severally means that they act as individuals separately.)

The deputy is entitled to be reimbursed out of P's property for his reasonable expenses in discharging his functions. In addition, if the court so directs when appointing the deputy, the deputy can receive remuneration out of P's property for discharging his functions. The court can give the deputy powers to take possession or control of all or any specified part of P's property and to exercise all or any specified powers in respect of it, including such powers of investment as the court decides.

The Office of Public Guardian acts as supervisor of the deputy and any complaints about the conduct of a deputy can be made to that Office. Further information on the role of the deputy, the Office of

Public Guardian and the Court of Protection can be obtained from the Ministry of Justice website.[51] See also the author's work.[52]

White Paper *Valuing People*

The White Paper *Valuing People – a New Strategy for Learning Disability for the 21st Century*[53] (which held that long-term hospitals were not an appropriate home environment for people with learning disabilities) recognised four key principles as lying at the heart of the government's proposals: rights, independence, choice and inclusion. The White Paper was described by the government as taking a lifelong approach, beginning with an integrated approach to services for disabled children and their families, and then providing new opportunities for a full and purposeful adult life. The proposals were intended to result in improvements in education, social services, health, employment, housing and support for people with learning disabilities and their families and carers. The White Paper estimated that there were about 210,000 people with severe learning disabilities and about 1.2 million with a mild or moderate disability. It set out the following proposals:

- New national objectives for services for those with learning disabilities
- A new Learning Disability Development fund
- A new central implementation support fund
- Disabled children and their families to be an integral part of the Quality Protects Programme, the Special Educational Needs Programme of Action and the Connexions Service
- Development of advocacy services to assist them in having as much choice and control over their lives as possible
- Supporting carers by implementing the Carers and Disabled Children Act 2000 and by funding the development of a national learning disability information centre and helpline in partnership with Mencap
- Improving health of those with learning disabilities by providing the same rights of access to mainstream health services as the rest of the population by appointing health facilitators, ensuring registration with a GP and a health action plan for each client
- Giving greater choice over where they live with more appropriate accommodation
- More local day services to assist them in leading a full and purposeful life
- New targets for increasing numbers of people with learning disabilities in work
- Raising of standards and quality of services provided for those with learning disabilities, including training and qualifications for care staff through a learning disability awards framework
- Effective partnership working through Learning Disability Partnership Boards.

To implement these changes, a Learning Disability Task Force was set up to advise the government, supported by an Implementation Support Team to promote change at regional and local level. In December 2007 the Department of Health published a consultation document 'Valuing People Now',[54] which set out the next steps on the Valuing People policy and its delivery. It saw the main priorities for 2008–2011 to be personalisation; what people do during the day; better health; access to housing and making sure that change happened. The wider agenda would include an emphasis on advocacy and human rights; partnership with families; ensuring all those with learning disabilities were included; working with the criminal justice system and the department of transport and local groups to ensure those with learning disabilities can become full members of their local communities; providing the same opportunities as others in the transition from childhood to adulthood and supporting those who work with those with learning disabilities. The consultation ended in March 2008 and a summary of the responses was published by the government in 2009.[55] One of the conclusions was that:

> **There were consistent worries about whether Valuing People Now will make a real difference to people's lives, particularly in terms of funding and legislative 'teeth'. Many respondents felt that Valuing People Now was strong on vision but short on the detailed implementation plans to make the vision a reality, particularly compared to the 'view from the ground' that many respondents were experiencing.**

The Green Paper 'Independence, Well-being and Choice'[56] and the White Paper *Our Health, Our Care, Our Say*[57] published in 2006 are discussed in chapter 19 in relation to risk management and the older person. The chapter also looks at the subsequent guidance published by the DH who issued a guide to 'Independence, Choice and Risk',[58] which provides a risk management framework for use by everyone involved in supporting adults using social care within any setting, including NHS staff working in multidisciplinary or joint teams. A report published in 2008 gave stark evidence of the discrimination suffered by those with learning disabilities in accessing healthcare[59] and showed the extent of the challenge in ensuring equality of healthcare provision for those with learning disabilities. See also Jo Corbett's work on health provision for people with learning disabilities.[60] The situation in Practical Dilemma 17.1 is probably not unusual.

Practical Dilemma 17.1 Not worth bothering about

Stan had fallen from a first-floor window in his community home and was taken to A&E by his carer. He had very limited speech and was unable to explain where he hurt and screamed when the doctor tried to examine him. The doctor suggested that the carer should take him home and give him paracetamol and a hot drink and return to the A&E department if it looked as though he had a fracture or any other serious problems. What action should the carer take?

Clearly the carer should try to ensure that Stan receives the reasonable standard of care which any person is entitled to in the A&E department and if the approved practice would have been to take X-rays and even admit overnight, then Stan is entitled to that standard. His difficulties in speaking should not be used by clinicians as a reason to provide a lower standard of care. The carer should try and make it clear to the doctor that Stan should be treated as an ordinary patient and that his learning disabilities should not be used as an excuse to refuse him a reasonable standard of care.

Other examples can be given where, because of a failure to X-ray, fractures are not diagnosed, or there is a failure to offer screening (e.g. cervical, breast, etc.) facilities which would be available to those with mental capacity. In a case reported to the author by an occupational therapist, the suggestion was made that a client with learning disabilities, who was non-verbal and autistic and whose fingers in her hand had curled tightly into her palm, getting tighter over recent years, should have her tendons cut. Her finger nails were growing into her palm, causing a lot of pain, and she was referred to a plastic surgeon who suggested that the tendons in her fingers should be cut. The usual practice would have been for the hand gradually to be opened up using a splint. The occupational therapist protested, pointing out that she still used her hands, and made good use of her thumb and little finger to manipulate objects.[61] In such conflicts where a health professional is aware that a patient/client with learning disabilities is not receiving an acceptable standard of care, an application can be made to the Court of Protection which has the power to appoint a deputy.

Horror stories abound on the ill-treatment of those with learning disabilities. The Health Service Ombudsman reported on a case where the hospital missed every opportunity to save the life of a woman with learning disabilities. She had been admitted to Basildon Hospital in Essex in 2009 with suspected pneumonia but had to wait five days to see a respiratory consultant. Staff failed to administer antibiotics immediately and did not consider moving her to a high dependency unit. Her parents who had complained to the Ombudsman felt that she had been denied adequate care because of her learning disabilities.[62]

The mother of an autistic boy placed a bug in his toy to catch foul-mouth carers. He came home from a respite stay spouting four-letter words. She handed the recordings to police and officials at Rhondda Cynon Taf council and four members of staff at Nantgwyn care home in Aberdare, South Wales were given formal warnings.[63]

Confidential Inquiry into premature deaths of people with a learning disability

It is sad reflection on the impact of the White Paper and subsequent documents that the Confidential Inquiry (commissioned by the Department of Health in 2010) reported in 2013 that one third of the deaths investigated could have been prevented if good quality healthcare had been provided. The Mencap website provides a summary of the report.[64] In a formal response to the report the Department of Health admitted unacceptable inequalities and said that it would look at making a series of improvements around coordination, record keeping and best practice. Mencap stated that it was hugely disappointed that key recommendations in the report were ignored.[65] A spokesman stated that over 1,200 children and adults with learning disabilities continue to die unnecessarily in England every year because of discrimination in the NHS.

Crossing service provision boundaries

Individuals do not of course fit into neat categories and all health professionals must be aware of the dangers of failing to treat the whole person and ignoring problems which do not fit into a specific form of service provision. These individuals are often vulnerable but can be excluded from support mechanisms owing to having the 'wrong' diagnosis to access services. For example, teenagers who have a dual diagnosis of learning disability and mental disorder may not come within any particular service. The Child and Adolescent Mental Health Service may not see a child with an IQ of 60 or less; the paediatric services may not work with major mental health issues. Any registered nurse who is involved in the care of a child or a person with learning disabilities would have a legal responsibility to ensure that all the appropriate services from other agencies and departments were involved and may herself become the coordinator of care for a particular client. The law requires that a reasonable standard of care is provided for the client, irrespective of the different service providers he or she may come under. Failures to cooperate across service boundaries were evident in the Baby P case discussed in chapter 13.

The Joint Committee on Human Rights published its report *A Life like Any Other? Human Rights of Adults with Learning Disabilities* on 6 March 2008.[66] The Joint Committee put forward 81 conclusions and recommendations for the government and other organisations on ensuring that the human rights of those adults with learning disabilities were respected. The government responded to the report in May 2008,[67] outlining the action it intended taking in relation to each recommendation, including the review of the *Valuing People* plan and the importance of the role of the Equality and Human Rights Commission in safeguarding the human rights of those with learning disabilities. Both the Joint Committee's Report and the Government Response can be accessed on the parliamentary website.[68] See also the DH publication on a review of human rights and equality of opportunity in mental health and learning disabilities.[69] In October 2010 the High Court held that there was no statutory obligation on a local authority to maintain a statement of special educational needs or to fund a young person to continue in secondary education beyond the age of 19 years to complete his A levels. Section 2(5) of the Education Act 1996 could not be interpreted to impose a duty on behalf of a young person over 19.[70]

Safeguarding vulnerable adults

A new Safeguarding Vulnerable Adults Policy and a protocol for joint working between the Office of the Public Guardian (OPG) and local authorities was launched in December 2008.[71] This policy provides a framework for delivering the OPG's role in safeguarding vulnerable adults, as the Mental Capacity Act 2005 introduced a statutory duty for the Public Guardian to supervise, investigate concerns and regulate court-appointed deputies. The policy is supported by the OPG's *Safeguarding*

Vulnerable Adults: Procedures and Guidance document. The protocol for joint working outlines the respective roles that the OPG, the Court of Protection and local authorities play in adult protection, ensuring that areas of overlap can be harmonised. The agencies work together to help prevent and respond to abuse, by sharing information and following principles laid down in the guidelines. To view the policy, protocol and guidelines, see the OPG website.[72] The Safeguarding Vulnerable Groups Act 2006 and the Disclosure and Barring Service is considered in chapters 10 and other safeguarding provisions in chapter 19.

Sexual relations and related issues

Implicit in the concept of normalisation is the view that those suffering from learning disabilities should be able to participate in sexual activity according to their mental understanding. See the case of *Local Authority X* v. *MM* (2007)[73] discussed above in relation to the mental capacity to consent to having sexual relations.

Protection by the criminal code

The law protects those who do not have the capacity to give consent to sexual intercourse. It was an offence for a man to have unlawful sexual intercourse with a woman who was a defective under the Sexual Offences Act 1956 section 7. This has now been repealed and replaced by the criminal offences under the Sexual Offences Act 2003. It was a defence if a man is able to prove that he did not know and had no reason to suspect that the woman was defective. In the case of *R* v. *Hudson*,[74] the Court of Criminal Appeal allowed the appeal of the defendant against conviction on the grounds that a subjective test should have been applied to determine whether he had reason to suspect this.

The Sexual Offences Act 2003 repealed the provisions of section 128 of the Mental Health Act 1959 which made it an offence for a man on the staff of or employed by a hospital or mental nursing home to have extramarital sexual intercourse with a woman who is receiving treatment for mental disorder in that hospital or home either as an outpatient or an inpatient.

Under the Sexual Offences Act 2003 the following offences are created in relation to carers:

Section 38 care worker: sexual activity with a person with mental disorder
Section 39 care worker: causing or inciting sexual activity
Section 40 care worker: sexual activity in the presence of a person with mental disorder
Section 41 care worker: causing a person with a mental disorder to watch a sexual act.

Section 42 includes in the definition of care worker a person who has functions in a home in the course of employment which have brought him or are likely to bring him into regular face-to-face contact with the person with mental disorder. The definition also covers the situation where the patient is receiving NHS independent hospital or clinic services and the person has functions to perform in the course of employment. Those who regularly have face-to-face contact with clients as a result of providing care, assistance or services to them in connection with their mental disorder, whether or not in the course of employment, also come within the definition.

Where a person with learning disabilities is suspected of a crime it is important that the Code of Practice C (revised 2012) under the Police and Criminal Evidence Act (see chapter 2) is followed and that before a person with learning disabilities is interviewed by the police he/she is represented by an appropriate adult (i.e a relative, guardian or other person responsible for their care or custody; someone experienced in dealing with mentally disordered or mentally vulnerable people who is not a police officer or employed by the police, or failing these, some other responsible adult aged over 18 who is not a police officer or employed by the police).

The Mental Capacity Act (s. 44(2)) creates an offence to ill-treat or wilfully neglect a person who lacks capacity (see chapter 19).

Sterilisation

As a result of the case of *Re D* in 1976[75] (where a mother sought a declaration that her daughter, a sufferer of Sotos syndrome, could be sterilised), it became a requirement that those seeking a non-therapeutic sterilisation (i.e. one which was not required for the physical health of the patient) should first obtain a declaration of the court. In the *Re D* case the judge refused to permit the sterilisation of a girl of 11 years since it was not established that the child would not have the ability to make a decision for herself at a later date. On the other hand, in Jeanette's case[76] the House of Lords gave its approval to the sterilisation of a girl of 17 years who suffered from learning disabilities and her parents consented to the sterilisation. In the case of *Re F*[77] (see pages 168 and 462), the House of Lords declared that it would be lawful to sterilise a woman who lacked the capacity to consent if it were in her best interests and the doctors acted according to the Bolam Test.

The situation is now covered by either the Children Act 1989 or the Mental Capacity Act 2005. Where the person is under 16 years an application for sterilisation would be made to the Family Division of the High Court. Where the person is over 18 years an application could be made to the Court of Protection. A young person of 16 or 17 could be referred to either court as appropriate. If there is a request from a relative that the client be sterilised then the professional should raise this issue with the multi-disciplinary team and ensure that, if necessary, an application is made to the appropriate court. The decision to sterilise a child is one of the most significant which can be taken and it is essential that any health professional who is involved in the court proceedings and the evidence which is required should follow the principles considered in chapter 13 in relation to children. In relation to adults, the Code of Practice on the Mental Capacity Act (issued by the Department of Constitutional Affairs and now available from the website of the DCA's successor, the Ministry of Justice[78]) notes in paragraph 8.22:

> **that cases involving non-therapeutic sterilisation will require a careful assessment of whether such sterilisation would be in the best interests of the person who lacks capacity and such cases should continue to be referred to the court.**

A local authority sought a declaration from the Court of Protection regarding the best interests of K who was 21 years with Down's syndrome and an associated mild/moderate learning disability. Her parents wished her to be sterilised. A best interests meeting between the parents, LA and staff from the NHS trust decided that a non-therapeutic sterilisation was not in her best interests. The parents indicated that they were taking K abroad. The LA brought proceedings seeking a declaration in relation to contraception and sterilisation and an injunction not to remove K from the jurisdiction. The LA and Official Solicitor commissioned a report from a gynaecology expert who stated that sterilisation was not in K's best interests and was not the least restrictive option. The Court of Protection laid down the principles and procedure which should apply when non-therapeutic sterilisation was being considered. Such a decision was so serious that the Court of Protection should make it. In the actual case the CoP stated that any issue of non-therapeutic sterilisation should be brought back before the court so that those who were responsible for K's care were clear about the requirements going forward.[79]

In the case of *Re A* a mother applied for a declaration that a vasectomy was in the best interests of A, her son (who had Down's syndrome and was borderline between significant and severe impairment of intelligence), in the absence of his consent. After balancing the burdens and benefits of the proposed vasectomy to A, the Court of Appeal held that the vasectomy would not be in A's best interests.[80] In August 2010 Justice Bodey of the Court of Protection[81] refused to grant an order forcing a woman with a low IQ to have compulsory contraception. He stated that such a plan had shades of social engineering. The facts were that a married woman of 29 years who had an IQ of 53 had two children who had been put up for adoption. The council applied for the order because her violent and bullying husband wished her to have more children and they considered that such an order would be in her best interests.[82]

In August 2013 the Court of Protection heard an application for a vasectomy to be permitted on DE. The NHS trust with the support of the parents, GP and local authority applied to the court to allow a

vasectomy on DE a 36-year-old with learning disabilities who already had a son born in 2010.[83] The court heard that DE did not want to become a father again and another child could cause him psychological harm. Experts stated that DE had the capacity to consent to sexual relationships but not to making decisions about contraception. Mrs Justice Eleanor King in a reserved decision ruled that a vasectomy could take place since it was in his best interests not to have another child. Mencap welcomed the decision but stated this decision should not be seen as a green light for other applications for sterilisation in respect of people with a learning disability.[84]

Abortion

A person with learning disabilities who has the capacity to give a valid consent could sign the form for an abortion to be carried out provided that the requirements of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) are met. Where the adult with learning disabilities lacks competence, then the Mental Capacity Act 2005 would now apply. The Code of Practice (paragraphs 6.18–6.19) points out that some treatment decisions are so serious that they must be made by the Court of Protection and it includes within this category termination of pregnancy in certain circumstances. The court has also given guidance on when certain termination of pregnancy cases should be brought before the court.[85]

Property

The legal issues relating to property are considered in chapter 25. Those with learning disabilities are vulnerable to exploitation and the duty of care owed to them would include the duty to take care of their property. Any moneys belonging to the client and handled by staff must be strictly accounted for and records kept. Facilities should be provided for cash or other valuables to be safely stored, and care should also be taken to prevent one client misappropriating property belonging to another. The new Court of Protection set up in October 2007 has a remit to make decisions on behalf of mentally incapacitated adults in respect of personal welfare and property and financial decisions. A deputy could be appointed to make decisions in relation to any property or financial interests of an adult lacking mental capacity. The jurisdiction of the Court of Protection is normally restricted to those over 16 years but where it is anticipated that the lack of the requisite mental capacity could continue beyond 16 years then it can hear cases involving persons who are younger than 16 years. For example, if a child was severely injured in a road accident which led to serious brain damage and received a payment for several million pounds as a consequence, the Court of Protection could hear an application relating to his case since the disability would persist beyond 16 years. A man with learning disabilities sought judicial review of the cutting of services by his council and its failure to fulfil its public service duties under section 149 of the Equality Act 2010. The Court of Appeal agreed that he had made out both grounds of appeal, but that since the council's budget had now expired it would not grant him any relief since that would effectively require the council to rewrite a now expired budget from an earlier year which would be detrimental to good administration.[86] (See chapter 25 for discussion of maladministration of the property of residents in homes run by Mencap.)

Direct payments

Direct payment for personal care was introduced in 1997. On 1 April 1997 the Community Care (Direct Payments) Act came into force which enabled social services departments to make payments in cash instead of kind to certain groups in receipt of community care. This enables a person to purchase their own care. However, the local authority originally retained its discretion and could not be compelled to offer cash rather than services. The level of payment must be sufficient to enable the recipient to buy

the services that the payments are intended to cover. New regulations came into force in 2003[87] under which there is now a duty to make direct payments to an eligible individual who appears to be capable of managing a direct payment by himself or with such assistance as may be available to him. (Persons listed in regulation 2 were ineligible but these regulations were replaced in 2009,[88] which reduced the categories of exclusion. Schedule 2 to the 2009 regulations excludes those under drug or alcoholic treatment or rehabilitation regimes imposed under criminal justice legislation.) If a person meets the criteria for direct payments and has had a community care assessment then the services needed are identified and he or she then has the choice of using the local social services or using the money provided to buy services from an alternative provider. In the DH circular 'Transforming Social Care' in January 2008,[89] it was estimated that only 54,000 out of a potential million recipients were receiving direct payments. The circular aimed at increasing the numbers of persons receiving direct payments or individual budgets. Further information on direct payments is available from the DH publication in March 2008,[90] which can be downloaded from its website.

An analysis of the purchase of assistive devices by older people who had fallen and called 999 ambulance showed that 54 per cent had purchased their own devices such as walking frames and bath boards, spending on average £700 each. The authors concluded that as social services' direct payments allow people to manage their own care packages, more people will be buying direct and may be looking for advice.[91]

Changes were introduced by sections 31–33 of the Care Act 2014 which are shown in Statute Box 17.1.

Statute 17.1 Sections 31 to 33 Care Act 2014

Direct payments

31 Adults with capacity to request direct payments

1 This section applies where –
   (a) a personal budget for an adult specifies an amount which the local authority must pay towards the cost of meeting the needs to which the personal budget relates, and
   (b) the adult requests the local authority to meet some or all of those needs by making payments to the adult or a person nominated by the adult.
2 If conditions 1 to 4 are met, the local authority must, subject to regulations under section 33, make the payments to which the request relates to the adult or nominated person.
3 A payment under this section is referred to in this Part as a 'direct payment'.
4 Condition 1 is that –
   (a) the adult has capacity to make the request, and
   (b) where there is a nominated person, that person agrees to receive the payments.
5 Condition 2 is that –
   (a) the local authority is not prohibited by regulations under section 33 from meeting the adult's needs by making direct payments to the adult or nominated person, and
   (b) if regulations under that section give the local authority discretion to decide not to meet the adult's needs by making direct payments to the adult or nominated person, it does not exercise that discretion.
6 Condition 3 is that the local authority is satisfied that the adult or nominated person is capable of managing direct payments –
   (a) by himself or herself, or
   (b) with whatever help the authority thinks the adult or nominated person will be able to access.
7 Condition 4 is that the local authority is satisfied that making direct payments to the adult or nominated person is an appropriate way to meet the needs in question.

32 Adults without capacity to request direct payments

1 This section applies where –
   (a) a personal budget for an adult specifies an amount which the local authority must pay towards the cost of meeting the needs to which the personal budget relates, and
   (b) the adult lacks capacity to request the local authority to meet any of those needs by making payments to the adult, but
   (c) an authorised person requests the local authority to meet some or all of those needs by making payments to the authorised person.
2 If conditions 1 to 5 are met, the local authority must, subject to regulations under section 33, make the payments to which the request relates to the authorised person.
3 A payment under this section is referred to in this Part as a 'direct payment'.
4 A person is authorised for the purposes of this section if –
   (a) the person is authorised under the Mental Capacity Act 2005 to make decisions about the adult's needs for care and support,
   (b) where the person is not authorised as mentioned in paragraph (a), a person who is so authorised agrees with the local authority that the person is a suitable person to whom to make direct payments, or
   (c) where the person is not authorised as mentioned in paragraph (a) and there is no person who is so authorised, the local authority considers that the person is a suitable person to whom to make direct payments.
5 Condition 1 is that, where the authorised person is not authorised as mentioned in subsection (4)(a) but there is at least one person who is so authorised, a person who is so authorised supports the authorised person's request.
6 Condition 2 is that –
   (a) the local authority is not prohibited by regulations under section 33 from meeting the adult's needs by making direct payments to the authorised person, and
   (b) if regulations under that section give the local authority discretion to decide not to meet the adult's needs by making direct payments to the authorised person, it does not exercise that discretion.
7 Condition 3 is that the local authority is satisfied that the authorised person will act in the adult's best interests in arranging for the provision of the care and support for which the direct payments under this section would be used.
8 Condition 4 is that the local authority is satisfied that the authorised person is capable of managing direct payments –
   (a) by himself or herself, or
   (b) with whatever help the authority thinks the authorised person will be able to access.
9 Condition 5 is that the local authority is satisfied that making direct payments to the authorised person is an appropriate way to meet the needs in question.

33 Direct payments: further provision

1 Regulations must make further provision about direct payments.
2 The regulations may, in particular, specify –
   (a) cases or circumstances in which a local authority must not, or cases or circumstances in which it has the discretion to decide not to, meet needs by making direct payments;
   (b) conditions which a local authority may or must attach to the making of direct payments;
   (c) matters to which a local authority may or must have regard when making a decision of a specified type in relation to direct payments;
   (d) steps which a local authority may or must take before, or after, making a decision of a specified type in relation to direct payments;
   (e) cases or circumstances in which an adult who lacks capacity to request the making of direct payments must or may nonetheless be regarded for the purposes of this Part or the regulations as having capacity to do so;
   (f) cases or circumstances in which an adult who no longer lacks capacity to make such a request must or may nonetheless be regarded for any of those purposes as lacking capacity to do so;

(g) cases or circumstances in which a local authority making direct payments must review the making of those payments.

3 A direct payment is made on condition that it be used only to pay for arrangements under which the needs specified under section 25(2)(a) in the care and support plan or (as the case may be) the support plan are met.

4 In a case where one or more of conditions 1 to 4 in section 31 is no longer met or one or more of conditions 1 to 5 in section 32 is no longer met, the local authority must terminate the making of direct payments.

5 In a case where a condition specified under subsection (2)(b) or the condition mentioned in subsection (3) is breached, the local authority –

(a) may terminate the making of direct payments, and

(b) may require repayment of the whole or part of a direct payment (with section 69 accordingly applying to sums which the local authority requires to be repaid).

Direct payments: health care

Under section 11 of the Health Act 2009, direct payment for healthcare was introduced into the NHS (ss. 12A–12D of the National Health Service Act 2006).

Regulations for the NHS Direct Payments came into force in June 2010[92] relating to the setting up of pilot schemes for providing direct payments in accordance with a care plan, for their monitoring and review and for the repayment of the payments in specified circumstances. In 2013 the pilot schemes were ended and the direct payments for healthcare extended across England.[93] Amendments were subsequently made to enable an individual living in the same household, a family member or a friend to be paid to provide care using part of a patient's direct payment in exceptional circumstances and which were omitted in error.[94]

Complaints about non-NHS providers of direct payment services for healthcare have been added to the jurisdiction of the Health Service Commissioner.[95]

Between 2009 and 2013 personal health budgets were piloted in over 60 sites across England. The government published a response[96] to the consultation on direct payments for healthcare in 2013. It concluded that with a phased implementation process, personal health budgets and direct payments for healthcare will pave the way to a more person-centred future for the NHS.

This led to new regulations in 2013[97] while regulations relating to the pilot schemes were repealed.[98] These specify the persons to whom or in respect of whom the direct payments can be made, those excluded (these include those subject to drug or alcohol rehabilitation requirements, or subject to youth rehabilitation orders), the nomination of a person to receive the payment on the patient's behalf (reg. 6), the requirements in relation to a care plan and care coordinator (reg. 8) and the provision of information, advice and support in connection with the making of the direct payment. The conditions which must be complied with are set out in regulation 10 and regulation 14 covers the monitoring and review of direct payments. Regulations 15–17 cover the repayment, recovery and stopping of direct payments. A person lacking the requisite mental capacity may under regulation 5 be the recipient of a direct payment if that person has a representative who consents to the making of a direct payment order and the health body making the grant must have regard to whether it is appropriate for a person with that person's condition, and the impact of that condition on the person's life and whether a direct payment represents value for money. The representative must agree to act on the patient's behalf, act in the best interests of the patient, be responsible contractually for the payment, use the direct payment in accordance with the care plan and comply with relevant provisions of the regulations.

Amendments were made to the 2013 regulations requiring a health body to reconsider a decision not to make a direct payment and to give reasons for the decision. The amending regulations also reinstate provisions in earlier regulations but omitted in error for an individual living in the same household, a

family member or a friend to be paid to provide care using part of a patient's direct payment in very limited circumstances.[99]

In the case of *Morgan* v. *Phillips*,[100] the defendant in a road traffic accident argued unsuccessfully that the amount of direct payments should be taken into account in calculating the compensation for future care costs.

Registration and inspections

Community homes for those with learning disabilities come under the aegis of the Care Quality Commission (see chapter 5) which replaced the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. A scandal was reported in Cornwall where significant failings were found at Buddock Hospital (a unit for 14 patients with severe disabilities). The Healthcare Commission carried out a national audit of learning disability services and then consulted on a three-year plan.[101] The three-year plan envisaged:

- Audit of all inpatient care being provided for learning disability service users across the NHS and independent sector, including commissioning arrangements
- Investigation into long-stay hospitals to ensure that they are providing a safe and acceptable service
- Review of the care of people with learning disabilities who are placed outside their local area away from family and friends
- Increase the accessibility of the Commission's services so that people with a learning disability can better raise complaints and concerns about their care
- Establish champions at the regional offices of the Healthcare Commission responsible for monitoring services for people with a disability.

Full reports by the CQC on its inspections of individual care homes for those with learning disabilities can be found on its website.[102] It uses the following criteria in its inspections: treating people with respect and involving them in their care; providing care, treatment and support that meets people's needs; caring for safety and protecting them from harm; staffing and management. The Winterbourne View Hospital Report is considered in chapter 5.

In December 2006, as a result of the Equality Act 2006, public bodies were placed under a new disability equality duty to ensure that their organisations had a policy to identify and eradicate discrimination against disabled people. Public authorities are required to carry out six duties:

To promote equality of opportunity between disabled and other persons
To eliminate discrimination that is unlawful under the Disability Discrimination Act 1995
To eliminate harassment related to their disabilities
To promote positive attitudes
To encourage participation in public life and
To take account of their disabilities, even where that involves them more favourably than other persons.

It remains to be seen how effective this duty is in relation to those with learning disabilities. (The legislation is now re-enacted in the Equality Act 2010 (see chapter 10).)

Conclusions

The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards have provided a significant framework in the protection of those with learning disabilities. It is clear from the reports of the Care Quality Commission that much still should be done to ensure reasonable standards of care and the

protection of their rights. NHS England issued guidance in 2012 on learning disabilities for clinical commissioning groups to assist them in commissioning high quality, cost effective general and specialist health services for those with learning disabilities.[103] It is available on the Improving Health and Lives website (a website belonging to Public Health England specifically for the care of learning disabilities).[104] A report published in 2010[105] showed that less than 50 per cent of calls to the police following anti-social behaviour against the disabled, especially those with learning disabilities, received a response. (Such behaviour led to the suicide of a mother, Fiona Pilkington, who killed her disabled daughter in 2007.) There are clearly still major challenges ahead for nurses working within this specialist field.

Reflection questions

1 A girl with learning disabilities aged 19 years has been admitted for an abortion and you hear that she is to be sterilised. You feel that the decision has been rushed and should be delayed. What action could be taken? How would your answer differ if she were 15 years old? (See also chapter 15).

2 A young man with severe learning disabilities has been admitted for an appendectomy. You are aware that there is a dispute between his elderly parents and the social workers over his long-term accommodation, since the social workers wish him to be placed in a community home for those with learning disabilities. What is the law which applies to the situation and what role could you have in the discharge planning and a decision being made?

3 Decisions on behalf of those adults lacking the requisite mental capacity to make their own decisions must be made in their best interests. What is meant by this? Draw up a table showing the stages to be followed in the decision-making process (see chapter 7).

Further exercises

1 What are the implications of the Mental Capacity Act 2005 for the making of decisions on behalf of those who have severe learning disabilities? (See also chapter 7).

2 As a community nurse who has specialised in the care of those with learning disabilities you are concerned that one client is given very little freedom and is often placed in a restraining chair which he cannot get out of. You consider that the community home is acting illegally. What action would you take and what is the law which applies to the situation?

3 Reflect upon any client/patient with severe learning disabilities whom you have cared for and consider the legal issues which arose in their care.

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Chapter 18

Nurse educator and researcher

This chapter discusses

- NMC and standards in education
- Record keeping by teachers
- Liability for instructing others
- Hearing about unsound practices
- Employment law
- Legal aspects of research
- Health Research Authority
- Confidentiality
- Consent
- Health Education England

Introduction

Law is relevant to the role of the nurse educator in several respects. Tutors have been involved in litigation in respect of what they have taught, how it was taught and when. NHS employees and nurse lecturers should be familiar with the differences and implications. The legal issues arising from research are also relevant to the lecturer. They need also to be concerned with all the general aspects of the law covered in the first part of this book – not only in relation to their own position, but also because they might have to teach some of it!

NMC and standards in education

Guidance on the standards for the preparation of teachers of nursing, midwifery and health visiting was provided by the UKCC[1] and developed by the NMC[2] with revised arrangements for the introduction of standards for practice teachers. The Higher Education Academy developed a national professional standards framework for teaching and supporting learning in higher education in 2006 which complemented the NMC standard to support learning and assessment in practice which applied from 2007. The HE Academy was asked to accredit the NMC standard so that NMC teachers could be recognised by the HE Academy. From 2006 all teachers new to teaching in HE must have a teaching qualification.[3] Pre-registration and post-registration standards set by the NMC and the NMC quality assurance arrangements for education are considered in chapter 11.

Good character and good health

To obtain registered status, students must not only pass the academic and practical requirements of the course, but they also need a declaration by the head of the college (or department) of nursing that there is no reason why the student is not eligible to be placed on the NMC Register. This places a clear duty on the lecturers to ensure that any information that indicates that the person would be unsuitable should be brought to the attention of the head of the college or department of nursing. This requirement is particularly important in the light of the recommendations of the Clothier Inquiry into Beverly Allitt. The report[4] recommended that those with a history of personality disorder should not be taken into nursing (see chapter 5). The NMC conducted a consultation on how registrants should certify their character and health for the purposes of re-registration, and published guidance on good health and good character in 2006 as an Appendix to Annexe 2 of circular NMC 06/16. This was revised in 2008 and updated in 2010.[5] The guidance sets out the law, defines what is meant by good character and good health, and presents several scenarios to illustrate the decisions which have to be made. It states that:

> **Good character** is important and is central to the Code; Standards of conduct, performance and ethics for nurses and midwives 2008 in that nurses and midwives must be honest and trustworthy. Good character is based on an individual's conduct, behaviour and attitude. It also takes account of any convictions, cautions and pending charges that are likely to be incompatible with professional registration. A person's character must be sufficiently good for them to be capable of safe and effective practice without supervision.
>
> **Good health** is necessary to undertake practice as a nurse or midwife. Good health means that a person must be capable of safe and effective practice without supervision. It does not mean the absence of any disability or health condition. Many disabled people and those with health conditions are able to practise with or without adjustments to support their practice.

The Guidance also considers what is meant by reasonable adjustments to enable a person to practise safely without supervision.

Research published in February 2014 showed that patients have a significantly better chance of surviving on wards where more nurses have degrees.[6] Anne Marie Rafferty, Professor of Nursing Policy at King's College London and the lead British author on the study published in the *Lancet*, said that the findings were a vindication of NHS England's decision in September 2013 to require all nurses to have a bachelor's degree.

Record keeping by teachers

Practical Dilemma 18.1 Instruction in lifting – the evidence

Beryl Sharp, a nurse tutor, received a request from her hospital claims manager to provide her with the information she had given to a staff nurse on a lifting course. It appeared that this staff nurse had sustained a serious back injury at work and was suing the NHS trust for a breach in its direct liability to take care of her safety. The claim was likely to amount to a considerable sum, since the prognosis was poor and she was unlikely to be able to return to work in the foreseeable future. The NHS trust was defending the claim on the grounds that the ward was adequately staffed and that the staff nurse had been given instruction in lifting. It now required evidence of that fact from Beryl. Fortunately, Beryl was a hoarder – a fact frequently greeted with derision by her colleagues. She never threw anything out and was able to go through her records and find the series of seminars that had been organised on lifting. She had both the dates and the names of participants, including the names of those who had failed to attend. She had not given the seminar herself: a physiotherapist had done the teaching. Beryl had simply organised it as part of her work as an organiser for continuing education. She checked her records and could find no record that the particular staff nurse had attended. In fact, she was able to see that she was included in the list of those who were supposed to attend, but was not present at a seminar and that 'sick' had been written against her name. There was no evidence that she had been invited to attend a subsequent seminar, although another three were held in the following months.

One can imagine that this information would disappoint the hospital claims manager in providing information to defend the staff nurse's claim. However, it is not completely fatal to any defence of the claim, since it might well be that the staff nurse had received appropriate training in lifting during her basic training. In addition, there may be some element of contributory negligence in that the staff nurse herself failed to ensure that she was included on another seminar once she had returned from sick leave.

Such a request gives rise to many further questions for the nurse lecturer. How long must records be kept? What sort of detail is necessary? It will be recalled from the section in chapter 6 dealing with the time limits for bringing a court action that in a case of negligence the action must be brought within three years of the negligent incident (unless the victim is under 18 years old, under a disability or, in cases where she was not aware of the fact of the negligence or the existence of harm, within three years of such information becoming available). A period of retention of seven years is therefore likely to cover most eventualities apart from these exceptions. In addition, it could be argued that in those areas where regular retraining and revision study days are necessary, if several years have elapsed since the opportunity to go on to a course, then the authority is at fault in not providing a revision course. The information that should be retained is set out in Box 18.1.

Box 18.1 Information that should be kept by the nurse tutor

- Names of those who should have attended the sessions
- Names of those who did attend
- Times and dates of the sessions
- Content of the sessions and who did the teaching
- Grades of achievement where there was any assessment

Records are, of course, kept of the content, standard and timetable of pre-registration students, and it is not difficult to extend this to the post-basic courses.

Liability for instructing others

In chapter 3, there is an explanation of the duty of care owed by those who are instructing others so that if harm were to occur as a result of negligent instructions, the tutor can be sued by the person who has suffered the harm. This applies not just to the classroom situation, but also to all those situations where advice is given in circumstances where the person receiving it can be expected to act on it. If the advice has been given negligently, then an action in negligence for breach of a duty of care may follow.

Practical Dilemma 18.2 Negligent instructions

Beryl Sharp acted as the course tutor on some of the post-basic courses. She ran one course, that of training nurses in the adding of drugs to IVs, and failed to mention that, according to the local guidelines, the first dose of the drug to be added to the IV should always be given by a doctor. One of the staff nurses who had been at that session and had been deemed competent to give IV drugs returned to the ward and was instructed that a patient who was already on an intravenous drip had been written up for an IV drug. At the appropriate time, the staff nurse prepared the drug, checked it with another nurse, and added it to the drip according to the instructions she had been taught on the course. The patient reacted violently against the drug and a doctor was summoned urgently. An inquiry was then held to find out why the first dose of this drug had been administered by a nurse and not by a doctor. It was the local policy for the doctor to administer the first dose of a drug intravenously. It then emerged that Beryl Sharp had failed to point out this requirement in her teaching on the course.

In this situation, the victim is a patient. In other cases, the victim could be the person who received the negligent information or advice. Where a patient is the victim, the claim is relatively simple: he would show that he has suffered harm as a result of a negligent act of an employee acting in the course of employment and therefore that the employer is vicariously liable for the harm. Alternatively, the individual employee could be sued as personally liable for the harm. In such a case, the employee may bring her own action against the tutor who was negligent in the instructions that she gave. In this type of action, the following facts would have to be shown:

1. A duty of care was owed by the instructor to the student and to a third party injured by the student.
2. There was a breach of this duty since the instructions were given negligently.
3. As a reasonably foreseeable consequence of this breach, the person has suffered harm (this might be personal injury, but it could also include financial loss or loss or damage to property).

It is essential that the person harmed can show that this harm was caused by the negligence of the tutor. If it were unreasonable for the person to rely on the instruction by the tutor, then compensation would not be payable on the basis of the tutor's negligence. The defendant might be able to show that there was no negligence since the latest NICE guidelines on intravenous fluid therapy[7] do not require the first dose to be given by a registered medical practitioner.

Hearing about unsound practices

If a lecturer in the college of nursing discovers from his/her learners about staff who are guilty of unacceptable practices or ill treatment of patients, what action should the nurse lecturer take? Should she investigate the allegation and, if challenged, say why? Should she keep her source secret? Should she report her suspicions to nurse management? Obviously, there can be no single answer since much depends on the circumstances. If, for example, the learner has witnessed ill treatment of a patient by a member of staff on a ward, then the learner should be encouraged to write a statement setting out

exactly what she has seen and the nurse lecturer should ensure that appropriate action is taken by nurse management, at the same time protecting the learner from any victimisation. (Refer to whistleblowing and the Public Interest Disclosure Act 1998 considered in chapter 4.) If the nurse witnesses a procedure being carried out on the wards that is not in line with present-day safe practices, the nurse lecturer could arrange appropriate revision courses with in-service training officer colleagues.

Conflicts could also arise where the college has been teaching students the basic principles of patients' rights, e.g. consent to treatment, and as a result the student encounters difficulties with some medical staff. There could be criticism of the lecturers and of the college for its teachings. Such a situation indicates the importance of very close contact between the college and the NHS trust. The college of nursing should not, however, be seen as a policing machine for the hospital. By the same token, it has an essential part to play in maintaining the highest standards of nursing care in cooperation with the managers. Close integration of nurse clinical teaching and practice is essential. The Kennedy Report on children's heart surgery in Bristol[8] recommended that there should be a duty of candour owed by health professionals to the patient and this idea was taken up in the proposals for a new NHS redress scheme[9] to provide compensation for clinical negligence. However, the eventual NHS redress scheme did not include this duty. The recommendation of the Francis Inquiry into Stafford Hospital and the duty of candour and call for greater openness and accountability is considered in chapter 5.[10]

A duty of candour can be read into the Code of Professional Conduct of the NMC.[11] Under the heading of 'Respect people's confidentiality' the Code states:

> **You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising.**

Under the heading 'Manage risk', the Code states:

- **You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.**
- **You must inform someone in authority if you experience problems that prevent you working within this Code or other nationally agreed standards.**
- **You must report your concerns in writing if problems in the environment of care are putting people at risk.**

The National Patient Safety Agency has provided guidance on being open in relation to hazards (see chapter 12).

Employment law

Students

Learners were once both employees and students. Following the introduction of Project 2000, learners are students, usually attached to a college of education. They are entitled to receive student bursaries and the college negotiates an agreement with accredited hospitals for the clinical placements (now known as practice learning opportunities). In theory, students are supernumerary to the workforce, but inevitably, especially in the last years of training, the hospitals and community services may exploit their services. There is no right in the learning contract for the student to insist on employment once she is qualified. There may, however, be a contractual relationship between the institution and the student: the institution agrees to prepare the student for a particular qualification and the student agrees to arrange payment and follow the requirements of the course. Andrew Croskery, a student who obtained a 2:2 degree in electrical engineering, sued the University of Belfast because he felt that had he had the appropriate supervision he would have obtained a 2:1 degree. His application for judicial review was heard on 25 September 2010 but failed on the grounds that the case should remain exclusively within the jurisdiction of the University's own appeal body.[12]

Dismissal on grounds of absenteeism or course failure

Since the student is not an employee, if she should be dismissed during the course on the grounds of absenteeism or failing course assessments or examinations, then the student's remedy is an appeal through the appeal mechanisms of the college. These should have clear guidelines on the rules that operate in these circumstances and these procedures should be carefully followed. There is a contractual relationship between the student and the college that is enforceable in law.

Practice learning opportunities

There is normally a memorandum of agreement between colleges providing clinical training and the hospitals and community trusts providing practice learning opportunities. This agreement should cover the issue of liability for the actions of the students if they cause harm to others through negligence. Since the students are not employees of the unit providing practice learning opportunities, the units can argue that they are not vicariously liable for the actions of students. In addition, the agreement should cover liability for harm to the student. Prior agreement between the college and the organisation providing the practice learning opportunities can resolve such issues and also cover the topic of supervision of the student and clinical instruction. The NMC has published a fact sheet on practice placement opportunities across borders within the UK.[13]

Contractual rights of lecturers

Lecturers, tutors and clinical instructors are, of course, under a contract of employment whether their employer is a university/higher education institution or an NHS organisation, and they are obliged to observe the express and implied terms of the contract of employment (see chapter 10). In addition, they are entitled to expect that their employer will recognise its contractual obligations under the contract of employment. A memorandum of understanding for joint staff of universities and NHS organisations was agreed in March 2007 and can be downloaded[14]. It was prepared in response to the VAT tribunal ruling in April 2005 in a case involving the University of Glasgow and HM Revenue and Customs. The memorandum sets out the NHS and university understanding of the role of joint staff, clarifies selected duties and responsibilities of their employers, documents established practice in respect of these staff and confirms that such arrangements are outside the scope of VAT.

Legal aspects of research

Research-based practice is an essential requirement of professional care. An analysis of the role and importance of research in midwifery practice is equally applicable to all areas of nursing[15]. The National Institute for Health and Care Excellence (see chapter 5) seeks to identify and publish recommended clinically effective practice that has a strong research basis. The Department of Health initiated in 2006 a programme for research in the NHS called Best Research for Best Health.[16] The five-year strategy and its implementation plans, prepared by the National Institute of Health Research[17] (NIHR), can be downloaded from its website. The NIHR has established a School for Social Care Research. The NIHR was established in 2006 and funded through the Department of Health to improve the health and wealth of the nation through research. It has 4 main strands:

NIHR Faculty: supporting individuals carrying out and participating in research
NIHR Research: commissioning and funding research
NIHR Infrastructure: providing facilities for a thriving research environment
NIHR Systems: creating unified, streamlined and simple systems for managing research and its outputs.

In 2010 the White Paper *Equity and Excellence: Liberating the NHS* was published as a vision for the NHS. It emphasised the core role of research in the NHS; the role of the NHS Commissioning Board (NHS England) in promoting research; the importance of clinical research and the NIHR; and the success of NIHR clinical research networks.

In January 2011 the Academy of Medical Sciences made recommendations in relation to medical research regulation[18] suggesting the establishment of a new arm's-length body (now the Health Research Authority); facilitating NHS trusts' timely approval of research studies; improving the UK environment for clinical trials; providing access to patient data that protects individuals' interests; and embedding a culture that values research within the NHS. A Research Support Service was launched by the NIHR in May 2011.

The Code of Professional Conduct of the NMC[19] has an explicit requirement that practitioners should follow evidence-based practice.

1 Provide a high standard of practice and care at all times
2 Use the best available evidence
   - You must deliver care based on the best available evidence or best practice
   - You must ensure any advice you give is evidence-based if you are suggesting healthcare products or services.

Under the heading of 'Keep your knowledge and skills up to date', the Code states:

- **You must keep your knowledge and skills up to date throughout your working life.**
- **You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.**

The nurse is increasingly likely to be involved in research, either conducting it herself or being involved in the care of patients who are the subjects of a research project. Often a research project is an integral part of a management course or post-registration qualification and she will be expected to prepare a dissertation or project that shows some original material and analysis. In addition, there may well be researchers coming into her department or ward: she should in either case be aware of the many legal issues that arise. Some of the basic problems relate to consent by the patient, confidentiality and disclosure of the findings, safety of the researcher and liability for any volunteer in a drugs research programme. The conduct of research and the rights of the research subject are set out in the Declaration of Helsinki, which was reproduced as an appendix in the Department of Health's guidance for local research ethics committees, originally issued in 1991.[20] New guidance on research ethics committees was issued in July 2001[21] and updated in 2005.[22] Since 2011 they have come under the remit of the NHS Health Research Authority (see page 496). A European Directive[23] on clinical trials has been incorporated into legislation[24] and is summarised in Box 18.2.

Box 18.2 EC Directive 2001/20/EC

On the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use

Article 1 Aim of the Directive:

- To establish specific provisions regarding the conduct of clinical trials, including multi-centre trials on human subjects involving medicinal product as defined by Article 1 of Directive 65/66/EEC
- Good clinical practice to be identified and complied with
- To adopt and if necessary revise principles of good clinical practice and detailed guidance to be published by the Commission

- All clinical trials to be designed, conducted and reported in accordance with the principles of good clinical practice.

Article 2 Definitions
Article 3 Protection of clinical trial subjects
Article 4 Clinical trials on minors
Article 5 Clinical trials on incapacitated adults not able to give informed legal consent
Article 6 Ethics Committee
Article 7 Single opinion
Article 8 Detailed guidance to be published by Commission
Article 9 Commencement of a clinical trial
Article 10 Conduct of a clinical trial
Article 11 Exchange of information
Article 12 Suspension of the trial or infringements
Article 13 Manufacture and import of investigational medicinal products
Article 14 Labelling
Article 15 Verification of compliance of investigational medicinal products with good clinical and manufacturing practice
Article 16 Notification of adverse events
Article 17 Notification of serious adverse reactions
Article 18 Guidance concerning reports
Article 19 General provisions
Article 20 Adaptation to scientific and technical progress
Article 21 Committee procedure
Article 22 Application
Article 23 Entry into force 4 April 2001

In addition, a researcher would be required to observe the rights set out in the European Convention on Human Rights, which, since 2 October 2000, are actionable in this country (see chapter 1). Where the nurse becomes aware that the rights of the patient are not being protected by the researchers, she would have a professional duty to raise this with senior management and, if no action were taken, to make use of the whistleblowing provisions of the Public Interest Disclosure Act 1998 (see chapter 4). Reference can be made to the author's chapter exploring the legal implications of research.[25]

Control of a research programme

Practical Dilemma 18.3 Gagged

Ann Jones, a ward sister, was on a management course that required her to complete a dissertation. She chose as her subject the consequences of the privatisation of cleaning services and studied one hospital where the services were contracted out to a private firm and another hospital where direct labour ancillary staff were used. Her conclusions were that privatisation led to a lower standard of cleaning, a less hygienic environment for patients, and nursing staff undertaking more cleaning work because the private firm sent cleaners to the wards for only a short proportion of the day. Just before she was due to submit the dissertation for her diploma, her nursing director heard of it and asked to see it. She has now been told that her findings are politically unacceptable, that she cannot present it to the college and that she must commence a totally different topic of research.

This situation gives rise to many legal issues. In this situation, the researcher is also an employee. She therefore has responsibilities to her employer. Even if she were an independent researcher funded

from outside the institution that is the subject of the research, she might well have had to agree to a clause that the research findings have to have the prior approval of the institution before the research results can be published. As an employee, she would be expected to obey the reasonable orders of the employer. Is it reasonable in these circumstances for the researcher to be silenced? The answer would depend on more detailed facts: for example, was it only because the results were unwelcome that they are being suppressed? Was the basis of her data collection and statistical analysis sound? If there is no criticism to be made of her method and findings other than that they are embarrassing, it could be argued that the same principles apply here as apply in the situation discussed in chapter 7 relating to reporting on negligence by a colleague or some other form of unacceptable practice. Where management itself fails to take action, i.e. when all the internal procedures for improving the situation have been used to no avail, then it would not be considered unreasonable to take the matter to a higher authority, initially within the organisation and, if necessary, ultimately outside, but this obviously depends on the findings and the reasons for prohibiting publication.

The Public Interest Disclosure Act 1998 can be used to ensure that any person properly reporting health and safety concerns or criminal matters is protected from victimisation (see chapter 4). In November 2003 a university criminologist, who was conducting research into assisted suicides by people with AIDS, was awarded £62,000 by a committee of academic enquiry into the actions of Exeter University because Exeter University withdrew a written promise to give him legal backing should a court order him to disclose the names of those to whom he had spoken.[26] He had been forced to abandon his research, because he promised those involved in helping him that he would protect their identities. Simon Singh was sued for libel by the British Chiropractic Association for writing about 'bogus treatments' and found liable by the High Court.[27] However, he succeeded in his appeal but had to meet his own costs of £200,000. There were calls for libel laws to have no place in genuine scientific research. Subsequently the Defamation Act has provided a public interest defence to such cases (see page 233).

Research ethics committees (RECs)

The researcher must ensure that she receives the proper approval before beginning any research. In some cases, this might mean obtaining the approval of a local ethics committee. Where this authority is received, it would be more difficult to prohibit publication of the results purely on the grounds of embarrassment at the findings.

Research involving patients or patient information may not be started until ethical approval has been obtained. It is the personal responsibility of the person named as principal investigator to apply for approval by the REC and this person retains responsibility for the scientific and ethical conduct of the research.

In 2011 (updated 2012) the UK Health Departments published the policy document 'Governance Arrangements' for research ethics committees which set out what is expected from research ethics committees that review research proposals relating to areas of the UK Health Departments' responsibility. The policy applies to all four parts of the UK and covers the principles, requirements and standards for research ethics committees, including their remit, composition, functions, management and accountability. It replaces the earlier editions on the policy of 2001.[28]

The Care Act 2014 section 112(2) defines a research ethics committee as

> **a group of persons which assesses the ethics of research involving individuals; and the ways in which health or social care research might involve individuals include, for example**
>
> **(a) by obtaining information from them;**
> **(b) by obtaining bodily tissue or fluid from them;**
> **(c) by using information, tissue or fluid obtained from them on a previous occasion;**
> **(d) by requiring them to undergo a test or other process (including xenotransplantation).**

The Health Research Authority is required to publish a document, called 'the REC policy document', which specifies the requirements which it expects research ethics committees it recognises or establishes to comply with, and to monitor their compliance with those requirements.

United Kingdom Ethics Committee Authority (UKECA)

In May 2004, the UK Ethics Committee Authority (UKECA), composed of UK health ministers, was created as the body responsible for establishing, recognising and monitoring RECs to review clinical trials of medicines under the EC Directive. Information on the work of UKECA can be found on the Health Research Authority website.[29] A Central Office for Research Ethics Committees (COREC – now National Research Ethics Service (NRES)) was set up to work on behalf of the Department of Health, to coordinate the development of the RECs, manage multi-centre research ethics committees (MRECs) and provide advice on policy, operational matters and training. COREC acted for UKECA in providing advice/assistance to these committees. An ad hoc advisory group was set up to review the operation of NHS RECs and reported in June 2005.[30] COREC was placed under the National Patient Safety Agency in 2005 and relaunched as the National Research Ethics Service (NRES) in March 2007. The NRES had a dual mission: to protect the rights, safety, dignity and well-being of research participants; and to facilitate and promote ethical research that is of potential benefit to participants, science and society.

Health Research Authority (HRA)

The review of arm's-length bodies proposed that the future of the NRES should be considered as part of the wider Academy of Medical Science's review of research regulation with a view to moving this function from the NPSA into a single research regulatory body.[31]

Subsequently in 2011 the NHS Health Research Authority was established as a Special Health Authority to protect and promote the interests of patients and the public in health research and to streamline the regulation of research. The National Research Ethics Service (NRES) was a core function and directorate within the Health Research Authority.

The Care Act 2014 (s. 109–116 and Schedule 7) established HRA as a body corporate, non-departmental public body, with responsibility for the UK-wide Research Governance Framework. It is responsible for Research Ethics Committees, the Gene Therapy Advisory Committees and the Confidentiality Advisory Group which advises on section 251 of the NHS Act 2006 (see chapter 8 for details of section 251). The RECs are managed through the NRES. (Further information on the HRA can be found on its website.[32])

The main functions of the HRA (under s. 110) are:

(a) functions relating to the coordination and standardisation of practice relating to the regulation of health and social care research (see section 111);
(b) functions relating to research ethics committees (see sections 112 to 115);
(c) functions as a member of the United Kingdom Ethics Committee Authority (see section 116 and the Medicines for Human Use (Clinical Trials) Regulations 2004 (S.I. 2004/1031));
(d) functions relating to approvals for processing confidential information relating to patients (see section 117 and the Health Service (Control of Patient Information) Regulations 2002 (S.I. 2002/1438)).

Its main objectives in exercising its functions are:

(a) to protect participants and potential participants in health or social care research and the general public by encouraging research that is safe and ethical, and
(b) to promote the interests of those participants and potential participants and the general public by facilitating the conduct of research that is safe and ethical (including by promoting transparency in research).

It is required to publish guidance on good practice in the management and conduct of health and social care research. Under section 112 it must ensure that research ethics committees it recognises or establishes provide an efficient and effective means of assessing the ethics of health and social care research.

Confidentiality

Where use is made of personal information, access to it and disclosure of it in such a form that the individuals can be identified is subject to the provisions of the Data Protection Act 1998 (see chapter 8). This means that if the data are not exempt from any of the provisions of the Act and if they are to be used in addition for research, then they must also be registered for research use. Even where the data are not automated, they would still come under the provisions of the Data Protection Act 1998, which applies to both computerised and manually held data. This means that they may be disclosed only in those exceptional circumstances outlined in chapter 8.

Difficulties can arise for the researcher where information is obtained that has nothing to do with the research, i.e. it is simply doing the research that has given the opportunity to gain this information. The General Medical Council states that information can be given by practitioners about their patients for the purpose of research, but the patient's consent should be sought or the information provided in an anonymous form.[33] The work of the Patient Information Advisory Group (PIAG), which was set up under section 61 of the Health and Social Care Act 2001, to consider proposals for the use of patient-identifiable information is discussed in chapter 8. The PIAG was replaced by the National Information and Governance Board for Health and Social Care (NIGB),[34] which was established under section 157 of the Health and Social Care Act 2008. NIGB was subsequently replaced by HRA. Further information can be found in chapter 8 and obtained from the HRA website.[35]

Practical Dilemma 18.4 Silence or disclosure?

Sandra James, a staff nurse, was conducting a research project into the care of a post-operative surgical patient. She was interested in the rate of infection, length of stay, convalescent care and the nature of community care. Her research therefore required visits to the patients' homes. One of her patients, Glenda Mitchell, had been operated on for gallstones. She was in hospital for seven days and was then discharged to her home. Her cohabitee had taken a few days off work to care for their 3-year-old daughter. While Sandra was visiting the home, she was surprised to see that the child was very frightened of her and was withdrawn and hostile. Sandra tried to talk to her and touch her and noticed severe bruising and pinch marks on the child's legs.

In a suspected case of non-accidental injury, there is a clear justification for disclosing confidential information in the interests of the child. In a case like this, Sandra might try to persuade the mother to explain the child's bruising and, if this were unsatisfactory, she should ensure that appropriate action is taken to protect the child, e.g. arranging for the health visitor to visit, initiating the non-accidental injury (NAI) procedure or even bringing in the NSPCC.

Whatever action she takes along these lines would be protected from any litigation for breach of confidentiality on the grounds that the public interest justified it. In one case,[36] the House of Lords stated that the NSPCC was entitled to maintain the secrecy of the names of its informants, even if they had been malicious. This decision is based on public policy because it is essential that people are prepared to report potential incidents of child abuse. If, however, the facts of this situation are changed slightly and instead of a potential NAI case a potential crime against property is suspected, e.g. stolen goods are seen in the house, many professionals would feel that their professional duty of confidentiality must be maintained.

Consent

Unfortunately, not all research subjects are notified that they are to be included in a research project and their consent is not always obtained to the participation. Even in randomised controlled trials of drugs, patients should be informed that they have the right to refuse to take part. If the treatment is

therapeutic rather than pure research, then in exceptional circumstances it could be argued that the doctor's right of therapeutic privilege (discussed by the House of Lords in the Sidaway case (see chapter 7)) applied and there are special circumstances to justify not informing the patient of that fact. The right of therapeutic privilege could be relied on only in exceptional circumstances and the presumption is that the patient's consent should be obtained.

The basic legal principles are as follows: consent to participate in research should be given freely by an adult, mentally competent person and should be preceded by sufficient relevant information about serious harmful side effects as approved practice would require the professional to give the patient. Where research is contemplated on minors, it should proceed only if it is in the subject's interests and the benefits substantially outweigh any potential harm and the research is approved by the REC. The question as to whether parents have the right to consent to non-therapeutic research on their children is discussed in chapter 13. The RCN has provided guidance on obtaining consent for research[37] and also on research ethics.[38] The Duff Report (which followed the tragedy at Northwick Park where six volunteers developed multiple organ failure while trying out a new drug) recommended that participants in clinical drug trials should be given information on how adverse events should be reported.[39]

Concern has been raised about a controversial research project where paramedics give heart attack victims either placebo injections or adrenaline to test the effectiveness of adrenaline. The trial will not allow for consent to be obtained through the usual means. The study is being led by the University of Warwick. Ethical approval has been given by the Oxford research ethics committee.[40] There are concerns that adrenaline could be doing more harm than good and needed to be tested.

Consent and the mentally incapacitated adult

In a case in 2003 Judge Butler-Sloss gave approval to treatment being carried out on two teenagers suffering from variant Creutzfeldt-Jacob disease even though the treatment had not yet been tested on humans. Their parents gave consent.[41] This situation involving research on those lacking the requisite mental capacity to give consent is now covered by the Mental Capacity Act 2005 (apart from clinical trials). The Act enables research to be carried out, but only if stringent conditions are met. These are set out in sections 30–34 of the Act and shown in Box 18.3.

Box 18.3 Conditions for research on those lacking mental capacity set by the Mental Capacity Act

- The research is connected with an impairing condition affecting P (the person lacking mental capacity) or its treatment
- An impairing condition is defined in section 31(3) as a condition which is (or may be) attributable to, or which causes or contributes to, the impairment of, or disturbance in the functioning of, the mind or brain
- There must be reasonable grounds for believing that the research would not be as effective if carried out only on, or only in relation to, persons who have the capacity to consent to taking part in the project
- 5a The research must have the potential to benefit P without imposing on P a burden that is disproportionate to the potential benefit to P or
- 5b be intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition
- If 5(b) applies and not 5(a), there must be reasonable grounds for believing:
  - **(a)** that the risk to P from taking part in the project is likely to be negligible, and
  - **(b)** that anything done to, or in relation to, P will not:
    - **(i)** interfere with P's freedom of action or privacy in a significant way, or
    - **(ii)** be unduly invasive or restrictive
- There must be reasonable arrangements in place for ensuring that the requirements of consulting carers and additional safeguards are met.

Regulations[42] cover the situation where an adult who had given consent to participation in research lost the requisite mental capacity during the research project. The Department for Constitutional Affairs (now absorbed in the Ministry of Justice) has provided a Code of Practice on the implementation of the Mental Capacity Act 2005,[43] which is available on the Ministry of Justice website.[44] The provisions of the Mental Capacity Act 2005 do not apply to research which comes under the Clinical Trial Regulations.

Consent to research and statutory provisions

The Department of Health has prepared guidance on consent by a legal representative on behalf of a person not able to consent under the Medicines for Human Use (Clinical Trials) Regulations 2003. Where there are any risks to the adult, an application to court would probably have to be made. Where there are no risks, the local research ethics committee (LREC) should be made aware of the lack of mental capacity of the research subjects. Failure to obtain consent to research or to give the necessary information could render the researcher liable to action. The Human Fertilisation and Embryology Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008) prevents research taking place on an embryo after the first 14 days from fertilisation. Section 3 of the amended 1990 Act places prohibitions on the use of human embryos and section 4 prohibits activities in connection with genetic material not of human origin and stipulates activities which a research licence cannot authorise (see chapter 22).

The law on the removal, storage and use of organs and tissue was changed by the Human Tissue Act 2004 as the result of the scandal at Bristol Royal Infirmary when, during an inquiry into allegations of professional misconduct in carrying out paediatric heart surgery, it was learnt that more than 11,000 children who had died in the past 40 years had had their organs used for research in British hospitals without the explicit consent of their parents. (The law relating to the removal, retention and storage of organs and tissue is discussed in chapter 16.)

In 2013 the National Institute for Health Research launched the campaign 'It's OK to ask' to encourage patients who are undergoing treatment for a medical condition to ask their doctor about clinical research and whether taking part in a study might be right for them. The campaign asks patients to give feedback to the NIHR via its Facebook page or by telephone.

Liability for volunteers in research

Practical Dilemma 18.5 Guinea-pig

Benjamin Robinson was a medical student who was very short of money because he sent part of his grant home to his family each week. He heard of a research project being undertaken in the pharmaceutical department and offered his services. Because he was anxious to be accepted, he failed to tell the medical officer in charge of the research that he had suffered from glandular fever as a child. He subsequently took drugs to test out the toxicity of a drug for migraine. A few weeks later, he had a heart attack and died. Is there any liability for his death by the NHS trust and/or the research team?

At present there is no law that the volunteer should automatically obtain compensation for harm that occurs as a result of the research participation. The Pearson Report of 1978[45] recommended that volunteers in medical research should be compensated on a no-fault basis, but this has not been implemented through legislation. At present, the Association of the British Pharmaceutical Industry (ABPI) has prepared guidelines for the provision of compensation to victims of research and supports through a written agreement with each research subject that any subjects who have been harmed as a result of participation in a drugs trial will be compensated on a strict liability basis without proof of

negligence. This is a voluntary agreement, but would normally be a part of the protocol of the research project approved by the LREC. Apart from this scheme, as the law stands at present, the volunteer who is harmed as a result of participation in a research project can obtain compensation only on the basis of negligence, i.e. he must establish that a duty of care was owed to him, this has been broken, and as a reasonably foreseeable result of this breach the subject has suffered some harm.

Applying these principles here, it is hoped that the pharmaceutical company undertaking the research would compensate Benjamin's family on a **strict liability** basis. If the pharmaceutical company failed to pay up, then the family would have to show that in one way or another the researchers were negligent; for example, the researchers failed to give Benjamin a proper medical examination or the design of the research was faulty and reasonably foreseeably dangerous to the volunteers. There is little evidence of that here and, in addition, Benjamin, by concealing his previous illness, would have been contributorily negligent and therefore considered to a certain extent to be responsible for what happened.

It is possible that if it can be established that Benjamin was harmed as the result of a defect in a product, then the Consumer Protection Act 1987 applies and Benjamin's family can obtain compensation under these provisions against the producer or supplier. This is considered in greater length in chapter 12. Much of the debate on liability would hinge on whether at the time of production the producer should have realised that there was a defect in the product.

Another possible defence against such a claim is the possibility of alleging that Benjamin, by volunteering willingly, assumed the risks of such an event occurring. This is known as the defence of *volenti non fit injuria* and is explained in more detail in chapter 6. In order to rely on this as a defence, it would have to be shown not only that Benjamin knew of the risks, but also that he consented willingly to run them and agreed to waive all claim for compensation as a result.

Fraud in research

There is a danger that the pressure to undertake research and provide significant results could lead to fraudulent research practices. For example, it was discovered that a cancer specialist had fabricated the results of his research into the efficacy of a chemotherapy drug.[46] Failure by a practitioner registered with the NMC to follow sound and honest research principles could be seen as evidence of unfitness to practise and lead to her being struck off the Register.

Health and safety of the researcher

Exactly the same principles of health and safety apply to the researcher as apply to other employees, i.e. the employer owes a duty of care at common law to ensure that they are provided with a safe environment, a safe system of work and competent staff. Where the researchers are not employees, the occupier of the premises on which they are working would still be expected to uphold the duty of care for their safety under the Occupiers' Liability Act 1957. It could be, however, that as specialists they would be expected to be aware of those risks that arise from their particular tasks and the NHS trust would not be liable for harm resulting from that. The provisions of the Health and Safety at Work Act 1974 would also apply (see chapter 12).

Research publication and libel

A recent decision by the Court of Appeal and new legislation in the Defamation Act 2013 in relation to the publication of research should remove from researchers the fear of a libel action over their findings. Dr Simon Singh, a science writer, successfully defended an action for libel brought against him by the British Chiropractic Association (BCA). The BCA had won in the High Court, the judge holding that Singh's comments about chiropractic were factual assertions rather than expressions of opinion, which meant that he could not use the defence of fair comment. The Court of Appeal overruled the High Court, holding that his criticism of the BCA's medical claims was honest opinion and he was entitled

to the defence of fair comment. The Court of Appeal held that 'scientific controversies must be settled by the methods of science rather than by the methods of litigation'.[47] (See also chapter 30.) However, threats of defamation action against Dr Dalia Nield, who has cast doubts on the efficacy of a breast-enhancing cream, suggested that the Court of Appeal has not resolved the issue.[48] Amendments to the Defamation Act which would introduce a stronger public interest defence and thus protect discussions about science, evidence and healthcare from defamation actions were included by Parliament in the Defamation Act 2013 (see chapter 9, page 233).

Health Education England

A special health authority known as Health Education England (HEE) was established in 2012. HEE describes itself as responsible for the education, training and personal development of every member of the healthcare workforce in England. It was abolished by the Care Act 2014 and replaced by a non-departmental corporate body of the same name with functions and constitution set out in sections 96 to 102 and Schedule 5 of the Care Act 2014. Further information on its role can be found on its website.[49] It was based on proposals outlined in *Liberating the NHS*[50] and most of its provisions extend to England and Wales. HEE has the responsibility for carrying out the Secretary of State's functions in relation to the planning and delivery of education and training. It is required under section 98 to exercise its functions with a view to ensuring that a sufficient number of persons with the skills and training to work as healthcare workers for the purposes of the health service is available to do so throughout England. It is also required (s. 99) to exercise its functions with a view to securing continuous improvement:

(a) in the quality of education and training provided for healthcare workers, and
(b) in the quality of health services.

It must also promote:

(a) research into matters relating to such of the activities listed in section 63(2) of the Health Services and Public Health Act 1968 (social care services, primary care services and other health services) as are relevant to HEE's functions, and
(b) the use in those activities of evidence obtained from the research.

It must also exercise its functions with a view to securing that education and training for healthcare workers is provided in a way which promotes the NHS Constitution.

The Secretary of State must publish before the start of each financial year a document which specifies the objectives and priorities that the Secretary of State has set for HEE for that year in relation to the education and training to be provided for healthcare workers. The Secretary of State must also publish at intervals of not more than three years a document (called the 'Education Outcomes Framework') which specifies the outcomes that the Secretary of State has set for HEE to achieve having regard to those objectives and priorities. In its turn HEE must publish a document which specifies the objectives and priorities that it has set, for the period specified in the document, for the planning and delivery of education and training to healthcare workers, and specifies the outcomes that HEE expects to achieve in that respect during that period having regard to those objectives and priorities and provides guidance for Local Education Training Boards. Section 101 sets out the matters to which HEE must have regard in performing its functions. These matters include:

(a) the likely future demand for health services and for persons with the skills and training to work as healthcare workers for the purposes of the health service,
(b) the sustainability of the supply of persons with the skills and training to work as such,
(c) the priorities that providers of health services have for the education and training of persons wishing to work as such,
(d) the mandate (see chapter 5) published under section 13A of the National Health Service Act 2006,

(e) the objectives of the Secretary of State in exercising public health functions (as defined by section 1H of that Act),
(f) the priorities that the National Health Service Commissioning Board has for the provision of health services,
(g) documents published by the Secretary of State under section 100(1), (2) or (3),
(h) the desirability of promoting the integration of health provision with health-related provision and care and support provision,
(i) the desirability of enabling healthcare workers to switch between different posts relating to health provision, health-related provision or care and support provision, and
(j) such other matters as regulations may specify.

HEE is required to make arrangements to obtain advice from those who have an interest in the provision of education and training for healthcare workers and must receive representations from health service providers, users, carers, healthcare workers, regulatory bodies and those providing education and training.

Local Education and Training Boards (LETBs)

Under section 103–7 and Schedule 6 of the Care Act 2014 the HEE must appoint committees for areas in England, each of which is to be called a Local Education and Training Board. The main function of an LETB is to exercise on HEE's behalf its functions to plan and deliver education for healthcare workers and ensure sufficient skilled healthcare workers in the health service in its area. It is required to publish an education and training plan and arrange for the commissioning of the necessary provision which will be funded by HEE. Further information on the role of LETBs and the location of each can be found on the NHS Employers' website.[51] The Secretary of State may specify a tariff setting approved prices in respect of education and training.

Conclusions

The content of nurse education and training and how it should be taught have come sharply into focus following criticisms of nursing care in the inquiry into Stafford Hospital (see chapter 5). A suggestion by the government that prospective nurses should be compelled to spend up to a year with hands-on care to avoid a repeat of the Stafford Hospital scandal was greeted by the Royal College of Nursing as a waste of public money, unworkable and having no benefit to patients[52] and was not supported by the well-known NHS commentator Professor Alan Glasper.[53] Subsequently, a survey carried out by the National Nursing Research Unit at King's College London found that almost 90 per cent of nurses found that they were too busy to carry out basic simple tasks such as comforting distressed patients, preventing bed sores and giving the right drugs. Minimum staffing levels were called for.[54] In his first week in office, the new Chief Inspector of Hospitals, Professor Sir Mike Richards, stated that nursing numbers needed to rise if quality of service was to be maintained. He said that the ability of nurses to provide compassionate care has been undermined through being overworked on understaffed wards.[55] In May 2014 NICE issued guidance on nurse staffing, but stopped short of giving recommended staffing levels.

The controversy as to how to bring back compassion into nursing has many implications for those working in nurse education. They need to take part in the debate as to whether the abandoned role of state enrolled nurse should be reintroduced, what should be the content of nurse education and what should be the balance between teaching in the classroom and practical work on the wards. In addition nurse tutors should be at the forefront of research into staffing levels and measuring patient dependency. It is too early at this stage to gauge the value and implications of the HEE and the LETBs. The dispute over restrictions on using patient information and research projects is considered in chapter 8.

Reflection questions

1 How could a nurse tutor defend herself if a nurse who is accused of causing harm to the patient blamed the teaching that she had received in the nurse training college?

2 What records do you currently keep on your teaching programmes? Review the period for which you keep them and their content in the light of this chapter.

3 What records do you keep in respect of external lecturers who are invited to teach in your department? How would you defend a case where an employee was suing for back injury and the manual handling training was carried out in your department?

4 In what ways does cooperation exist between the nurse training school and the wards and departments to ensure that the nurses' training meets the standards of approved accepted practice?

5 Researchers state that they are carrying out research on those who are unable to give consent. What protection does the Mental Capacity Act 2005 apply to such participants?

Further exercises

1 Prepare a procedure for initiating a research proposal, for obtaining the necessary approvals, for envisaging any possible difficulties in carrying it out and for publishing the results.

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Chapter 19

Legal aspects of the care of older people

This chapter discusses

- Rights to care
- National Service Framework for Older People
- Intermediate care
- Consent to treatment
- Force, restraint and assault
- Medication and the confused older patient
- Dementia
- Standard of care
- Risk management
- Abuse of older people
- Mental Capacity Act 2005 and decision making for the mentally incapacitated adult

Introduction

It is a truism that every elderly person is different. The fact that a person is over 60 or 70 or 80 or 90 says absolutely nothing else about them. Standards of health, loneliness, housing, finance, mobility and capability are as varied as with any other age group. All that can be said of them as a group is that it is more likely than not that they will be faced with some problems – social, economic, health or others – and that these are more likely to be multiple problems, interrelated, with one triggering off another.

For example, it might be that an older person living on his own has limited mobility and therefore finds it difficult to get to the shops. He thus does not feed himself properly and comes under the hospital's care as a result of lack of proper nourishment. Figures produced by the NHS Information Centre show that people over the age of 60 accounted for almost half of all the 16.8 million hospital admissions in 2009–2010. Provision against discrimination on grounds of age is now included in the Equality Act 2010. The government has provided guidance on banning age discrimination in services.[1] (Age discrimination laws relating to employment are discussed in chapter 10.) In addition, older people can claim discrimination in respect of their human rights as set out in the European Convention on Human Rights as a result of Article 14 (see chapter 1). All that has been said of the general principles of negligence and vicarious liability applies equally to the nurse who cares for older people. Discrimination issues may also arise in the care of older people from black and minority ethnic communities or from ageism, and these must also be addressed.[2] The Equality Act 2010 has recognised the right not to suffer combined discrimination. Section 14 protects against combined discrimination where (1) a person (A) discriminates against another (B) if, because of a combination of two relevant protected characteristics, A treats B less favourably than A treats or would treat a person who does not share either of those characteristics. Discrimination on grounds of age could thus be linked with discrimination on grounds of: disability; gender reassignment; race; religion or belief; sex; or sexual orientation.

In February 2007 Age Concern noted that ageism is the most common form of discrimination in the UK. Its survey revealed that more than three times more people have been the victims of ageism than any other form of discrimination.[3] Older people are the highest users of acute services in the NHS.[4] There are particular difficulties that the nurse who cares for older people is more likely to encounter than other nurses and these are considered in this chapter. In 2008 the RCN published a resource pack for students learning to work with older people[5] and a mentorship A5 card designed to explain the positive benefits of mentorship for those caring for older people to raise standards of care.[6] The NMC published guidance on the care of older people in March 2009 which is available on its website.[7]

[The] guidance is constructed around the views of older people. It sets out what older people expect when receiving care and therefore provides a framework to help nurses to focus on the issues that matter most to them and enables nurses to provide a safe and positive care experience from the perspective of older people.

The guidance is put within the context of clauses of the Code of Professional Conduct to illustrate the link between professional standards of care and the care of the older person. The guidance supports the Code. Its key principles concern independence, participation, care, self-fulfilment and dignity, and it aims to influence the way that older people are cared for in all care settings by promoting dignity, respect and the rights of older people.

There are, in addition, problems relating to the property and possessions of older people and these are dealt with in chapter 25. In chapter 29, there is a discussion on the law relating to the making of wills and other aspects of dealing with death. Those nurses who care for older people in the community should refer to chapter 23 for coverage of that topic. Those caring for older people who are mentally disordered should refer to chapter 20. Living wills (advance decisions) are considered in chapter 29.

Rights to care

There are no laws that set a cut-off point at which interventions for older people are not justified. On the contrary, the human rights legislation and the Equality Act 2010 would prohibit discrimination on the grounds of age. In the past, for example, there have been occasions where ambulances have been told to take patients over 65 to a geriatric ward rather than to a coronary care unit; where a non-resuscitation policy has been based on the age of the patient rather than their physical condition and prognosis; where they have been refused surgical treatment because of their age. Age UK reports that such discrimination is still occurring[8]. Research published in December 2013 suggested that there was a culture of ageism

in the NHS since the elderly were being denied hip and knee replacements as the NHS attempted to save £20 billion.[9] Older lung cancer patients are six times less likely to be offered potentially life-saving surgery than younger people.[10] In January 2013 Macmillan Cancer Support reported that doctors were discriminating against older patients in cancer care and in a survey of 101 oncologists 81 per cent would offer chemotherapy for a high risk breast cancer patient of 68, but only 47 per cent would do so for an identical patient of 73.[11]

Such discrimination has no legal basis. There are in law no age limits for accessing treatment. The only criteria are the prognosis of the patient and the extent to which further investment in their health is justified in terms of the benefit that it would bring to that individual. The Equality Act 2010 recognises age as one of eight characteristics to be protected against discrimination (see chapter 10). A tool has been designed to identify whether or not age discrimination is occurring in hospital, primary care and social care.[12] Discrimination of the grounds of age would be a breach of Article 14 of the European Convention on Human Rights (see the website of this book) when linked with violation of another Article. However, in one case the High Court held that it was not a breach of Article 8(1) of the European Convention on Human Rights, or, if it was, it was justified under Article 8(2), when a local authority closed a day centre, because it was working well below full capacity and the cost savings would release resources for domiciliary care. The local authority had not acted irrationally.[13]

A plea to retain a specialism of old age psychiatric services was made by a group of distinguished health professionals to the editor of *The Times*[14] who argued that a misunderstanding of the age discrimination laws will lead to a much worse service for elderly people.

National Service Framework for Older People

The Social Services Inspectorate report on improving older people's services[15] in 2001 showed that local authorities were expanding their services to promote independence through prevention and rehabilitation. This was in accordance with the philosophy of the National Service Framework (NSF) for Older People[16] published by the Department of Health in 2001. Guidance was issued in March 2001.[17] (See chapter 5 for further details on NSFs.)

The NSF for Older People is:

> **A strategy to ensure fair, high quality, integrated health and social care services for older people. It is a 10-year programme of action linking services to support independence and promote good health, specialised services for key conditions, and culture change so that all older people and their carers are always treated with respect, dignity and fairness.**

The eight standards cover the following areas:

Standard 1	Rooting out age discrimination
Standard 2	Person-centred care
Standard 3	Intermediate care
Standard 4	General hospital care
Standard 5	Stroke
Standard 6	Falls
Standard 7	Mental health in older people
Standard 8	Promotion of health and active life in older age.

Each standard sets out its aim, defines the standard and identifies its rationale and the key interventions. In addition, a timetable of milestones is set by which specific targets must be achieved. A booklet on medicines and older people is also published to ensure that older people gain maximum benefit from medication and do not suffer unnecessarily from illness caused by excessive, inappropriate or inadequate consumption of medicines. The NSF also identifies how the standards are to be implemented at local level and the national support that will underpin the standards. The National Institute for Health

and Care Excellence (NICE) has an important role to play in ensuring that the standards are based on clinically effective research-based practice and is currently engaged in controversy as to the extent to which wider societal benefit should be taken into account when considering giving priority to specific medicines[18] (see chapter 5).

In March 2014 the Chief Executive of NICE Sir Andrew Dillon stated that 'age would inevitably be a factor (in assessing new drugs) as the young have more years left to contribute. Elderly people would not be denied new drugs because NICE plans would raise the number of treatments approved.'[19] The NSF for Older People is underpinned by a programme of research commissioned by the Policy Research Programme and Service and Delivery Organisation Programme.[20] The Care Quality Commission (replacing the Healthcare Commission (i.e. CHAI) and the Commission for Social Care Inspection (CSCI)) ensures through inspections that the standards are implemented across health and social services. In addition, progress overall was initially overseen by the NHS Modernisation Board and the Older People's Taskforce. A progress report on the NSF was issued by the National Director for Older People's Health in November 2004, entitled *Better Health in Old Age*.[21] In 2007 the Department of Health and the National Director for Older People issued a review outlining the next steps in implementing the NSF.[22] It looked at three themes: dignity in care, joined-up care and healthy ageing, and considered 10 programmes for progress with a review of the available resources. In 2008 the Department of Health published an overview report on research to support the NSF for Older People.[23] It identified the demographic significance of older people and considered the progress in implementing some of the initiatives (for example, it concluded that reimbursing hospitals for delayed discharges was no longer a necessary policy in England) and set out new areas for research. The National Director for Older People also published in 2007 guidance on a change of direction in the provision of services for older people by bringing the services closer to their homes.[24] Additional guidance has been issued on specific standards.

The priorities for the second phase of the 10-year programme for the NSF for Older People were set out by the Department of Health in April 2006 and can be downloaded from the DH website.[25] In October 2010 it was announced that paramedics were in a pilot trial to give drugs to stroke victims before they reach hospital to reduce high blood pressure and reduce the damage from the stroke.[26] Updates on the NSF for older people can be found on the NHS Choices website.[27]

The National Service Framework (NSF) for long-term conditions 2005

In 2005 the DH published a strategy for long-term conditions setting five key outcomes for people with long-term conditions.[28] It points out that one in three of the population suffers from a long-term condition and the number of people with a long-term condition is expected to rise by 23 per cent over the next 25 years. A revised edition of the compendium on long-term conditions first issued in 2004 was published in 2008.[29]

The NSF for long-term conditions sets out 11 quality requirements in health and social care services:

1 A person-centred service
2 Early recognition followed by prompt diagnosis and treatment
3 Emergency and acute management
4 Early and specialist rehabilitation
5 Community rehabilitation and support
6 Vocational rehabilitation
7 Providing equipment and accommodation
8 Providing personal care and support
9 Palliative care
10 Support for family and carers
11 Care during admission to hospital.

Other initiatives to improve the services for older people include the Dignity in Care campaign, launched in November 2006, which aimed to ensure that older people are treated with dignity when

using health and social care services. It wished to create a zero tolerance of lack of dignity in the care of older people in any care setting. In 2007 the Healthcare Commission carried out a review of acute services to ensure that older people are treated with dignity and respect. Further information can be obtained on the Care Quality Commission website and on the DH websites. The Care Services Improvement Partnership (CSIP) set up an initiative for older people and physical disabilities and its change agent team (now merged with the integrated community equipment services team) works with social care, health and housing to promote independence, extend choice and improve people's quality of life. The CSIP's work was transferred to the Department of Health and the regions in 2008.[30] The Older People's Care Group Workforce Team (CGWT) links with the CGWTs for access, cancer, coronary heart disease, long-term conditions and mental health to ensure that older people's issues are considered in all these areas of workforce development. Information on all these CGWT sites can be obtained from the UK government website. The Healthcare Commission (predecessor of the CQC) published in 2009 *Equality in Later Life* which focused on the extent to which social services in England were addressing the outcomes for service users and carers around the themes of age discrimination, quality of inpatient care, comprehensiveness of services and cooperation with other services. The Kings Fund published a report (*Older People and Emergency Bed Use*) online[31] in August 2012 suggesting that over 5,700 fewer hospital beds would be required if services for the elderly were better developed and integrated.

Intermediate care

Intermediate care has been described[32] as a core element of the government's programme for improving services for older people. In conjunction with improvements to community equipment services, home care support and related services, it should enable increased numbers of older people to maintain independent lives at home.

To come within the definition of intermediate care, services must meet *all* of the following criteria:

- are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS inpatient care
- are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- have a planned outcome of maximising independence and typically enabling patients/users to resume living at home
- are time-limited, normally no longer than 6 weeks and frequently as little as 1–2 weeks or less
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Intermediate care is covered in Standard 3 of the NSF for Older People.

Various models are envisaged, including rapid response, hospital at home, residential rehabilitation, supported discharge and day rehabilitation. Guidance on the responsibilities for intermediate care and charging, planning its development, the role of the independent sector, the funding of intermediate care and community equipment services and the evaluation of the service has been provided by the Department of Health. The 2001 guidance suggested that intermediate care should last no longer than six weeks with discretion in individual cases. The 2009 guidance recognised the short-term nature of intermediate care but recommended the need for flexibility and avoiding unrealistic expectations. Sanctions against local authorities that fail to provide discharge arrangements for an older person in hospital, thereby blocking a bed, are provided under the Community Discharge (Delayed Discharges) Act 2003, which is discussed in chapter 23. A fact sheet published by Age Concern in November 2009 gives the current situation on intermediate care.[33] See also the Hospital 2 Home resource pack which is considered in chapter 23.

Consent to treatment

Practical Dilemma 19.1 An operation at 90?

Amy Ash was admitted to hospital suffering from severe abdominal/chest pain. Amy was intermittently competent. There were days when she recognised Gwen, her daughter, and others where she did not, but instead abused Gwen when she came to visit her. The physician diagnosed a hiatus hernia. There was considerable debate over the best method of treatment. Initially, a strict diet and medication were proposed, but there were signs that this was not working when Amy started bleeding internally. The physician asked Gwen to come in and see him to talk about Amy's future care. He said that possibly the only long-term course of treatment was an operation. However, at Amy's age there were considerable risks in undertaking this. Although she was in a reasonably good state of health, she might not withstand the operation. Gwen was in a dilemma, not knowing whether to sign the form of consent on Amy's behalf. She attempted to explain the position to Amy. Amy grasped the fact that she would have to have an operation. She made it clear to Gwen that she had had a good life and did not want to be cut open now. Gwen also spoke to the ward sister who explained that Amy was in very good health and would probably survive the operation, but, of course, one could not be 100 per cent sure. What should Gwen do?

In Practical Dilemma 19.1, if Amy is assessed as lacking the requisite mental capacity to make a decision about the operation, the Mental Capacity Act 2005 would apply. Does Amy lack mental capacity?

It could well be that in her saner moments she is fully capable of understanding what is happening to her and of giving a valid consent or refusal. At other times, she may well be far removed from reality. If the doctor obtains her signature on a form consenting to the operation in one of these rational spells, can he rely on it when she becomes mentally confused? The answer is probably yes. Section 2(2) of the Mental Capacity Act 2005 states that 'It does not matter whether the impairment or disturbance is permanent or temporary'. Provided that Amy has the mental capacity at the time she gives consent to the operation, that would be a valid consent. It is essential, however, that only a reasonable time elapses between the signing of the form and the operation being carried out and the operation must clearly be in the interests of the patient. What is reasonable? Certainly not as long as a year, but possibly up to three months. It depends on the operation to be performed and whether the circumstances remain exactly as they were when the patient signed the form.

If Amy is incapable of making a decision when the operation is required, then under the Mental Capacity Act 2005 (in the absence of an advance decision in which Amy when mentally capable had set out her wishes as to what should happen in this situation (see chapter 29)), action must be taken in her best interests. The steps set out in the Mental Capacity Act 2005 in determining the best interests of Amy must be followed (see chapter 7). If the operation for a hiatus hernia is seen as serious medical treatment then there must be consultation with carers over what Amy would have wished, and what her feelings, views, values and beliefs would have been in order to determine her best interests. In the absence of such persons to consult it would be necessary to appoint an independent mental capacity advocate. (This appointment is not necessary here because her daughter Gwen can be consulted.) Advance decisions or living wills are considered in chapter 29.

Case 19.1 *London Borough of Redbridge v. G (2014)*

In February 2014 the LA applied to the court for a declaration that G an elderly lady lacked the requisite mental capacity to make her own decisions and were concerned at the influence of C, a live-in carer, and F, another carer over her. Russell J made a declaration of incapacity in relation to the relevant decisions and that proceedings in relation to her welfare and in particular her residence with C should continue in the Court of Protection.[34] Subsequently her carers C and F were involved in public protests outside Ilford town hall to protest about the involvement of the LA in G's care. There was a dispute as to whether G herself wished to be in contact with the press. Cobb J ordered an assessment to be made about G's mental capacity to communicate directly with the press and for the interim determined that it was probably not in G's best interests to be in communication with the press. He also made an interim order that C and F should facilitate visits by the LA social workers.[35] Sir James Mumby in the Court of Protection held that G's Article 8 rights not to be involved with the press took precedence over Article 10 rights of the press. He refused the application of Associated Newspapers Ltd to be joined as a party to the case.[36]

In a case decided in July 2014 Mr Justice Cobb of the Court of Protection decided that it was in the best interests of a patient with dementia to continue to stay in a care facility despite the recommendation of the social worker that she would be happier at home. The judge held that the patient (who was German and had moved to the UK after the Second World War) was physically well cared for, and had a social life readily at hand.[37]

Force, restraint and assault

Caring for confused older patients raises concerns about what action can be taken in fulfilment of the duty of care, when treatment is being refused contrary to the best interests of the patient or when they are at risk of harm and need to be restrained. Updated guidance is provided by the RCN on restraint and rights, risks and responsibilities.[38] Anyone using restraint of any sort must ensure that their actions are compatible with Article 3 of the Human Rights Convention, which is discussed in chapter 1 and can be found on the website of this book. Advice is also given by Counsel and Care on minimising the use of restraint in residential and nursing homes for older people.[39] It includes flowcharts to assist in assessing the level of risk and making decisions on the use of restraint. Counsel and Care has also published a discussion document[40] that considers the meaning of restraint, examples of why restraint is used and suggests some working principles. Reference should also be made to publications of the Social Services Inspectorate, such as *No Longer Afraid*.[41] Where an adult lacks the mental capacity to make their own decisions a limited form of restraint can be used under the Mental Capacity Act 2005. Under Section 5 of the MCA restraint cannot be used unless two conditions are satisfied. These are:

- that the decision maker must reasonably believe that it is necessary to do the act in order to prevent harm to the client/patient, and
- that the action is a proportionate response.

Proportionate means that the act of restraint is proportionate to both the likelihood of harm to the client/patient and the seriousness of the harm.

The use of restraint is defined as including both the decision maker using or threatening to use force to secure the doing of an act which the client/patient resists and also restricting the mentally incapacitated person's liberty of movement, whether or not he or she resists.

Examples of justified restraint might include pulling a person back from crossing in front of a car or moving a person away from an open window. The Mental Capacity Act was amended to enable a person's liberty to be restricted in circumstances where the use of mental health legislation was not justified or possible. These amendments, known as the Deprivation of Liberty Safeguards (DoLS) were made to fill what was known as the Bournewood gap and they are considered in chapter 17. The Supreme Court has ruled that the severely disabled are entitled to the same protection from the Deprivation of Liberty Safeguards as are applicable to others.[42] The case is considered in chapter 17 (see Case 17.4) and is likely to lead to many more applications to the Court of Protection.

Examples of bad practice

The Parliamentary Joint Committee on Human Rights in August 2007[43] found that more than a fifth of care homes have been found to be failing basic standards of care for privacy and dignity. Its recommendations are considered in chapter 23.

Four care workers were found guilty of ill-treatment or neglect of elderly residents at a nursing home and three were imprisoned the other given a community order.[44]

In 2013 there were 109,000 referrals to social services last year of suspected elder abuse a rise of 2,000 on 2012. A quarter of cases involved a spouse, partner or family member and the abuse ranged from neglect to physical violence.[45] The charity Action on Elder Abuse is concerned at the government's slowness in acknowledging the problem.

A report by the Good Care Guide stated that staff at a care home tied an elderly lady to a chair to stop her wandering.[46] It found that more than a quarter of families had claimed that relatives had suffered poor treatment in care homes or by carers in their own home.

Restless patients

Practical Dilemma 19.2 The wanderer

One further difficulty that the staff had with Amy (described in Practical Dilemma 19.1) was that she could never stay in one place. She always liked to be on the move. Her restlessness took her all around the hospital where she was well known and those with time on their hands would eventually bring her back to the ward. Unfortunately, building work started on site and the contractors were asked to take special care in crossing hospital roads. The nursing officer instructed Amy's ward sister to keep her on the ward because of the danger. The ward sister could not be sure that someone was always available to keep an eye on Amy and, rather than lock the ward door and imprison all the patients, she decided to use a restrainer on Amy so that every time Amy tried to get out of her chair a belt, which was fastened around Amy and to the chair, rang a bell and prevented Amy from leaving the chair. Gwen visited Amy and was distressed to see this form of restraint; Amy herself protested about it. What is the legal position?

To restrict a person's movement without lawful authority so that they have no way of escape is a form of false imprisonment. This effectively is what Amy is – imprisoned. Limited restraint could be used under the Mental Capacity Act, as described above. However, any form of restraint which could be seen as a breach of Article 5 and a person's right to liberty and security of person must comply with either the Mental Health Act 1983 (as amended) or the Deprivation of Liberty Safeguards enacted by amendments to the Mental Capacity Act 2005 and introduced to fill the Bournewood gap.

The form of restraint used by the ward sister would appear to be neither temporary nor reasonable. What alternatives are available to the ward staff, given that they have a duty to care for Amy and to

prevent her exposure to danger? Adequate staffing to keep an eye on each person is obviously one possibility, but given present-day economic constraints and nurse staffing levels it may not be a realistic option. Another possibility is the use of more volunteers to supervise certain patients. One suggestion is to change the locks so that it takes some ingenuity to open the door without the help of the ward staff, although this is not a happy compromise. Electronic tagging devices are also used, so that if a patient wearing such a device goes through an exit, then a bell warns the staff. Even if there are no contractors onsite, there may be other dangers such as a main road nearby, a stream in the grounds, etc. If unreasonable methods of restraint are used, this could be a violation of the patient's human rights as set out in Article 3, 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment', or under Article 5.

Where staff consider that some form of restraint is necessary to control very aggressive older patients, they should obtain advice on the application of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. (See chapters 7 and 17 or the Mental Health Act 1983, chapter 20.) The Alzheimer's Society suggested in December 2007 that electronic tagging should be offered to dementia sufferers to allow their relatives to locate them quickly should they wander off. The Society advised that, where possible, permission should be sought from the sufferer, perhaps in advance, before he or she has reached the later stages of dementia.[47]

Control at night

At night, cot sides are often used to prevent patients climbing or falling out of bed. In one sense, where the older person is clearly struggling against them, these represent a form of restraint. By the same token, they may in some circumstances be justified and indeed necessary where the patient is very confused and restless. Failure to use them might lead to action against the authority for failing in its duty of care for the patient. However, the potential danger of the patient trying to climb over the cot sides and causing himself harm must always be borne in mind. A risk assessment has to be carried out on whether the use of cot sides in each individual situation is justified and safe. Records should be kept of this risk assessment. Information is available from the Medicines and Healthcare Products Regulatory Agency (MHRA)(see chapter 12) on the use of bed safety rails.[48] Its Device Bulletin in 2006[49] provides guidance on the use of bed rails which are not supplied by the bed manufacturer, the need for a full risk assessment on the suitability of using a bed rail and general guidance on their use.

Daily care

Practical Dilemma 19.3 Chiropody case

One form of treatment that Amy could not tolerate was having her toenails cut. She was abusive to the podiatrist, who found it very difficult to keep her nails in reasonable order. The podiatrist asked the ward sister if she would hold Amy down while she attempted to cut her nails. The ward sister was not happy with this suggestion and felt that they should first seek medical guidance as it might be preferable to cut the nails when Amy was mildly sedated. What is the legal position?

Chapter 7 discusses consent to treatment where it is stated that touching another person without their consent or some other lawful authority is a trespass to their person. Does the fact that Amy needs to have her toenails cut constitute lawful authority? The answer to this is, in general, no. However, the fact that Amy lacks the capacity to give a valid consent may well justify the professionals taking some action to care for her. As has been seen earlier, professionals are justified in acting in the best interests of a patient incapable of making his or her own decisions under the Mental Capacity Act 2005. This is

quite clear if the patient is unconscious. In considering podiatry, we are not talking of something that is, at least initially (although it may well be ultimately), a life-saving procedure. In addition, there are numerous nursing tasks and social tasks such as bathing, hairwashing and brushing to which patients like Amy may well object. In theory, of course, to brush Amy's hair without her consent is a trespass to her person. There may be occasions when Amy can be persuaded to have it done and will not struggle against it. However, inevitably, there may come a time when Amy needs to have something done despite her protests. In such cases restraint may be used, providing the conditions set out in the Mental Capacity Act as described above are satisfied. If the level of restraint required is such that it could infringe her rights under Article 5 of the European Convention on Human Rights, then it may be necessary to consider using the Deprivation of Liberty Safeguards (DoLS) resulting from the Bournewood case.

Medication and the confused older patient

The above principles apply equally to the administration of medication. The majority of patients in general and psychiatric hospitals are on some form of medication, but only a few of them are under a section (about 5–10 per cent of psychiatric patients). There are many occasions when, through a variety of reasons ranging from justifiable ones to pure cussedness or confusion, they reject the tablets, injections or liquid. What does the nurse do? Obviously, where the patient is capable of making that decision, his refusal should be respected. But this is rarely the case. Often the patient is in Amy's situation: intermittently or permanently confused and mentally infirm. The provisions of the Mental Capacity Act which enable action to be taken in the best interests of the person lacking the capacity to make decisions can be applied (see chapter 7).

In 2001 the UKCC published[50] a position statement on the administration of medicines by covert means. This is discussed in chapter 28 on medicines.

Practical Dilemma 19.4 Resistance in the elderly

On one occasion Amy made it clear that she would not have her medication, which was prescribed as a sedative and for her heart condition. As an informal patient, could she be forced to take the medication since it was for her benefit and she lacked the mental capacity to make a reasoned judgement over whether she should be taking it?

It is necessary in a situation such as Practical Dilemma 19.4 for a clear assessment to be made of Amy and whether she lacks mental capacity to make a decision about her medication and whether or not she is suffering from mental disorder. If Amy is assessed as lacking the mental capacity to decide whether she should take medication, then she would come under the provisions of the Mental Capacity Act 2005 and action must be taken in her best interests. The provisions of the Act are set out in chapter 7 and also considered in chapter 17. If she is assessed as suffering from mental disorder then consideration should be given as to whether she should be detained under the Mental Health Act 1983 (as amended) and given compulsory treatment under Part 4 of the Act (see chapter 20). The answer to the question in Practical Dilemma 19.4 is that as an informal patient lacking the requisite mental capacity to determine whether or not to take medication, she could be compelled to take medication if it was considered to be in her best interests.

Medication may sometimes be used as a form of restraint. There are considerable dangers in so doing and the practice may be declared illegal under Article 3 of the Human Rights Convention (see chapter 1 and the website of this book) on the grounds that it is degrading or inhuman treatment. A line has to be drawn between medication that is in the best interests of a mentally incompetent patient

(and could therefore be given under the Mental Capacity Act) and medication that is for other purposes. The latter would be unlawful. In January 2004 a House of Commons Health Committee Investigation into elder abuse reported that more than half of the care homes for older people were failing to administer old people's medication properly. Only 45 per cent of homes met minimum standards. The situation found by the Joint Committee in August 2007 on elder abuse in care homes suggested that standards had not improved (see page 625). A review carried out for the Department of Health in November 2009[51] found that over 144,000 patients suffering from dementia were being given anti-psychotic drugs unnecessarily. The Care Services Minister undertook to appoint a national clinical director for dementia to conduct an audit of GPs' and hospital doctors' prescribing of anti-psychotic drugs. The review considered that their use could be reduced by two-thirds.

An expert report from the Royal College of Physicians on the feeding of patients at the end of life concluded that care homes were insisting on feeding residents with feeding tubes because there are not enough staff to provide conventional feeding.[52]

Dementia

The National Audit Office reported in 2007 that too little is being done to deal with the growing problem of dementia care. Its report stated that Britain was slow to diagnose cases and lagged behind other European countries in providing care. There were estimated to be about 500,000 persons with dementia in England. In July 2014 the number of people known to have dementia rose by almost two-thirds in seven years following a big push to tell sufferers that they have the disease.[53] A survey in 2009 by the Alzheimer's Society found that dementia patients over 65 years were kept in hospital too long and received disgraceful care that worsened their condition.[54] Many patients were malnourished, dehydrated or unable to return home.

In January 2008 the Public Accounts Committee of the House of Commons published a report on improving services and support for people with dementia.[55] The report came to the following conclusions:

1. Dementia affects over 560,000 people in England, costs about £14 billion a year but has not been an NHS priority. The National Dementia Strategy now being developed by the DH should have a clear timetable for implementation, and criteria for evaluation and reporting progress. It should also have an effective communication strategy to engage professionals, patient groups, the Royal Colleges, inspectorates and the voluntary sector.
2. Unlike cancer and coronary heart disease, there is no single individual with responsibility or accountability for improving dementia services. The DH should appoint a Senior Responsible Officer.
3. Between a half and two-thirds of people with dementia never receive a formal diagnosis. Diagnosis should always be made, regardless as to whether interventions are available, and could be assisted if GP practices had greater support from mental health services, if the Royal College of General Practitioners developed a dementia care pathway, and by the Institute of Innovation and Improvement promulgating good diagnostic practice.
4. There is a poor awareness among the public and some professionals of dementia and what can be done to help people with the disease. DH should commission a dementia awareness campaign.
5. People with dementia require support from multiple health and social care providers but this is often difficult to manage. On diagnosis, people with dementia and their carers should be given a single health or social care professional contact point (e.g. a social worker or community psychiatric nurse) to improve the coordination of care.
6. Carers save the taxpayer £5 billion a year, yet between a half and two-thirds of all carers do not receive the carer's assessment to which they are entitled. The DH should emphasise to local health organisations and their social care partners that they need to develop an action plan which gives

priority to assessing and meeting the needs of carers and develop a commissioning toolkit to demonstrate the cost benefits of the different options for providing support, including respite and domiciliary care.

7 Sixty-two per cent of care home residents are currently estimated to have dementia but less than 28 per cent of care home places are registered to provide specialist dementia care. CSCI (now the Care Quality Commission) should assess staff qualifications and training as part of its review of the quality of care for people with dementia, and local mental health teams should use the finding when allocating resources to community psychiatric teams.

8 Hospital care for people with dementia is often not well managed, increasing the risk of longer stays, admission to a care home and deterioration in the patient's health. Hospitals should routinely undertake a mental health assessment. Care records should be shown to paramedics, so that an informed decision on admission to hospital or to care home can be made.

Following the Public Accounts Committee report the DH promised that a National Dementia Strategy would be developed. As part of an awareness campaign on dementia, the Alzheimer's Society published in 2008 a booklet 'Worried about your Memory' to assist in the identification of Alzheimer's which is available from its website.[56]

The Department of Health published its dementia strategy in February 2009.[57] The key objectives are shown in Figure 19.1. Experts say that dementia will affect at least 1.4 million people and cost the economy £30 billion a year within a generation. The implementation plan published by the DH at the same time as the strategy recognised that all areas would not be able to implement the strategy within five years. Therefore seven key priority outcomes were identified that were likely to need focused attention for early delivery:

- Early intervention and diagnosis for all
- Improved community personal support services
- Implementing the New Deal for Carers
- Improved quality of care for people with dementia in general hospitals
- Living well with dementia in care homes
- An informed and effective workforce for people with dementia
- A Joint Commissioning strategy for dementia.

Dementia care was allocated £150 million for the first two years of the five-year strategy. The Alzheimer's Society welcomed the initiative but was surprised that research was not a fundamental component of the strategy and was disappointed that the review of anti-psychotic drugs had been delayed.

A report published on 17 March 2009 by a firm of health and social care analysts, Laing and Buisson, which surveyed 6,000 care homes, found that training was 'fragmented and ad-hoc' with a third of homes failing to provide staff with specialist instruction. The need for the implementation of the national strategy was obvious.

In 2013 the DH launched 'Making a Difference in Dementia: Nursing Vision and Strategy' using the 6 Cs of care, compassion, competence, communication, courage and commitment to emphasise the strategic role of the nurse.[58] Subsequently, a G8 Conference held in London agreed that dementia should be curable by 2025. New treatments were to be fast tracked for approval as part of an international action plan. A global dementia envoy was to be appointed to keep the condition high on the political agenda and to ensure international research efforts are properly coordinated.[59] It was estimated that in Britain 800,000 people live with a form of dementia, and more than half of them have Alzheimer's. By 2023 it is expected that this number will reach one million. UK spending on dementia research is to be doubled over the next decade (£66 million by 2015 and £130 million by 2025). The CQC has initiated a programme of inspections of hospitals and care homes to check how people with dementia are treated.[60] Following a survey the Alzheimer's Society reported that 1 in 3 dementia sufferers leaves home only once a week and 1 in 10 only leave home once a month. It urged the need to change

- **Objective 1: Improving public and professional awareness and understanding of dementia.** Public and professional awareness and understanding of dementia to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behaviour change in terms of appropriate help-seeking and help provision.
- **Objective 2: Good-quality early diagnosis and intervention for all.** All people with dementia to have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis. The system needs to have the capacity to see all new cases of dementia in the area.
- **Objective 3: Good-quality information for those with diagnosed dementia and their carers.** Providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.
- **Objective 4: Enabling easy access to care, support and advice following diagnosis.** A dementia adviser to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their carers.
- **Objective 5: Development of structured peer support and learning networks.** The establishment and maintenance of such networks will provide direct local peer support for people with dementia and their carers. It will also enable people with dementia and their carers to take an active role in the development and prioritisation of local services.
- **Objective 6: Improved community personal support services.** Provision of an appropriate range of services to support people with dementia living at home and their carers. Access to flexible and reliable services, ranging from early intervention to specialist home care services, which are responsive to the personal needs and preferences of each individual and take account of their broader family circumstances. Accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.
- **Objective 7: Implementing the Carers' Strategy.** Family carers are the most important resource available for people with dementia. Active work is needed to ensure that the provisions of the Carers' Strategy are available for carers of people with dementia. Carers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia. This will include good-quality, personalised breaks. Action should also be taken to strengthen support for children who are in caring roles, ensuring that their particular needs as children are protected.
- **Objective 8: Improved quality of care for people with dementia in general hospitals.** Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.
- **Objective 9: Improved intermediate care for people with dementia.** Intermediate care which is accessible to people with dementia and which meets their needs.
- **Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.** The needs of people with dementia and their carers should be included in the development of housing options, assistive technology and telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.
- **Objective 11: Living well with dementia in care homes.** Improved quality of care for people with dementia in care homes by the development of explicit leadership for dementia within care homes, defining the care pathway there, the commissioning of specialist in-reach services from community mental health teams, and through inspection regimes.
- **Objective 12: Improved end of life care for people with dementia.** People with dementia and their carers to be involved in planning end of life care which recognises the principles outlined in the Department of Health End of Life Care Strategy. Local work on the End of Life Care Strategy to consider dementia.
- **Objective 13: An informed and effective workforce for people with dementia.** Health and social care staff involved in the care of people who may have dementia to have the necessary skills to provide the best quality of care in the roles and settings where they work. To be achieved by effective basic training and continuous professional and vocational development in dementia.

Figure 19.1 Key objectives of the National Dementia Strategy from the DH, February 2009

- **Objective 14: A joint commissioning strategy for dementia.** Local commissioning and planning mechanisms to be established to determine the services needed for people with dementia and their carers, and how best to meet these needs. These commissioning plans should be informed by the World Class Commissioning guidance for dementia developed to support this Strategy and set out in Annex 1.
- **Objective 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.** Inspection regimes for care homes and other services that better assure the quality of dementia care provided.
- **Objective 16: A clear picture of research evidence and needs.** Evidence to be available on the existing research base on dementia in the UK and gaps that need to be filled.
- **Objective 17: Effective national and regional support for implementation of the Strategy.** Appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

Figure 19.1 *continued*

attitudes and build awareness in the community.[61] A report from the Rush University Medical Centre in Chicago suggested that Alzheimer's is responsible for almost as many deaths as heart disease or cancer, but is unreported on death certificates which list the immediate cause of death such as pneumonia rather than the underlying cause.[62]

A report in October 2013 by the Leonard Cheshire Disability Charity stated that many elderly people were being forced to choose between going thirsty and going to the lavatory because more home care visits last for only 15 minutes. The charity has started a campaign to end the scandal of the 15-minute care visit.[63] In April 2014 the director of social care at the CQC stated that care visits to dementia patients that lasted 15 minutes or less were 'ineffective, inappropriate and unsafe'. A new inspection regime was being introduced which would penalise care companies who supplied this type of visit to patients with dementia.[64]

A report in 2014 by Baroness Kingsmill criticised the fact that the 1.8 million of care workers for the elderly were underqualified, undertrained and paid below the minimum wage which led to the frail and elderly not receiving the help they required.[65] (See chapter 24 and healthcare support workers.)

In October 2013 it was reported that a dementia patient was discharged to the wrong house (her previous home) and put in the owner's bed. The mistake was only discovered when her son asked where she was and the police were sent to find her.[66]

Dementia and other legal issues

A person suffering from dementia may involve a nurse in many other legal areas; for convenience a guide to the relevant chapters is given below.

- The Mental Capacity Act – see chapters 7 and 17
- The Mental Health Acts 1983 and 2007, compulsory admission, guardianship, powers of the nearest relative, supervised community treatment order and Section 117 – see chapter 20
- Deprivation of Liberty Safeguards – see chapter 17
- Safeguarding adults issues – see below and also chapter 10
- Financial management and the Court of Protection – see chapters 17 and 25
- Powers of deputy and the Office of Public Guardian – see chapters 17 and 25
- Lasting powers of attorney – see below in this chapter and chapter 25
- Advance decisions/Living wills – see chapter 29.

Standard of care

Practical Dilemma 19.5 An unknown break

Fred, a patient, aged 75, recovering from an orthopaedic operation, was occasionally restless in the night. On one such occasion, he fell out of bed. The night sister rushed to his aid and with the help of the other night nurses, she put him back in bed. Fred appeared none the worse, was happy to have a cup of tea and then he settled down. The next morning, the night sister was about to mention to the day shift that Fred had had a disturbed night, but did not give them the details as they were distracted by a patient with a query. A few days later, Fred was seen to be avoiding putting any weight on his left leg. He was examined, sent for X-ray and a fracture diagnosed. His son asked how this had happened. However, no one could recall any incident in the day and the night staff had not entered the earlier incident in the records or reported an accident. An investigation was then initiated.

Even if the night nurse considered on reasonable grounds that there was no need to call the doctor out in the night, her failure to ensure that the incident was reported to the doctor on the following morning and her failure to arrange for a doctor to examine Fred was clearly not in accordance with approved practice. In addition, she failed to give to the day staff a full account of the night's events so that they were unable to ensure that the appropriate action was taken. The night sister compounded these omissions by failing to fill in an accident report. Unless there are any other mitigating factors in an incident like this, Fred would undoubtedly have a possible claim for compensation against the negligent night nurse and therefore against the NHS trust for its vicarious liability for their employee. Compensation is unlikely to amount to very much, since it would cover only the additional days of pain and suffering because the fracture had not been diagnosed earlier (unless, of course, the nurses were negligent in failing to put cot sides up and prevent the original fall). However, if it is discovered that those few days' delay have had considerable effects on the long-term prospects for Fred's recovery, then, clearly, compensation would be greater. The night sister would obviously face disciplinary proceedings and also fitness to practise investigations. In its annual report for 2002–2003, the NMC highlighted the fact that many cases heard by its Professional Conduct Committee related to poor practice in the care of older people and vulnerable patients. This category made up almost 30 per cent of complaints during 2002–2003. Two of the four cases it describes in detail in its report are concerned with practitioners' failure to deal appropriately with older patients who had falls. A survey by Age UK (a merger of Age Concern and Help the Aged) found that almost one in three nurses would not trust the NHS to care for a malnourished elderly relative. It found that elderly people were not helped with feeding, with unopened food trays being removed without any questions.[67] Age UK's evidence is supported by figures provided by the National Confidential Enquiry into Patient Outcome and Death published in November 2010, which showed that only a third of elderly patients received good hospital care and, for one-fifth, surgery was so delayed that it impaired recovery. In June 2013 NICE published clinical guidance on preventing falls in older people.[68] In May 2014 the chairman of NICE, David Haslam, criticised the care of thousands of elderly patients who were dumped on to an unthinking conveyor belt of NHS care and made to endure operations and medications they do not need. He said that NICE was attempting to reverse the behaviour.

In November 2013 it was reported that nurses had forgotten a patient aged 84 over a weekend.[69] The case was revealed by the Patients Association which stated that the NHS was struggling to provide basic care and was in desperate need of reform. It appeared that the patient had been admitted with a suspected fractured hip and had suffered a stroke, had been prescribed 17 different drugs, but was left to lie in urine and had not been offered food or water for a day. She died a few days later following discharge.

In another tragic death managers refused to allow paramedics to enter the room of a stroke victim in a care home because it breached company policy.[70] A telephone operator refused to let the paramedics have the code to a wall-mounted safe containing the master key because it was not confirmed that it was a paramedic calling.

Pressure ulcers

It is accepted that the breakdown of tissue is not confined to older patients, but since they may be more vulnerable to pressure ulcers, this subject is discussed in this chapter. Many years ago the possibility of suffering from pressure ulcers was believed to be an inevitable result of long-term immobilisation. Now, however, pressure ulcers are seen as evidence of negligence by those providing the care and inevitably are therefore likely to result in litigation. In recent years awards have been made of £32,000[71] and £14,000[72] and where death results from the inadequate care that leads to pressure ulcers, manslaughter charges could be brought[73] (see chapter 2, pages 33–4). Disciplinary proceedings by the employer and fitness to practise proceedings could also be brought against those who have failed to act according to appropriate standards. NICE has prepared guidelines on pressure ulcer risk management and prevention[74] that will be updated as the research basis for best practice improves. Eventually NICE guidance is likely to be incorporated into the Bolam Test of reasonable professional practice. In July 2010 the National Patient Safety Agency (NPSA) (now incorporated within NHS England) announced that it was adopting a zero tolerance approach in relation to pressure ulcers and it provided guidance on prevention.[75] Pressure ulcers were one of the 10 key areas of clinical activity chosen by NPSA for 2010. There may be disputes over which hospital, care home or other establishment is responsible for the breakdown of tissue, and documentation of the examination of a patient on admission (or discharge) and of the risk assessment and management undertaken would be essential to establish which institution and staff were liable for the patient's condition. Prevention and management of pressure ulcers is one of the fundamental areas of patient care for which the Department of Health has identified essence of care benchmarks, first published in 2001 and revised in 2010[76] (see chapter 3).

Winter crises

An agreement was made between the government and the Red Cross, the RVS and Age UK to provide over 5,000 trained volunteers to ease the elderly winter crisis in 2013. Volunteers were to act as part of triage schemes to try to reroute people away from A&E and to provide support possibly reducing admissions.[77] However, Jeremy Hunt said subsequently that it was up to individual hospitals to approach the charities and most of the fund to help hospitals prepare for the winter had been allocated and the £38 million was rejected.[78] NHS England urged neighbours, forming an army of good Samaritans, to help the elderly during the winter. Charities criticised the plan as being ludicrous and an ill-thought-through idea.

An Audit of Intermediate Care found that almost no more of the services were being offered in 2013 than the previous year. Yet the pressure to fill existing intermediate care capacity with people leaving hospital appears to have worsened with 70 per cent of (intermediate care) beds now occupied by people coming off the wards.[79]

Continuing care of older people

In December 1997, the UKCC published a policy paper on the continuing care of older people.[80] Among its recommendations were: that the UKCC should recognise that the central features of the nursing role in continuing care are holistic assessment, health promotion and the ability to work in multi-professional partnership with clients, their carers and other agencies; that specialist practitioners, in particular community nurses and health visitors, be actively involved in all continuing care settings; and community nurses and health visitors have a key role in the assessment of older people for continuing

care services and in ongoing assessment and review following placement. The NMC in its professional conduct annual report for 2002–2003 placed emphasis on the practitioners' duty of care to older patients and clients. The NMC published guidance for the care of older people. Lack of services following the discharge of older people was highlighted by the Royal Voluntary Service which reported that one in 10 elderly people discharged from hospital arrives home to an empty house with no help.[81] Fifteen per cent of over-75s are readmitted within 28 days of discharge. A report from Age Concern in 2014 found that the number of people receiving council care had dropped considerably with only 896,000 receiving help with washing, dressing and eating despite an increase in the numbers of over-65s by 1 million. The amount spent on social care for older people had dropped by £1.2bn (15.4 per cent) since 2010.[82]

The Equality and Human Rights Commission reported in October 2013 that elderly people are being put at risk of neglect and abuse by overstretched home care workers who are paid less than the minimum wage.[83]

In 2011 the EHRC published a report[84] on an inquiry into older people and human rights in home care[85] which recommended that it should:

(a) address gaps in the legal and regulatory framework (e.g. definition of public function under s. 73 Care Act 2014 extends the protection of the human rights convention and the Care Act 2014 places duties on local authorities to promote individual well-being);
(b) address lack of awareness among local authorities about what human rights obligations mean in practice;
(c) address the lack of awareness about human rights and care entitlements among older people and their families;
(d) ensure that there are better arrangements in place to detect threats to human rights in home care;
(e) address the status of home care workers.

Many of these recommendations have been implemented in the Care Act 2014 which is considered in chapter 23.

Registered homes

The Royal Commission[86] recommended that a National Care Commission should be set up to monitor trends, including demography and spending, to ensure transparency and accountability in the system, to represent the interests of consumers and set national benchmarks, now and in the future. The Care Standards Act 2000 set out a new framework for regulation of the independent healthcare sector and most social care. A National Care Standards Commission was established. This was subsequently abolished and its health registration and inspection functions transferred to CHAI (i.e. the Healthcare Commission) and its social services registration and inspection functions transferred to the Commission for Social Care Inspection. From 1 April 2009 the Care Quality Commission is one regulatory authority, with enhanced powers, combining the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection(see chapters 5 and 23). The CQC standards for quality and reports of its inspections of individual homes can be found on its website.[87] From 2013 it has tightened up its inspections and appointed professionally qualified inspectors with expertise in specific areas.

Risk management

It is recognised that if vulnerable clients are to lead lives with a reasonable quality then certain risks must be faced. Thus it would be less risky keeping clients in an institution rather than taking them out for walks or other activities. The report[88] on the responses to the government's Green Paper on 'Independence, Well-being and Choice'[89] points out that 'Care cannot and should not strive to be 100 per cent risk free'.

It recognised that there is a balance to be struck between enabling people to have control over their lives and ensuring that they are free from harm, exploitation and mistreatment. The Green Paper sought to encourage a more open debate about risk management. The feedback showed that there was support for the development of a risk management framework to include guidance and training to provide staff with the support they needed to operate in a new culture which favoured greater exposure to risk. The White Paper *Our Health, Our Care, Our Say*, published in 2006,[90] emphasised choice and control as critical components of the future strategy for health and social care. It gave a commitment to developing a national approach to risk management. Subsequently the Department of Health issued a guide to independence, choice and risk.[91] The guide can be downloaded from the DH website.[92] The guide provides a risk management framework for use by everyone involved in supporting adults using social care within any setting, including NHS staff working in multidisciplinary or joint teams. It states that:

> **The governing principle is that people have the right to live their lives to the full as long as that doesn't stop others from doing the same. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which enables them to manage risks and to live their lives in ways which best suit them.**

The DH has also developed a supported decision tool template which is designed to guide and record the discussion when a person's choices involve an element of risk. This can be adapted to fit into local formats or used as a stand-alone tool.

Abuse of older people

In 2007 the National Centre for Social Research and King's College London reported on a two-year study which showed that almost 350,000 pensioners were abused or neglected in their own homes by carers (family members were responsible for 51 per cent). Campaigners called for new laws to give social workers the same rights of entry as they have where child abuse is suspected.[93]

The Health and Social Care Information Centre published figures on cases of abuse against the elderly in October 2013 which suggested a 28 per cent rise in alerts to local authorities to the year ending March 2013 from the year before. Campaigners are seeking a tightening of the law to ensure that elder abuse is taken as seriously as child abuse and prosecutions are made earlier.[94] Sections 42–47 of the Care Act 2014 places a duty on local authorities to safeguard adults at risk of abuse or neglect. The Disclosure and Barring Service (which replaced the Criminal Bureau and Independent Safeguarding Authority) processes checks on people seeking employment with children or vulnerable adults (see chapter 10).

In 2013 the Department of Health published an updated policy statement on safeguarding adults who are vulnerable to abuse and neglect. It is available on the government website.[95] It sets out the following principles of safeguarding adults:

empowerment
prevention
proportionality
protection
partnership, and
accountability,

and shows how these should be implemented by the various organisations involved in the care of the vulnerable and has a useful bibliography of related guidance.

The Care Act 2014 sections 42–45 and Schedule 2 made further provision in relation to Safeguarding Adult Boards and is shown in Statute Box 19.1.

Statute 19.1 Care Act 2014 sections 42–5

Safeguarding adults at risk

Section 42

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) –
  (a) has needs for care and support (whether or not the authority is meeting any of those needs),
  (b) is experiencing, or is at risk of, abuse or neglect, and
  (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3) 'Abuse' includes financial abuse; and for that purpose 'financial abuse' includes –
  (a) having money or other property stolen,
  (b) being defrauded,
  (c) being put under pressure in relation to money or other property, and
  (d) having money or other property misused.

Section 43

Each local authority must establish a Safeguarding Adults Board (an 'SAB') for its area with the objective of helping and protecting adults in its area in cases of need. The way in which an SAB must seek to achieve its objective is by coordinating and ensuring the effectiveness of what each of its members does. An SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.

Section 44

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –
  (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
  (b) condition 1 or 2 is met.

(2) Condition 1 is met if –
  (a) the adult has died, and
  (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if –
  (a) the adult is still alive, and
  (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must cooperate in and contribute to the carrying out of a review under this section with a view to –
  (a) identifying the lessons to be learnt from the adult's case, and
  (b) applying those lessons to future cases.

Section 45 sets out the right of the SAB to obtain information from persons providing specified conditions are met.

Code of practice

Each local authority should have in place a code of practice to protect older people from abuse. An agreed procedure should be followed where there are concerns that an older person may be subject to

abuse. Community nurses should obtain a copy of their local code of practice if they have reason to fear that one of their patients is subject to abuse, whether physical, sexual, emotional or financial. Box 19.1 sets out the steps that a community nurse should follow. Age UK has been running a campaign to prevent elder abuse and further details and leaflets can be obtained from its website.[36] A confidential helpline has been set up by Action on Elder Abuse[37] which also provides guidelines for health and social workers in detecting and preventing elder abuse, available on its website.[38]

Box 19.1 Guidelines for action in abuse of older people

1. Find out if the local authority has a procedure for the protection of vulnerable adults where abuse is suspected. If so, follow this procedure. Ensure you document your concerns and action.
2. In the absence of a procedure, seek the advice and guidance of senior management. Information can also be obtained from the Action on Elder Abuse helpline.
3. Keep clear records of the facts on which your suspicions are based.
4. Check if the circumstances set out in section 135(1) of the Mental Health Act 1983 (see chapter 20) appear to be present.
5. Report your concerns to the appropriate social worker, suggesting, if appropriate, a community care assessment under section 47 of the NHS and Community Care Act 1990.
6. Ensure that the patient's general practitioner is also notified of your concerns.

Legal protection

The Domestic Violence Crime and Victims Act (DVCV Act) 2004 requires persons living in a household where there is a child or vulnerable adult to take reasonable steps to prevent the unlawful death of that person. Reasonable steps suggested by Counsel and Care[39] would include:

- reporting suspicions of abuse to the police;
- contacting local social services;
- making sure that any injuries are treated promptly;
- explaining concerns to the GP;
- contacting an organisation such as Action on Elder Abuse.

The DVCV Act defines a vulnerable person as:

> any person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise.

In addition, under the Mental Capacity Act 2005 it is a criminal offence under section 44(2) to ill-treat or wilfully neglect a person who lacks capacity. The Act applies to a person 'D' who has the care of a person 'P' who lacks, or whom D reasonably believes to lack, capacity; to the donee of a lasting power of attorney; or an enduring power of attorney created by P; or to a deputy appointed by the court for P. In one of the first prosecutions under section 44(2), the owner and the manager of a Southampton care home were sentenced: the former to a 30-week jail sentence suspended for 18 months and a fine of £27,000, costs of £25,000 and 200 hours' community service; and the latter to 200 hours' of community service. Nine residents of the 34-bedded care home were found in urine-soaked beds, malnourished, dehydrated and some with bed sores.[40] Four care staff from Hillcroft Nursing Home in Lancashire were charged and convicted under the MCA for ill-treatment or neglect of a person who lacks capacity under the Mental Capacity Act in November 2013.[41] The judge stated that lack of proper management allowed a culture to develop where 'abusive' conduct was allowed to carry on. A registered nurse failed in her appeal against her conviction for wilfully neglecting a person who lacked capacity under section 44

of the Mental Capacity Act 2005. She had failed to apply cardiac pulmonary resuscitation to a patient and by the time the ambulance arrived, he had died. The Court of Appeal held that the judge had been right to direct the jury that the offence of wilful neglect could be made out even if failure to act was the result of panic. Neglect was wilful if a nurse or medical practitioner knew that it was necessary to administer a piece of treatment but deliberately decided not to do so because she could not face it.[102] In contrast, in another case under section 44.2, the Court of Appeal ruled that the appeal of a registered nurse, N, against her conviction should succeed. She cared for a former resident in a care home run by her who now lived in a property owned by N. The Court of Appeal held that the judge had misdirected the jury over the issue of autonomy and the nature of wilful neglect. The Court of Appeal stated that section 44 did not create an absolute offence. Therefore, actions or omissions, or a combination of both, which reflected or were believed to reflect the protected autonomy or the individual needing care did not constitute wilful neglect.[103]

Details of the Safeguarding Vulnerable Groups Act 2006 and subsequent developments can be found in chapter 10.

Long-term funding of care for older people together with the Dilnot Report is considered in chapter 23. Direct payments for health and social care are considered in chapter 17.

Mental Capacity Act 2005 and decision making for the mentally incapacitated adult

The Mental Capacity Act 2005 which came fully into force in October 2007 provides a statutory definition for mental capacity and those acting on behalf of those lacking the requisite mental capacity must act in those persons' best interests. The Act also makes provision for advance decisions or living wills (see chapter 29). The Act also provides for a lasting power of attorney to be granted to a donee, which can include the power to make decisions on treatment and care, once the donor loses the requisite mental capacity. A new Court of Protection has been established which has a wider jurisdiction and can make decisions on personal welfare and appoint deputies to make decisions. (See chapters 17 and 25 and the Court of Protection and property.) In Scotland, the Adults with Incapacity (Scotland) Act 2000 covers the situation of decision making on behalf of incapacitated adults.

Lasting powers of attorney

A lasting power of attorney (LPA) is a new statutory form of power of attorney recognised in section 9 of the Mental Capacity Act. By means of this power of attorney the donor (P) confers on the donee (or donees) or the attorney(s) authority to make decisions about all or any of the following:

(a) P's personal welfare or specified matters concerning P's person welfare, and
(b) P's property and affairs or specified matters concerning P's property and affairs, and this includes authority to make such decisions in circumstances where P no longer has capacity.

Different forms are available for the two kinds of LPA, i.e. a property and affairs LPA and a personal welfare LPA.

The 'donor' is the person granting the power (known in the legislation as 'P'); and the 'donee' or the 'attorney' is the person who is given the power. The 'instrument' is the document granting the power and the conditions on which it is given.

The power to make care and welfare decisions only comes into force when the donor no longer has the mental capacity to make his or her own decisions. This contrasts with the donation of powers in relation to finance and property, where the actual delegation can take place when the donor still has the requisite mental capacity.

To create a valid LPA, the conditions laid down in section 10 must be complied with. These are as follows:

- it must be registered in accordance with the provisions of Schedule 1
- it must be registered at the time when P executes the instrument
- P has reached 18
- P has capacity to execute it.

Since October 2007, enduring powers of attorney cannot be created. Those which exist, however, can continue to be valid (they cannot cover matters of personal welfare) but it is possible for the donor, if he or she has the requisite mental capacity, to replace the enduring power of attorney with a lasting power of attorney. Further information and the requisite forms can be obtained from the Office of Public Guardian.[104] The Court has held that while an attorney appointed under a lasting power of attorney can appoint a replacement, a replacement attorney cannot appoint a replacement.[105] A lasting power of attorney was revoked by the Court of Protection. It had been granted by an elderly lady (H), who resided in a care home, to her daughter. The Office of Public Guardian raised concerns about the failure to pay care home fees: the fact that the daughter was giving her very little pocket money; a credit card and overdraft had been applied for in H's name; and unaccounted transfers and frequent cash withdrawals had been made from H's accounts. H lacked the capacity to revoke the LPA and it was appropriate for the Court to revoke it on her behalf and appoint a deputy. Her Article 8 rights were not infringed since the revocation and appointment of a deputy was a proportionate response for the protection of her rights.[106]

Conclusions

There have been a plethora of statements of policy and guidelines and initiatives on the care of the older person. They include 'A Vision for Social Care' in November 2010 published by the government; Partnerships for Older People were funded by the Department of Health to improve services for older people. Between 2006 and 2009, 29 pilot schemes were set up and an evaluation of their effectiveness, published in October 2009. Yet there are major issues which still need resolving in the care of older people. The first is the demographic time bomb with the numbers of those over 60 increasing in comparison with those of working age and the consequent problems of meeting the costs of their care. The Coalition government set up a Commission to explore all the previous White Papers and make recommendations on the future funding. Secondly, it is still abundantly clear that the elderly suffer abuse and low standards of care. In September 2007 the Healthcare Commission called upon NHS hospitals to step up efforts to provide dignity in care to older people[107] and *Equality in Later Life* was published in 2009. However, there still appears to be a gulf between the exhortations of public bodies and the reality of the standards provided. Every registered health professional has a professional duty to ensure that there is greater respect for the dignity and privacy of the older person. The Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards and the European Convention of Human Rights, have provided the framework for the protection of the rights of those incapable of making their own decisions and protecting themselves, but much still needs to be done to ensure that the law is enforced. The contribution of the elderly to the costs of their care and their entitlement to continuing health care are considered in chapter 23.

Reflection questions

1 A crucial factor in the care of older people is the extent to which the patient is mentally capable and able to make decisions. Look at the Mental Capacity Act 2005 and determine how the definition of capacity can be applied to your patients (see also chapter 7).

2 What particular precautions should you take when caring for older patients who are disturbed?

Further exercises

1 To what extent do you consider the nurse should be the advocate for the patient and to what extent do you think that this role can be left to relatives?

2 Obtain a copy of your NHS trust's summary of accidents to patients and analyse those relating to older patients. To what extent do you consider some of these accidents could have been prevented if different procedures had been adopted by the carers or by the NHS trust itself?

3 Obtain a copy of the NHS National Service Framework for Older People. Take one of the standards and analyse the extent to which they are implemented within your department/organisation. What action would need to be taken to ensure full implementation?

4 Consider the dementia strategy (see Figure 19.1, pages 517–18) and analyse the extent to which your department is implementing it.

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Chapter 20

Nursing the mentally disordered

This chapter discusses

- Informal patients
- Patients detained under mental health legislation
- Holding power of the nurse
- Compulsory detention of an informal inpatient
- Compulsory admission
- Definition and role of nearest relative
- Role of the approved mental health professional
- Informing the patient and relatives
- Consent to treatment provisions
- Community provisions
- National Service Frameworks
- Mental health strategy and priorities

Introduction

This chapter cannot cover all the law relevant to the nursing of the mentally ill.[1] The intention is to deal with some of the more common dilemmas faced by these nurses through the case study approach and to include in the diagrams a summary of some of the main points of the Mental Health Act 1983 (as amended by the Mental Health Act 2007). This Act is the main legislation covering the detention of the mentally disordered and for the most part replaces the Act of 1959, which, by the end of the 1970s, was seen as failing to protect the rights of the mentally disordered. The chapter also considers the amendments introduced by the Mental Health Act 2007. Chapter 17 considers the amendments to the Mental Capacity Act 2005 (known as the Deprivation of Liberty Safeguards (DoLS)) which were introduced as a result of the Bournewood case where the European Court of Human Rights criticised the reliance on common law for restricting the liberty of those unable to give a valid consent (the Bournewood gap). Reference should be made to the Code of Practice of the Department of Health on the Mental Health Act.[2] The NMC has republished guidelines for mental health and learning disabilities nursing[3] and also guidance for the nursing, midwifery and health visiting contribution to the continuing care of people with mental health problems.[4] The legislation must be read in conjunction with the Articles of the European Convention on Human Rights (see chapter 1 and the website of this book). For example, in 2003 the House of Lords ruled that conditional discharge under section 73 of the Mental Health Act 1983 was not incompatible with the European Convention on Human Rights.[5] In 2002 the High Court held that a same-sex couple should be recognised as having the same rights as heterosexual cohabitees and therefore after six months' cohabitation the partner would be treated as the nearest relative.[6] Article 2 and the right to life came under scrutiny in relation to the duties of NHS trusts when the daughter of a detained patient who had committed suicide on a railway line claimed that the trust was in breach of Article 2. The case was heard on the preliminary issue as to the proper test to be used to establish a breach of Article 2. The court held that the correct test was one of gross negligence of the kind sufficient to sustain a charge of manslaughter. Using this test the daughter had no reasonable chance of succeeding in her claim and the trust's application for summary judgment striking out the claim succeeded.[7] (See, however, Case 20.1.) In 2013 the European Court of Human Rights held that the extradition of a prisoner suffering from paranoid schizophrenia to the USA where he might be held at the Administrative Maximum Facility in Colorado would be inhuman or degrading treatment because the detention conditions would be likely to exacerbate his condition and his extradition would therefore be a violation of Article 3.[8] In 2013 the Supreme Court held that the Secretary of State had acted unlawfully when he declined to exercise his statutory discretion to refer the case of a detained patient to a mental health review tribunal for review in circumstances where the patient had a right to make an application for herself.[9]

Informal patients

Britain has the highest number of people claiming employment benefits for mental health conditions in the developed world as mental illness costs the UK economy £70 billion each year.[10]

The vast majority (well over 90 per cent) of patients who are cared for in psychiatric hospitals are not detained. They have either given consent to admission or, if they lack the mental capacity to consent to admission, they are treated under the provisions of the Mental Capacity Act 2005 (which replaces the common law powers recognised by the House of Lords in the *Re F* case[11]) (see chapter 7). Some patients may be deprived of liberty and come within the Deprivation of Liberty Safeguards which are discussed in chapter 17. (See also chapter 19 and restraint and the elderly.) The implementation of the Mental Capacity Act 2005 in 2007 saw the common law power to act in the best interests of a mentally incapacitated adult replaced by the statutory provisions (see chapters 17 and 7).

Nature of the duty of care owed to the informal patient

Case 20.1 Duty owed to the informal patient[12]

Melanie Rabone, aged 24, had a history of depression and had attempted suicide several times. She agreed to be admitted to hospital voluntarily and two days later her father expressed grave concern about her condition and told staff that she should not be discharged. Despite this information a consultant psychiatrist agreed to give her home leave for two days at her request and she hanged herself the next day. The High Court held that the NHS had no duty under the Human Rights Act to protect Melanie because she was not a detained patient. The remedy for clinical negligence was an action for negligence and the claimants had already settled a negligence action.[13] The Court of Appeal upheld this decision. However, the Supreme Court held unanimously that she was entitled to the same duty of care as a patient detained under the Mental Health Act. The Trust should have taken reasonable steps to protect her even though she was a voluntary patient.

A coroner condemned an NHS mental health team who had refused to admit a girl to the Antelope House mental health unit in Southampton on the grounds that she was an attention seeker. Three hours later she committed suicide.[14]

The Confidential Inquiry into Suicide and Homicide by people with mental illness for 2014[15] shows that the number of suicides by mentally ill people has fallen but more could be done by NHS trusts in the risk assessment and implementation.

Patients detained under mental health legislation

Only about 5–10 per cent of psychiatric patients are at any one time detained under the mental health legislation. However, the numbers are increasing: the CQC reported in January 2014 that mental health detentions were at a record high. Sections were up 14 per cent in five years with 50,408 detentions in 2012–3. The next section gives an account of the main statutory provisions of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) that apply to the detention and treatment of such patients. The Court of Appeal has ruled that there is no statutory or public policy reason for an absolute bar on the provision of facilities recommended by or consistent with the recommendations of the responsible physician, which might be available at a price, within or without the NHS system. A detained patient was entitled to pay for his care and treatment.[16]

Fundamental principles

The Mental Health Act 2007 amends the Mental Health Act 1983 to require the Secretary of State to include in the Code of Practice (prepared under section 118 of the 1983 Act) a statement of principles. Each of the following matters must be addressed in this statement:

(a) respect for patients' past and present wishes and feelings
(b) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006, as amended by the Equality Act 2010)
(c) minimising restrictions on liberty
(d) involvement of patients in planning, developing and delivering care and treatment appropriate to them

(e) avoidance of unlawful discrimination
(f) effectiveness of treatment
(g) views of carers and other interested parties
(h) patient well-being and safety, and
(i) public safety.

The Secretary of State shall also have regard to the desirability of ensuring the efficient use of resources and the equitable distribution of services.

Definition of mental disorder

No person may be compulsorily detained under the Mental Health Act 1983 unless he or she is suffering from mental disorder as defined in the Act. The definition as revised by the 2007 Act is as follows:

any disorder or disability of the mind.

(The previous classifications of mental illness, mental impairment and psychopathic disorder are no longer used in the statutory definition.)

Learning disability (which is defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning') is not considered to be mental disorder unless the disability is associated with abnormally aggressive or seriously irresponsible conduct on the person's part (see chapter 17).

Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder.

Holding power of the nurse

Practical Dilemma 20.1 To stop or let go

Bill Smith, an informal patient in a psychiatric hospital, admitted three weeks before, wakes up at 3.00 a.m. and starts abusing nursing auxiliary Mavis Jones who is on her own, Staff Nurse Rachel Robinson having just gone for her break. Bill starts throwing furniture around and is threatening to leave the ward. Mavis contacts the night operator and asks for immediate help. What is her legal position in relation to Bill? Rachel Robinson returns with a charge nurse. They telephone for the responsible medical officer and are informed that he will not be able to arrive until 9.30 a.m. What are their legal powers?

Statute Box 20.1 sets out the main points of the holding power of the nurse laid down by section 5(4) of the Act. As a nursing auxiliary, Mavis is not a prescribed nurse for the purposes of using the holding power under the Mental Health Act. The only nurses designated as prescribed nurses under the Act are those who have been trained in mental illness or learning disabilities. She does, however, have the health carer's duty to act in an emergency to save life. She also has the powers of the citizen to effect an arrest on the limited occasions set out in the Police and Criminal Evidence Act. If she feared for the life of Bill were he to be allowed to leave hospital immediately or for the life of anyone else, she could legally prevent his leaving the ward in an emergency. Rachel Robinson would be regarded as

a prescribed nurse if she were registered as a nurse with an entry in the Register indicating that the nurse's field of practice is either mental health nursing, or learning disabilities nursing.[17] She can exercise the holding power set out under section 5(4) of the Mental Health Act 1983 if the conditions set out in Statute Box 20.1 are present. If all these requirements are present, then Rachel has the power to detain Bill for up to six hours. As soon as the appropriate medical practitioner arrives, however, the holding power will cease.

Statute 20.1 Section 5(4) of the Mental Health Act 1983

1. The patient is receiving treatment for mental disorder.
2. The patient is an inpatient.
3. It appears to the prescribed nurse that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital.
4. It is not practicable to secure the immediate attendance of a practitioner who could exercise the powers under section 5(2).

Rachel must fill in the appropriate forms and ensure that these are taken to the managers of the hospital immediately. Procedures vary: in some hospitals, it is the practice for the hospital manager to be on call for such purposes; in others, this duty is delegated to the nurse manager on duty at night and weekends. If the doctor arrives and decides that Bill should be detained under section 5(2), then whatever part of the holding power has elapsed before his arrival will become part of the 72 hours' detention.

From the situation described here, it is apparent that the appropriate doctor will not be able to arrive within the six hours. In this case, it is essential for the doctor to exercise his powers of nomination under section 5(3) so that another medical practitioner (or approved clinician) can act as nominee and see Bill at the earliest possibility. (The 2007 Act amendments introduced the 'approved clinician' who can be a health professional, other than a doctor, who has had the appropriate training.)

This situation gives rise to other questions. Must Rachel remain with Bill personally even though she is due off duty at 7.30 a.m.? There is no requirement in the Act that Rachel should stay. The fact that Bill is under a holding power should, of course, be made clear to the senior nurse on the shift that takes over from Rachel. In particular, she should be informed of the time of commencement of the holding power and, if a doctor or the approved clinician, fails to arrive, the time when the holding power is due to end.

What powers does Rachel have in relation to Bill? Could Bill, for example, forcibly be given some medication for which he has been written up? The Act gives Rachel the power to restrain Bill from leaving hospital. She does not have power under the Mental Health Act to compel Bill to have treatment. Informal patients or those who have been placed under short-term detention orders covered by sections 5(2), 5(4) and section 4 are specifically excluded from the compulsory treatment provisions of Part 4 of the Act.

What if Bill runs off during the period of the holding power – can he be brought back? Section 18(5), by implication, allows Bill to be brought back as long as the time limit for the holding power has not elapsed. Section 18(1) (as amended by the 2007 Act) enables a patient who is absent without leave to be taken into custody and returned to the hospital by any approved mental health professional, by any officer on the staff of the hospital, by any constable or by any person authorised in writing by the managers of the hospital.

Could the holding power be used if Bill were an inpatient in a general hospital? From the requirements listed above, it is clear that Bill must be receiving treatment for mental disorder. It is, of course, possible for Bill to be admitted for surgery while still under treatment for a mental disorder and in this case the holding power could be exercised, but only if the nurse had the appropriate registration.

Compulsory detention of an informal inpatient

What would happen in a general hospital if a patient became severely mentally disordered? Temporary emergency measures could be taken to save life: either the life of the patient or of others. In addition, it is possible for any registered medical practitioner or approved clinician in charge of the patient to exercise the powers under section 5(2).

This section applies to an inpatient in a hospital. There is no requirement that he should be having treatment for mental disorder. The registered medical practitioner or approved clinician in charge of the patient's treatment must consider that an application ought to be made under the Act for the admission of the patient to hospital. He then furnishes the managers with a report to that effect and the patient may then be detained in the hospital for a period of 72 hours from the time the report is furnished.

In such circumstances on a general ward, it would also be possible to make use of the powers under section 4. In this case, it would be necessary for the nearest relative or an approved mental health professional to make the appropriate application for admission.

Compulsory admission

Table 20.1 sets out the section numbers and requirements for each section that enable compulsory admission to take place and the length of detention. The requirements in relation to the two medical recommendations are set out in Box 20.1.

In the case of *MH* v. *United Kingdom*[18] a severely disabled adult with Down's syndrome was removed under section 135 and detained for assessment under section 2 which she did not challenge within 14 days. Her mother as nearest relative applied to discharge her but it was barred, and when she objected to a proposed guardianship order proceedings were commenced to displace her as nearest relative. As a consequence MH was detained for six months rather than the maximum 28 days. MH argued that Article 5(4) was violated since the right to challenge her detention was ineffective if she lacked the ability to instruct solicitors. The House of Lords[19] had held that Article 5(4) did not require every case to be considered by a court and the scheme was capable of being operated compatibly. The automatic extension of time as a result of the displacement proceedings suggested that the Secretary of State should make a tribunal reference as soon as possible. The European Court of Human Rights held that MH's Article 5(4) rights were violated in relation to the initial 28 days of detention but not thereafter.

The nearest relative's claim that the exclusion of the relative's right to apply to a tribunal (s. 66) following the extention of a patients's detention under section 29(4) was a violation of her human rights was rejected.[20]

The Court of Appeal held that making a restriction order was the responsibility of the judge, irrespective of the views of the medical practitioners.[21]

Table 20.1 Compulsory admission provisions

Section	Duration (up to)	Applicant	Medical requirements	Other requirements
4 Emergency admission for assessment	72 hours	Approved mental health professional or nearest relative	1 recommendation only stating that patient is suffering from mental disorder and stating the provisions of Section 2 exist (see below)	Applicant must have personally seen patient within 24 hours before the application. Admission must be of urgent necessity
2 Admission for assessment	28 days	Approved mental health professional or nearest relative	2 medical recommendations: **(a)** patient is suffering from mental disorder of a nature or degree which warrants detention in hospital for assessment and; **(b)** he/she ought to be so detained in the interests of his/her own health or safety or with a view to the protection of others	Applicant must personally have seen patient within the period of 14 days ending with the date of the application
3 Admission for treatment	6 months, renewable for a further 6 months, then for a period of 1 year	Approved mental health professional or nearest relative	2 medical recommendations: **(a)** patient is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital and **(b)** repealed by 2007 Act **(c)** it is necessary for the health or safety of the patient or for the protection of others that he/she should receive such treatment and it cannot be provided unless he/she is detained under this section and **(d)** appropriate medical treatment is available	As above under section 2. Approved mental health professional must consult with nearest relative before making an application unless this would not be reasonably practicable or would involve unreasonable delay. The application cannot be made if the nearest relative objects

37 Hospital order without restrictions	6 months, renewable for a further 6 months, then for a period of 1 year	Order can be made by Crown Court in case of person convicted of an offence punishable by imprisonment or by magistrates: **(a)** if convicted of offence punishable on summary conviction with imprisonment or **(b)** if person is suffering from mental disorder and magistrates are satisfied that he committed the crime	2 doctors required to give oral or written evidence that: **(a)** offender is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to be detained for medical treatment and appropriate medical treatment is available for him **(b)** repealed by 2007 Act **(c)** the court is of the opinion, having regard to all the circumstances, that the most suitable method of disposing of the case is by means of a hospital order
41 Restriction order (imposed in conjunction with hospital order section 37)	For a specified period	Crown Court that has made a hospital order can impose a restriction order. Magistrates' court cannot make a restriction order but can send offender over 14 to Crown Court for a restriction order to be made	As for section 37; at least 1 of the 2 doctors must give evidence orally before the court

Box 20.1 Requirements for the two medical recommendations of section 12 (as amended by 2007 Act)

1 Practitioners must have personally examined the patient either together or separately, but where they have examined the patient separately not more than 5 days must have elapsed between the days on which the separate examinations took place.

2 One of the medical recommendations must be from a practitioner approved by the Secretary of State for such purposes as having special experience in the diagnosis or treatment of mental disorder and unless that practitioner has previous acquaintance with the patient, the other practitioner should have, if practicable.

2A A registered medical practitioner who is an approved clinician shall be treated as also approved for the purposes of this section under subsection (2) above as having special experience as mentioned there.

3 No medical recommendation shall be given for the purposes of an application mentioned in subsection (1) above if the circumstances are such that there would be a potential conflict of interest for the purposes of regulations under section 12A below.

5 After that section insert –

12A Conflicts of interest

1 The appropriate national authority may make regulations as to the circumstances in which there would be a potential conflict of interest such that –
   (a) an approved mental health professional shall not make an application mentioned in section 11(1) above;
   (b) a registered medical practitioner shall not give a recommendation for the purposes of an application mentioned in section 12(1) above.

2 Regulations under subsection (1) above may make –
   (a) provision for the prohibitions in paragraphs (a) and (b) of that subsection to be subject to specified exceptions;
   (b) different provision for different cases; and
   (c) transitional, consequential, incidental or supplemental provision.

3 In subsection (1) above, 'the appropriate national authority' means –
   (a) in relation to applications in which admission is sought to a hospital in England or to guardianship applications in respect of which the area of the relevant local social services authority is in England, the Secretary of State;
   (b) in relation to applications in which admission is sought to a hospital in Wales or to guardianship applications in respect of which the area of the relevant local social services authority is in Wales, the Welsh Ministers.

4 References in this section to the relevant local social services authority, in relation to a guardianship application, are references to the local social services authority named in the application as guardian or (as the case may be) the local social services authority for the area in which the person so named resides.

These provisions also apply to the two medical recommendations for guardianship.

The Mental Health (Approved Functions) Act 2012 gave retrospective validation to the power to approve practitioners or clinicians under the Mental Health Act 1983 and ensure the lawfulness of any detention or other action which was taken on the basis that a valid power to approve existed. This was required because four strategic health authorities had unlawfully delegated the exercise of their approval powers to NHS trusts.

Statute 20.2 Section 26(i) of the Mental Health Act 1983

Definition and powers of the nearest relative

Definition: the highest in the following hierarchy:

relative who ordinarily resides with or cares for the patient
husband or wife or civil partner
son or daughter
father or mother
brother or sister
grandparent
grandchild
uncle or aunt
nephew or niece.

Preference is given in relatives of the same description to the whole blood relation over the half-blood relation and the elder or eldest regardless of sex.

Husband and wife include a person who is living with the patient as the patient's husband or wife and has been so living for not less than 6 months. A person other than a relative with whom the patient ordinarily resides for a period of not less than 5 years shall be treated as if he were a relative.

Power of nearest relative:

1 To apply for the admission of the patient for assessment, for assessment in an emergency, for treatment and for guardianship.
2 To be informed about the approved mental health professional's application to admit patient for assessment.
3 To be consulted about the approved mental health professional's proposed application for treatment and to object to it.
4 To be given information about the details of the patient's detention, consent to treatment, rights to apply for discharge, etc. (but subject to the patient's right to object to this information being given).
5 To discharge the patient after giving 72 hours' notice in writing to the managers.
6 To apply to a mental health review tribunal under sections 16, 25 and 29.

Definition and role of nearest relative

The nearest relative has an important role to play and has to be given specific information; this task often falls on the nurse. The definition of nearest relative and the hierarchy is given in Statute Box 20.2, which also sets out the powers of the nearest relative.

Role of the approved mental health professional

Table 20.2 sets out the main tasks of the **approved mental health professional** (AMHP) (which replaces the **approved social worker** as a result of the amendments in the Mental Health Act 2007). Only mental health professionals who have completed the appropriate training (and are not registered medical practitioners) can be recognised as approved for the purposes of the Act. While the Act allows the nearest relative to be an applicant for compulsory admission under sections 2, 3, 4 and 7, in practice the applicant will usually be the approved mental health professional and this is the preferred procedure. The Court of Appeal held that the scope of the legal duty of the AMHP should be considered at a full

Table 20.2 Role of the approved mental health professional

Duty	Details
Duties of the approved mental health professional	
Section 11(3) Inform nearest relative of admission of patient and of nearest relative's right to discharge	1 In admission for assessment (sections 2 and 4) 2 Before or within a reasonable time after an application for admission for assessment is made 3 Such steps as are practicable to inform the person appearing to be the nearest relative
Section 11(4) Consult nearest relative on admission for treatment or guardianship and discontinue application if nearest relative notifies objection	1 Consultation with person appearing to be the nearest relative of the patient 2 Unless it appears that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay
Section 13(1) To apply for admission or guardianship order if satisfied application ought to be made and is of the opinion that it is necessary or proper for application to be made by him	1 In respect of patient within the area of local social services authority by whom he is appointed 2 Must have regard to wishes expressed by relatives of patient or any other relevant circumstances that are necessary or proper for application to be made by him
Section 13(2) To interview patient in suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need	1 Before making application for admission to hospital
Section 13(4) To take patient's case into consideration with a view to making an application for admission. If he decides not to make an application he will inform the nearest relative in writing of his reasons	1 If nearest relative so requires local social services authority of area in which patient resides, authority must direct approved mental health professional as soon as practicable
Section 14 To provide report on social circumstances	1 Where patient admitted to hospital an application by nearest relative other than section 4 2 Managers must as soon as practicable give notice of that fact to local social services authority for area in which patient resided immediately before his admission
Section 117 Duty of district health authority and of local social services authority to provide or arrange for the provision of aftercare services	1 Applies to patients detained under section 3 or admitted under hospital order (section 37) or transferred under transfer direction (sections 47 or 48) who cease to be detained and leave hospital 2 Authorities must cooperate with relevant voluntary agencies 3 Aftercare services to be provided until such time as the authorities are satisfied that the person concerned is no longer in need of such services

hearing in allowing the appeal of a patient against the refusal of his application for leave to bring proceedings (under s. 139(2)) against local authorities for the failures of two AMHPs to discharge their duties under the Act. The patient argued that the AMHPs, among other failures, should have assessed the suitability of the unit to which the patient was to be transferred.[22]

Informing the patient and relatives

Informing the patient

The task of explaining his legal rights to the patient once a detention order has been imposed often falls on the nurse.

Statute 20.3 Section 132 of the Mental Health Act 1983

Informing the patient

The managers of the hospital in which a patient is detained under the Act must:

1 Take such steps as are practicable to ensure the patient understands:
   - under which provisions of the Act he is for the time being detained and the effect of that provision
   - what rights of applying to a mental health review tribunal are available to him in respect of his detention under that provision, and
   - the effect of certain provisions of the Mental Health Act including the consent to treatment provisions, the role of the Care Quality Commission (formerly the Mental Health Act Commission) and other provisions relating to the protection of the patient.

2 The steps to inform the patient must be taken as soon as practicable after the commencement of the patient's detention under the provision in question.

3 The requisite information must be given to the patient in writing and also by word of mouth.

Practical Dilemma 20.2 Information

Edna Johns, an informal patient in a psychiatric hospital, became very disturbed and aggressive in the early hours of the morning, threatening to kill herself and wishing to leave hospital. Staff Nurse Thomas, a registered mental nurse (RMN), on learning that the responsible medical officer would take at least 30 minutes to arrive on the ward, decided to exercise the holding power under section 5(4). When the appropriate doctor arrived, he decided to detain Edna under section 5(2). Within the next 48 hours, the approved mental health professional applied for admission under section 3 on the recommendation of Edna's doctor and a second recommendation. What duties exist in relation to informing Edna?

The duties set out under section 132 are illustrated in Statute Box 20.3. Forms are available covering the information to be given under each section. Often the nursing staff have the task of giving out the forms and telling the patient about the provisions. It is vital that it is recorded that the patient has been informed since it is a statutory duty and there should be evidence that the statutory duty has been carried out.

In Edna's case, she will have been placed under three separate sections in less than 72 hours. She must be given the relevant information each time the section is imposed and will be given a different form each time. Section 132 requires the information to be given as soon as practicable after the commencement of the section. 'Practicable' must take into account the patient's physical and mental ability to take in what is said. To stand over a screaming or even unconscious patient reading him his rights would not seem to be a proper fulfilment of the statutory duty.

Informing the relatives

Where the patient is too disturbed to take in the information, the statutory duty to inform the nearest relative assumes even greater importance. Section 132(4) requires the managers to furnish the person appearing to them to be the patient's nearest relative with a copy of any information given to the patient, in writing, under the duty outlined above. The steps for this must be taken when the information is given to the patient or within a reasonable time thereafter. The patient has the right of veto and can request that this information is not given. Reasonable time here would seem to imply that it is not necessary to phone Edna's relative in the middle of the night to inform them of the exercise of the holding power, but this should be done as soon as possible the next day.

Consent to treatment provisions

Treatment is defined in section 145 of the Mental Health Act 1983 (as amended by the 2007 Act) as including 'nursing, psychological intervention, and specialist mental health habilitation, rehabilitation and care'. Any reference in the Act to medical treatment for mental disorder refers to medical treatment with the purpose of alleviating, or preventing a worsening of, the disorder or one or more of its symptoms or manifestations. In the case of *MD* v. *Nottinghamshire Healthcare NHS Trust* it was held that the treatment did not have to lower the risk of the patient being less dangerous to come within the statutory definition[23] and that appropriate treatment was available at Rampton hospital.

Statute Box 20.4 and Box 20.2 set out the main provisions.

Long-term detained patients

Under the provision of Part 4 of the Mental Health Act 1983, those patients who are detained under long-term detention provisions (e.g. sections 2, 3, 37 and 41) can in certain circumstances be given compulsory treatment. For these patients, the Act covers all possible treatments for mental disorder, both in emergency and non-emergency situations. The provisions are set out in the Statute Box 20.4 below.

Statute 20.4 Sections 57, 58 and 63 of the Mental Health Act 1983

1. Treatments involving brain surgery or hormonal implants can only be given with the patient's consent, which must be certified and only after independent certification of the consent and of the fact that the treatment should proceed (section 57).
2. Treatments involving electroconvulsive therapy or medication where 3 months or more have elapsed since medication was first given during that period of detention can only be given either (a) with the consent of the patient and it is certified by the patient's own approved clinician in charge of the treatment or another registered medical practitioner appointed specifically for that purpose that he is capable of understanding its nature, purpose and likely effects, or (b) the registered medical practitioner appointed (not being the responsible clinician or the approved clinician in charge of the treatment in question) has certified in writing that the patient is not capable of understanding the nature, purpose and likely effects of that treatment or has not consented to it, but that . . . the treatment should be given (section 58) (as amended by the 2007 Act, see Box 20.3).
3. All other treatments: these can be given without the consent of the patient provided they are for mental disorder and are given by or under the direction of the approved clinician in charge of the treatment (section 63).

Box 20.2 Consent to treatment: urgent treatments

These can be given according to the degree of urgency and whether they are irreversible or hazardous.

Any treatment	which is immediately necessary	to save the patient's life
Treatment which is not irreversible	if it is immediately necessary	to prevent serious deterioration
Treatment which is not irreversible or hazardous	if it is immediately necessary	to alleviate serious suffering
Treatment which is not irreversible or hazardous	if it is immediately necessary and represents the minimum interference necessary	to prevent the patient from behaving violently or being a danger to himself or others

Irreversible is defined as 'if it has unfavourable irreversible physical or psychological consequences' and hazardous is defined as 'if it entails significant physical hazard'.

A new section 62A has been added to the Mental Health Act 1983 to enable treatment to be given to those community patients who have been recalled. The patient is to be treated as if he had remained liable to be detained since the making of the community order.

Electroconvulsive therapy (ECT) and other specified treatments

Amendments were made to section 58 of the Mental Health Act 1983 by section 27 of the Mental Health Act 2007 to cover electroconvulsive therapy (ECT) and other treatments specified in regulations. A person shall not be given such treatments unless he or she falls within certain specified conditions. These conditions include those listed in Box 20.3.

Box 20.3 Section 58A

Specified conditions for treatments

1 The patient is at least 18 years, has consented to the treatment and his capacity to consent has been certified by the approved clinician in charge of it or by the appointed registered medical practitioner
2 The patient is below 18 years, has consented to the treatment and an appointed registered medical practitioner (not being the approved clinician in charge of the treatment) has certified in writing the patient's capacity to consent and that it is appropriate for the treatment to be given, or
3 An appointed registered medical practitioner (not being the responsible clinician or approved clinician in charge of the treatment) has certified in writing:
   (a) that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but
   (b) that it is appropriate for the treatment to be given and
   (c) that giving him the treatment would not conflict with:
      (i) an advance decision which the registered medical practitioner concerned is satisfied is valid and applicable, or
      (ii) a decision made by a donee or deputy or by the Court of Protection.

Before a certificate is given in circumstance 3, the appointed registered medical practitioner must consult two persons who have been professionally concerned with the patient's medical treatment; one must be a nurse and the other neither a nurse nor a registered medical practitioner. In addition, neither shall be the responsible clinician or the approved clinician in charge of the treatment in question.

Role of the nurse

What is the role of the nurse in consent to treatment provisions? Under the provisions of sections 57 and 58, the independent registered medical practitioner, in determining whether the treatment should proceed, must consult with a nurse and another professional who have been professionally concerned with the patient's medical treatment. The independent doctor must record the fact that he has consulted these two persons. Interestingly, however, there is no requirement on the form that he should actually record their opinions, so it could well happen that both the nurse and the other professional counselled against, say, ECT, but that the doctor still recommended ECT. A disagreement is unusual, but it is advisable for the nurse, whether there is agreement or not with her views, to ensure that the advice she gave is recorded clearly and comprehensively.

Challenges to compulsory treatment

A detained patient challenged the fact that she had been given treatment against her will, arguing that the judge should not have concluded that although there was a body of responsible medical opinion that the statutory test for medication had not been satisfied, it was in her best interests and necessary for the purposes of Article 3 that the proposed treatment should be administered. The Court of Appeal dismissed her appeal, holding that the standard of proof that medical necessity was shown is not the criminal standard, but it has to be convincingly shown, and whether the treatment satisfies the Bolam Test is a necessary but not a sufficient condition of treatment in a patient's best interests. Determining best interests may involve choosing the best option between what may be a number of options, all of which satisfy the Bolam Test. Even where there is a responsible body of opinion that the proposed treatment is not in the patient's best interests and is not medically necessary, it does not follow that it *cannot* be convincingly shown that the treatment proposed is in the best interests or medically necessary.[24]

Ian Brady, a detained patient at Ashworth Hospital, wished to go on hunger strike and challenged the responsible medical practitioner's decision that he could be force-fed[25] on the grounds that it was contrary to his human rights. In the judicial review hearing the court held that his decision to go on hunger strike was a symptom of his personality disorder. He was therefore mentally incapacitated and his doctor had a duty to act in his best interests by feeding him. Unlike the Broadmoor patient C[26] (see chapter 7 Case 7.3), he was incapable of weighing up risks and benefits. In 2013 Brady was again in the news when he applied to a Mental Health Review Tribunal for transfer to prison (where he wished to commit suicide) and spoke personally at the hearing which was not held in private. The Tribunal refused the application stating that he should remain at Ashworth Hospital since he suffered from a mental disorder which is of a nature and degree which makes it appropriate for him to continue to receive medical treatment. The publicity given to Brady was condemned by family and friends of his victims.[27]

The case of an Iranian doctor who went on hunger strike is considered in chapter 7.[28]

Seclusion

There is no provision in the Mental Health Act 1983 relating to seclusion. Placing a detained patient under seclusion was challenged by judicial review as being contrary to Article 3 of the European Convention on Human Rights, i.e. 'inhuman and degrading treatment or punishment'.[29] The High Court held that seclusion is capable of infringing a patient's rights under Article 3; it did not per se amount to a breach of those rights. Seclusion could also be negligent, **Wednesbury unreasonable** or a breach of Article 8 of the European Convention on Human Rights. Whether in fact seclusion amounts to inhuman or degrading treatment will depend on the circumstances of the particular case and will involve consideration of any intention to humiliate or debase the position of the alleged victim, the consequences of the treatment and the availability of resources. A power to seclude can be implied within the provisions of the Mental Health Act 1983 if there is a 'self-evident and pressing need' for that power. Seclusion did not amount to false imprisonment or a breach of Article 5 of the European

Convention on Human Rights. Seclusion was not medical treatment for the purposes of the Act since it is not used to alleviate or prevent the deterioration of an illness or its symptoms or to enable treatment to be given, but its use is authorised to ensure that control is maintained over patients. The court held that there was no infringement of the patient's rights when he was secluded and the fact that there was a departure from the Code of Practice on the Mental Health Act did not affect the duration or conditions of the claimant's seclusion, which was not unlawful. In 2012 the European Court of Human Rights held that Ashworth's seclusion policy was foreseeable and in accordance with the law for the purposes of Article 8 of the ECHR, which gave a qualified right to respect for private and family life. Nor did it violate Article 5 and the right to liberty and security of person.[30]

Physical illness

These provisions on consent to treatment would thus appear to cover all eventualities concerning the long-term detained patient. However, there is a gap in relation to treatment for physical illness which in the case of a patient lacking mental capacity would be heard by the Court of Protection.

Practical Dilemma 20.3 Appendicitis

Paul, a severely depressed patient, had been detained under section 3 for two months. One morning, he complained of severe stomach pains. He was sick, with a high temperature. Paul was taken to the 'sick' ward for the treatment of physical illnesses within the mental hospital and was diagnosed as suffering from appendicitis. It was recommended that an operation be performed immediately. When Paul heard this, he immediately said there was no way in which he would agree to the operation. What is the legal position?

If Part 4 of the Act is seen as applying only to the treatment of mental illness, then its provisions are irrelevant in these circumstances. Alternatively, it could be argued that if brain surgery can be undertaken under section 62 to save the life of a patient (and this may cover informal patients, since they are covered by the provisions of section 57), where the treatment is given for a mental disorder, then the words 'any treatment' in section 62 can cover not only treatment for mental disorder, but also treatment for physical disorders. If the purpose is to save life, then section 62(1)(a) covers the situation. This is a logical view, but it has not gained universal acceptance. The alternative is to say that the situation is not covered by Part 4 of the Act and therefore the provisions of the Mental Capacity Act 2005 would apply. These provisions enable treatment to be given without the patient's consent as part of the doctor's duty of care to the patient, but only if the patient lacks the requisite mental capacity to decide. In cases prior to the implementation of the MCA, *In re C* 1994[31] (see Case 7.3), a Broadmoor patient's refusal to have an amputation was upheld by the court. In the case of *B* v. *Croydon Health Authority*, the Court of Appeal held that compulsory feeding by tube came under section 63.[32] There have also been several cases where a pregnant woman detained under the Mental Health Act 1983 has been compelled to undergo a Caesarean under section 63 of the Act.[33] This has been disputed by the Court of Appeal in *Re MB*[34] (see chapter 14, page 387). It is clear that if a detained patient, suffering from mental disorder, has the mental capacity to understand the proposed treatment and the implications of his or her refusal, then the court would not order the treatment to proceed unless it could clearly be seen to be treatment for the mental disorder and therefore comes within section 63. This was the situation in the case of JB who suffered from schizophrenia, but was held to have the mental capacity to refuse a life-saving amputation of her leg[35] (see chapter 7). If, however, the patient lacks the mental capacity to refuse treatment in his or her best interests, treatment could lawfully be given under the Mental Capacity Act 2005. There are considerable advantages in securing a declaration of the Court of

Protection that it is lawful to provide the treatment. In a case in 2010 a woman with longstanding schizophrenia was suffering from a prolapsed uterus. She refused treatment believing that there was a conspiracy on the part of medical personnel to subjugate and experiment upon her, if not kill her. The court was informed that if not treated, the condition could become life threatening. She required sedation, surgery and a period of recovery in hospital. The Judge Mrs Justice Macur accepted that it was in her best interests to be treated and for the court to sanction the deprivation of liberty.[36]

Section 63 came under consideration in the case of *Nottinghamshire Healthcare NHS Trust* v. *RC*[37] where a patient who self-harmed was refusing a blood transfusion. He had made an advance decision refusing blood transfusions because of his religious beliefs. The doctor considered that the advance decision could be overridden because of section 63 but wished to secure the protection of a court declaration that her decision was lawful. The judge postponed a decision until the patient could be brought to court because of the importance of the issues including Article 2 (right to life), freedom of religion (Article 9) and respect for private life (Article 8). The full hearing decided that RW had capacity to refuse blood transfusions, the advance decision was valid and applicable, the self-harming was a symptom or manifestation of mental disorder, so a blood transfusion would be treatment under section 63. It would be an abuse of power to impose a blood transfusion given his current capacity and the advance decision.[38] In contrast, in a case in July 2014 the Court of Protection declared that a mentally ill woman, detained at a specialist hospital, who was not capable of making decisions about her treatment could have a hysterectomy in her best interests and necessary restraint could take place.[39]

Independent mental health advocates (IMHA)

The Mental Health Act 2007 amends the Mental Health Act 1983 to make provision for independent mental health advocates (IMHAs) to be available to help qualifying patients. Regulations[40] have been drawn up to specify the circumstances in which the IMHAs should be appointed and the conditions for their approval. New sections 130A, B, C and D are inserted into the 1983 Act to cover the details of these appointments, the qualifying patients and the information to be given to the IMHA. Guidance for commissioners of IMHAs was published in 2008.[41] This covers the framework for an IMHA service, the appointments of IMHAs and engagement with patients. Appendices include the regulations, relevant part of the Code of Practice and a model service specification. Supplementary guidance on access to patient records under section 130B of the Mental Health Act 1983 for IMHAs was published in April 2009.[42] This gives guidance to record holders and to IMHAs on when patient records can be withheld from IMHAs and the restrictions on IMHAs when disclosing information to the patient. For example, an IMHA must not pass on information which would not have been disclosed to the patient because of a risk of serious harm.

Short-term detained patients and informal patients

Short-term detained patients and informal patients are not covered by the Part 4 treatment provisions of the Mental Health Act. There is only one exception to this: informal patients are specifically covered by the provisions of section 57 relating to brain surgery and hormonal implants and by the relevant provisions of sections 59, 60 and 62. As far as section 57 is concerned, this means that brain surgery for mental disorder or hormonal implants cannot be given without the safeguards set out above. The short-term detained patient is not explicitly covered, but there would appear to be no reason why he should not receive the same protection.

As far as all other treatments are concerned, one has to look outside the Act for the law relating to consent to treatment and this is set out in chapter 7. Since only some 5–10 per cent of mentally ill and mentally handicapped patients are under the detention of the Mental Health Act 1983, the vast majority of patients are outside the basic provisions of the Act. Those who lack the requisite mental capacity to make specific decisions would come under the provisions of the Mental Capacity Act 2005 (see chapters 7 and 17).

Community provisions

The philosophy behind the Mental Health Act 1983 is that a patient should be compulsorily detained in hospital only if informal admission is not an option and if alternative services in the community cannot be provided. There were very few community provisions in the 1983 Act except for guardianship, section 17 (leave), and section 117 (aftercare). The Mental Health Act 2007 amended the Mental Health Act 1983 to make provision for a community treatment order which replaces aftercare under supervision (supervised discharge).

Guardianship

Practical Dilemma 20.4 How much control?

Paul has been under a guardianship order for three months. He lives with his mother, the guardian, and attends a day centre three times each week. He sees the community psychiatric nurse (CPN) regularly, both at the centre and also at home, and is on substantial levels of medication. One day, he decides not to take the drugs. His mother pleads with him, but is unable to persuade him to take them. She informs the CPN who also attempts to persuade Paul, but is unsuccessful. His behaviour deteriorates and he becomes more aggressive. His mother asks if there is any way in which he could be compelled to take the drugs as she fears that he will ultimately have to be readmitted. Is there a way?

The answer is that the Mental Health Act 1983 excludes from the provisions relating to consent to treatment those patients on guardianship orders. There are three statutory powers in relation to guardianship and these are set out in section 7 (see Statute Box 20.5).

There are no means of enforcing the guardianship powers over the patient other than the right of returning the patient to the specified place if he absconds. The ultimate sanction is possibly the knowledge that if the patient does not cope in the community, then he is likely to be admitted to hospital. It is not, however, good professional practice to use this as a threat. Apart from gentle professional persuasion, there is no way to force a patient to take drugs. The Mental Health Act 2007 has introduced a community treatment order (see pages 548–52), and this is an option for patients who have been detained under section 3.

Statute 20.5 Statutory powers of the guardian under the Mental Health Act 1983 Section 7

1. The power to require the patient to reside at a place specified by the guardian.
2. The power to require the patient to attend at places and times specified for the purpose of medical treatment, occupation, education and training.
3. The power to require access to the patient to be given at any place where the patient is residing to any responsible clinician, approved mental health professional or any person specified.

Section 17 Leave

A detained patient can be given leave of absence by the responsible medical officer in charge of the patient. The leave does not have to be in writing, but good practice as recommended by the Code of

Practice of the Department of Health[43] suggests that there should be a written record of the leave granted and the terms on which it is granted. Section 17 leave can be used as part of the care plan of the patient towards ultimate discharge from the section and from the hospital. Thus a patient on section 17 leave can be required to stay in residential accommodation. However, the patient cannot be charged for residential accommodation he is required to stay in as a condition of Section 17 (see Statute Box 20.6). Section 17 leave can be withdrawn at any time on the written instructions of the responsible medical officer (RMO). Any nurse responsible for a patient would have to assess the patient prior to leave commencing, so that there were no grounds for preventing the leave taking place. The Mental Health Act 2007 supplements section 17 to provide for community treatment orders and inserts after section 17(2) the following (2A): 'But longer-term leave may not be granted to a patient unless the responsible clinician first considers whether the patient should be dealt with under section 17A instead.'

Section 117 Aftercare services

A statutory duty is placed on the health authority and local authority in conjunction with the voluntary sector to provide or arrange for the provision of aftercare services for the patient. This duty continues until such time as the health and local authority consider that the patient is no longer in need of the services that they can provide. The duty cannot end if the patient is under a community treatment order (see Statute Box 20.6). The section applies to patients who have been detained under sections 3, 37, 47 and 48. However, the duty to provide a community care assessment under section 47 of the National Health Service and Community Care Act 1990 applies to these patients and also to patients detained under other sections of the Act (e.g. sections 2, 4, 5(2) and 5(4)) and to informal patients. The Care Act 2014 defines aftercare services as:

(a) meeting a need arising from or related to the person's mental disorder, and
(b) reducing the risk of a deterioration of the person's mental condition,

and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder.

A new section 117A enables regulations to be made which require a local authority to provide or arrange for the provision of accommodation which is the preference of the person with the person paying any extra cost which results. The LA can discharge its duty under this section by making direct payments.

The duties under section 117 cannot be forced on the patient, who may refuse to accept the treatment plan or services provided. This therefore led to concerns that patients were being released from psychiatric care without adequate supervision in the community. The case of Christopher Clunis, who killed Jonathan Zito, and the case of Ben Silcock, who was mauled in a lion's den, reinforced these fears. Some local authorities had been charging patients on a means-tested basis for residential accommodation provided under section 117. The Court of Appeal[44] made it clear that where accommodation is provided under section 117 for a patient, then a local authority may not provide it under section 21 or charge for it under section 22 of the National Assistance Act 1948. Where patients are required to live in residential accommodation under section 17, then they are entitled to this accommodation as an aftercare service under section 117 when discharged from detention under the Act and cannot therefore be charged for it. Section 117 does not cover patients detained under section 2, 4, 5(2) or who were informal.

Community treatment order (CTO)

The provisions on aftercare under supervision, or supervised discharge introduced by the Mental Health (Patients in the Community) Act 1995 were replaced by the community treatment order introduced by section 32 of the Mental Health Act 2007 which added new sections 17A, 17B, 17C, 17D, 17E, 17F and 17G into the Mental Health Act 1983.

Statute 20.6 New Sections 17A, 17B, 17C, 17D, 17E, 17F and 17G of the Mental Health Act 1983

Under section 17A the responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E.

Under 17A(4) the responsible clinician may not make a community treatment order unless –

(a) in his opinion, the relevant criteria are met; and

(b) an approved mental health professional states in writing –

- **(i)** that he agrees with that opinion; and
- **(ii)** that it is appropriate to make the order.

(5) The relevant criteria are –

- **(a)** the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- **(b)** it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
- **(c)** subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
- **(d)** it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and
- **(e)** appropriate medical treatment is available for him.

(6) In determining whether the criterion in subsection (5)(d) above is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).

17B Conditions for a community treatment order

(1) A community treatment order shall specify conditions to which the patient is to be subject while the order remains in force.

(2) But, subject to subsection (3) below, the order may specify conditions only if the responsible clinician, with the agreement of the approved mental health professional mentioned in section 17A(4)(b) above, thinks them necessary or appropriate for one or more of the following purposes –

- **(a)** ensuring that the patient receives medical treatment;
- **(b)** preventing risk of harm to the patient's health or safety;
- **(c)** protecting other persons.

(3) The order shall specify –

- **(a)** a condition that the patient make himself available for examination under Section 20A below; and
- **(b)** a condition that, if it is proposed to give a certificate under Part 4A of this Act that falls within section 64C(4) below in his case, he make himself available for examination so as to enable the certificate to be given.

(4) The responsible clinician may from time to time by order in writing vary the conditions specified in a community treatment order.

(5) He may also suspend any conditions specified in a community treatment order.

(6) If a community patient fails to comply with a condition specified in the community treatment order by virtue of subsection (2) above, that fact may be taken into account for the purposes of exercising the power of recall under section 17E(1) below.

(7) But nothing in this section restricts the exercise of that power to cases where there is such a failure.

17C Duration of community treatment order

A community treatment order shall remain in force until –

(a) the period mentioned in section 20A(1) below (as extended under any provision of this Act) expires, but this is subject to sections 21 and 22 below;

(b) the patient is discharged in pursuance of an order under section 23 below or a direction under section 72 below;
(c) the application for admission for treatment in respect of the patient otherwise ceases to have effect; or
(d) the order is revoked under section 17F below,

whichever occurs first.

17D Effect of community treatment order

(1) The application for admission for treatment in respect of a patient shall not cease to have effect by virtue of his becoming a community patient.
(2) But while he remains a community patient –
  (a) the authority of the managers to detain him under section 6(2) above in pursuance of that application shall be suspended; and
  (b) reference (however expressed) in this or any other Act, or in any subordinate legislation (within the meaning of the Interpretation Act 1978), to patients liable to be detained, or detained, under this Act shall not include him.
(3) And section 20 below shall not apply to him while he remains a community patient.
(4) Accordingly, authority for his detention shall not expire during any period in which that authority is suspended by virtue of subsection (2)(a) above.

17E Power to recall to hospital

(1) The responsible clinician may recall a community patient to hospital if in his opinion –
  (a) the patient requires medical treatment in hospital for his mental disorder; and
  (b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.
(2) The responsible clinician may also recall a community patient to hospital if the patient fails to comply with a condition specified under section 17B(3) above.
(3) The hospital to which a patient is recalled need not be the responsible hospital.
(4) Nothing in this section prevents a patient from being recalled to a hospital even though he is already in the hospital at the time when the power of recall is exercised; references to recalling him shall be construed accordingly.
(5) The power of recall under subsections (1) and (2) above shall be exercisable by notice in writing to the patient.
(6) A notice under this section recalling a patient to hospital shall be sufficient authority for the managers of that hospital to detain the patient there in accordance with the provisions of this Act.

17F Powers in respect of recalled patients

(1) This section applies to a community patient who is detained in a hospital by virtue of a notice recalling him there under section 17E above.
(2) The patient may be transferred to another hospital in such circumstances and subject to such conditions as may be prescribed in regulations made by the Secretary of State (if the hospital in which the patient is detained is in England) or the Welsh Ministers (if that hospital is in Wales).
(3) If he is so transferred to another hospital, he shall be treated for the purposes of this section (and section 17E above) as if the notice under that section were a notice recalling him to that other hospital and as if he had been detained there from the time when his detention in hospital by virtue of the notice first began.
(4) The responsible clinician may by order in writing revoke the community treatment order if –
  (a) in his opinion, the conditions mentioned in section 3(2) above are satisfied in respect of the patient; and
  (b) an approved mental health professional states in writing –
    (i) that he agrees with that opinion; and
    (ii) that it is appropriate to revoke the order.

(5) The responsible clinician may at any time release the patient under this section, but not after the community treatment order has been revoked.
(6) If the patient has not been released, nor the community treatment order revoked, by the end of the period of 72 hours, he shall then be released.
(7) But a patient who is released under this section remains subject to the community treatment order.
(8) In this section –
  (a) 'the period of 72 hours' means the period of 72 hours beginning with the time when the patient's detention in hospital by virtue of the notice under section 17E above begins; and
  (b) references to being released shall be construed as references to being released from that detention (and accordingly from being recalled to hospital).

17G sets out the effect of revoking a community treatment order

Statute 20.7 Sections 20A and 20B of the Mental Health Act

Section 20A Community treatment period

A community treatment order shall cease to be in force on expiry of the period of six months beginning with the day on which it was made and this period is referred to in this Act as 'the community treatment period'. The community treatment period may be extended for a period of six months and then on for further periods of up to one year at a time. Section 20A subsections 4–10 set out the conditions for renewal and the procedure to be followed.

20B Effect of expiry of community treatment order

When the community treatment order expires, the community patient shall be deemed to be discharged absolutely from liability to recall under this Part of this Act, and the application for admission for treatment ceases to have effect.

An NHS foundation trust failed in its appeal against the decision of a tribunal to make a deferred discharge for a patient, (who was diagnosed as suffering from paranoid schizophrenia,) from a community treatment order. The tribunal found that she had been symptom free for three years. The Trust claimed that she had a history of improving, failing to take her medication and then deteriorating. The Upper Tribunal held that if the statutory conditions were not present, the patient had to be discharged from the CTO. 'She might be a classic revolving-door patient, but she was entitled to be free from control when the door was open outwards.'[45]

Treatment provisions for those on a community treatment order (CTO)

The Mental Health Act 2007 inserts into the Mental Health Act 1983 a new Part 4A which sets out the provisions for the treatment of community patients who are not recalled to hospital. Sections 64A–K set out the conditions on which treatment can be given in the community: 64D enables treatment to be given to an adult who lacks the requisite capacity, if specified conditions are met, but force may not be used; 64G enables emergency treatment to be given to patients lacking the capacity or competence to give consent and under this section force can be used, provided certain conditions are met and the treatment is to prevent harm to the patient and the force must be a proportionate response to the likelihood of the patient suffering harm and to the seriousness of that harm. Amendments were made

to 64C and 64E under section 299 of Health and Social Care Act 2012 to vary the certificate requirement where the patient has capacity to consent to the treatment and has consented, with the effect that the approval of a SOAD will not generally be necessary if the patient is consenting to the treatment in question. If the patient withdraws his or her consent, then the appropriate certificate will be required. However, if the approved clinician in charge of the treatment considers that the discontinuance of the treatment, or of treatment under the plan, would cause serious suffering to the patient then the approved clinician can continue to give treatment. Electroconvulsive therapy may not be given without the consent of a patient, who has the requisite capacity, unless it is an emergency situation.

Failures in the community

The dangers of release from prison without an assessment of the prisoner's mental health were shown in the case of Phillip Simelane, a paranoid schizophrenic, who, following release from prison without supervision, killed Christina Edkins, a teenager on a bus. He admitted manslaughter on the grounds of diminished responsibility.[46] At present, the authorities have no power to place prisoners who had served less than 12 months under supervision. Legislation to change this is being introduced.

In another tragic case a woman was killed by her former partner who suffered from mental illness. Rachel Slack had driven Andrew Cairns to the police station where he was detained under the Mental Health Act. He was subsequently released by mental health workers who found no major mental illness. He killed himself after killing Rachel and her 23-month-old son. The inquest jury found that there were failures by the police to impress upon the mother the risk of serious injury or death.[47]

Section 135(1) Removal to place of safety

Statute Box 20.8 sets out the basic provisions of this power of the approved mental health professional. The section has been amended by the Police and Criminal Evidence Act 1984, so it does not now have to be a named constable who accompanies the approved mental health professional to the house.

Statute 20.8 Mental Health Act 1983 section 135(1) and (4)

(1) If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is a reasonable cause to suspect that a person believed to be suffering from mental disorder

(a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice; or

(b) being unable to care for himself, is living alone in any such place

the justice may issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part 2 of this Act, or of other arrangements for his treatment or care.

Section 135(4) In the execution of a warrant issued under section 135(1) a constable shall be accompanied by an approved mental health professional and by a registered medical practitioner (as amended by Police and Criminal Evidence Act 1984 Schedule 6 para 26 and the Mental Health Act 2007).

Amendments to section 135 by the 2007 Act (adding sections 135(3A) and (3B)) enable a patient to be transferred to one place of safety and from there to one or more other places of safety within the 72-hour period.

Section 136 Removal from a public place by police

The basic provisions of this section are set out in Statute Box 20.9. There has been considerable concern over the use of the section since the documentation has been inadequate; the police have not always recorded the details as to when they have used this section; and when the patient has been brought to hospital, the details have not always been recorded by the hospital staff and managers. Many hospitals have now designed their own forms for this purpose that record the date and time the patient arrives and the number and name of the constable who brings the patient in.

In April 2014 the Department of Health initiated a consultation on sections 135 and 136 to examine whether changes to primary legislation would improve outcomes for people experiencing a mental health crisis. The consultation closed in June and while the CQC published its response in September, the DH had yet to announce a decision.

Statute 20.9 Section 136 of the Mental Health Act 1983 (as amended by 2007 Act)

Police powers

(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.

Time limits for mental health review tribunals

Table 20.3 illustrates the time limits for applying to the tribunal, the powers of the tribunal, and the applicants. A major innovation of the 1983 Act was that the managers must automatically refer a patient to the tribunal if he has failed to apply himself. There must be a tribunal hearing at least once every three years. Every child under 18 must be referred by the managers every year if he has not himself applied.

Role of managers

The managers are given certain statutory duties under the Act (set out in Box 20.4). Of these, all can be delegated by the NHS trust board, except the duty to hear an application from a patient for discharge. In this case, the NHS trust is empowered to appoint a subcommittee for hearing such applications.

Table 20.3 Applications to mental health review tribunals

Section	Patient	Nearest relative	Manager
2 or 4	Applications by patients within first 14 days of detention	No application by nearest relative	Application by manager under 2007 Act amendments
3	Application by patient within first 6 months of detention, once within second 6 months, then annually	Yes, within 28 days of being informed that responsible medical officer has issued report barring discharge of patient When an order is made appointing a nearest relative under section 29 On reclassification of patient under section 16	Automatic referral if tribunal has not considered case within first 6 months of detention, thereafter if tribunal has not considered case within previous 3 years (1 year if patient is under 18)
37	Yes, once within second 6 months of detention, then annually	Yes, once within second 6 months of detention, then annually	Automatic if the case has not been considered by tribunal within previous 3 years (1 year if patient is under 18)
41	Yes, once within second 6 months of detention, then annually	No application by nearest relative	Automatic referral by Home Secretary if tribunal has not considered case within the preceding 3 years

Box 20.4 Role of managers

1 To accept a patient and record admission (section 140).
2 To give information to detained patient (section 132) and community patient (section 132A).
3 To give information to nearest relative (section 132(4)) and inform him of discharge (section 133(1)) or of detention (section 25(2)).
4 To discharge patient (section 23(2)(b)). Powers may be exercised by any three or more members of the authority (section 23(4)).
5 To refer patient to mental health review tribunal (section 68 as amended by the Mental Health Act 2007).
6 To transfer patient (section 19(3), section 19(1a) reg. 7(2) and reg. 7(3)).
7 To give notice to local social services authority specifying hospitals in which arrangements are made for reception in case of special urgency of patients requiring treatment for mental disorder (section 140).

Definition of managers

NHS trust, PCT or NHS Foundation Trust or special health authority responsible for the administration of the hospital (section 145).

All powers can be delegated by manager to the officers except for (4) above: discharging the patient. Special provisions apply to NHS Foundations Trusts.

Care Quality Commission

Box 20.5 illustrates the powers of the Care Quality Commission in relation to mental health legislation. From April 2009 the Mental Health Act Commission (MHAC) was merged with the Healthcare

Commission and the Commission for Social Care Inspection into the Care Quality Commission, a new regulatory body with enhanced powers (see chapter 5). The CQC Mental Health Act report for 2011/2012[48] is available on its website.

Box 20.5 Powers of the Care Quality Commission in relation to mental health legislation

1. Duty to draft and monitor Code of Practice.
2. Prepare a biennial report to Parliament.
3. Review any decision at a special hospital to withhold a postal packet or its content.[49]
4. Carry out on behalf of the Secretary of State duties in relation to the review of the exercise of powers and discharge of duties under the Act, visiting and interviewing detained patients and hearing complaints from detained patients.
5. Exercise duties and appointment of second-opinion doctors in relation to Part 4, consent to treatment provisions.

Mentally ill patients and the European Convention on Human Rights

Several patients have won cases in Strasbourg for breach of their rights as set out in the European Convention on Human Rights, including the case of Bournewood (discussed in chapter 17). In one case,[50] the European Court of Human Rights held that the UK was in breach of Article 5 of the European Convention on Human Rights because for a considerable period of time the patient was not lawfully detained. Several mental health review tribunals had given the patient a deferred conditional discharge under section 73 of the Act, but discharge had been delayed because the local authority had been unable to find suitable supervised hostel accommodation. After 2 October 2000, those who allege that their human rights have been infringed have been able to bring action in the courts of the UK, instead of going to Strasbourg (see chapter 1 and the website of this book).

National Service Frameworks

As envisaged in the White Paper on the NHS,[51] the Government has published National Service Frameworks (NSFs) for different specialties to ensure that there is a minimum standard of provision across the country. The National Service Frameworks for Mental Health were published in 1999 and set standards in five areas:

Standard one: mental health promotion
Standards two and three: primary care and access to services
Standards four and five: effective services for people with severe mental illness
Standard six: caring about carers
Standard seven: preventing suicide.

The Frameworks document describes the standards as 'realistic, challenging and measurable, and are based on the best evidence available':

> **They will help to reduce variations in practice and deliver improvements for patients, service users and their carers, and for local health and social care communities – health authorities, local authorities, NHS trusts, primary care groups and trusts, and the independent sector.**

NMC practitioners working in mental health services should ensure that they obtain a copy of these standards, and their updates, in order that they can ensure that the services they are providing are

comparable with these national standards. In Wales revised NSF mental health standards were published in 2005 and are available on the Welsh NHS website.[52] The report that a brain scan which could detect autistic spectrum disorders within 15 minutes was likely to be available on the NHS within two years could have major implications for the detection and treatment of such disorders.[53] So too could genetic links to schizophrenia and other mental disorders (see also chapters 22 and 28).

Mental health strategy and priorities

In 2012 the Schizophrenia Commission made 42 detailed recommendations on the improvements which should be made to the care of those diagnosed with schizophrenia based on a report which revealed major failings in their care.[54] Some of these deficiencies should be rectified by the government's mental health strategy. In 2011 the government published its mental health strategy *No Health without Mental Health* which had six objectives:

1 more people will have good mental health;
2 more people with mental health problems will recover;
3 more people with mental health problems will have good physical health;
4 more people will have a positive experience of care and support;
5 fewer people will suffer avoidable harm; and
6 fewer people will experience stigma and discrimination.[55]

In 2012 an implementation and framework and suicide prevention strategy was published.[56] Subsequently, on 20 January 2014 the Deputy Prime Minister Nick Clegg announced a new support document for the mental health strategy setting out priorities, known as a mental health action plan.[57] This document set out 25 areas where people can expect to see and experience the fastest changes. These include increasing access to mental health services, setting clear waiting time limits for mental health services, overcoming inequalities around access to mental health services and increasing the availability of psychological services. Adults will have the right to make choices about the mental health care they receive and the use of all restrictive practices will be radically reduced with an end to high-risk restraint, including face down restraint and holding people on the floor. (In 2013 MIND published a report revealing widespread use of physical restraint across the NHS: in 2012 42,000 instances of physical restraint were recorded causing about 1,000 injuries. MIND warned that many instances of its use may go unrecorded. In its annual report for 2012, the CQC noted that three patients had died as a result of the use of face down restraint.[58]) Physical and mental health care will be integrated at every level. Mental well-being will be promoted early and there will be greater emphasis on prevention. Schools will be supported to identify mental health problems sooner. The quality of life of people with mental health problems will be improved with support for employers and stamping out discrimination around mental health. In February 2014 the Minister for Mental Health announced a new agreement between police, mental health services, A&E departments, ambulance services and 999 services will lead to the sharing of information about dangerous mentally ill patients with alert markers on their names in the emergency databases.[59]

The priority relating to children and teenagers is important since there is evidence that mental health problems among young people are growing: one in ten children between 5 and 16 have suffered from a diagnosable mental health disorder and 1 in 15 self-harm. The head of Uppingham, a leading co-educational boarding school, has warned of the dangers to young people's mental health from social media internet sites.[60] Dame Sally Davies, the Chief Medical Officer, warned that cuts to the Children and Adolescent Mental Health Services (CAMHS) were putting children at risk and leading to long waiting times. She gave evidence to the House of Commons Health Committee on 4 March 2014 at an inquiry into child and teenage mental health services. On the eve of the inquiry commencing, the Minister for Mental Health Services Norman Lamb stated that he would set up a national investigation into the scale of mental health problems among children and teenagers. The last prevalent study was

undertaken in 2004 by the Office for National Statistics.[61] In August 2014 he announced the appointment of a task force to look at how best to improve the organisation of mental health services for children and young persons and how they are commissioned, and the use of charity and voluntary groups.

Post-legislative scrutiny

A post-legislative scrutiny by the Health Committee of the House of Commons[62] of the Mental Health Act 2007 considered the following areas:

1 The background to the 2007 Act
2 The appropriate treatment test, community treatment orders and detention
3 Independent mental health advocates
4 Places of safety
5 Supervised community treatment
6 Interaction with Mental Capacity Act 2005
7 Ethnicity and the use of the Mental Health Act
8 Conclusions and recommendations.

Among its conclusions it noted that the increase in the numbers of detained patients and the effect of a CTO appeared to have led to an increase in section 2 admissions. It expressed concern that the Department of Health did not appear to have a clear picture as to the factors which are driving increased rates of detention, and recommended that the DH urgently investigate whether patients had been sectioned in order to access psychiatric units. The committee was concerned that patients admitted voluntarily felt themselves to be under de facto detention, and emphasised the duty of staff to raise concerns. It recommended that IMHA services become opt out rather than opt in and that, in the absence of a regulator of independent mental health advocacy services, LAs as commissioners of such services should work cooperatively to ensure that patients across the country can access effective advocacy services. The DH, the committee recommended, should review the practice of detaining children under section 136 and it proposed the extension of IMHAs to voluntary patients. It recommended a review of CTO's in the light of findings by Professor Tom Burns that CTOs have not succeeded in reducing the readmission to hospital as compared with section 17 leave.[63] It found that the effective application of DoLS was profoundly depressing and complacent and recommended that the DH initiated an urgent review of the implementation of the sageguards.

The UK government responded in October 2013[64] in positive terms agreeing to issue new guidance for IMHAs and will consider wider availability of advocacy services. However, unlike in Wales, the government would not extend entitlement to IMHAs to voluntary patients. It would work through a newly set up Mental Capacity Act Steering Group to review DoLs and support improvements in their use. It is revising the Code of Practice for the 1983 Act which will include guidance on the interface between the 1983 Act, the Mental Capacity Act 2005 and DoLS. It concluded that it will feed consideration of all the recommendations into future work programmes, in particular the revision of the Code.

Conclusions

The changes effected by the Mental Capacity Act 2005 and the implementation of the amendments to the Mental Health Act 1983 by the Mental Health Act 2007 are now well established and the new community treatment order is being increasingly used. However, the conclusions and recommendations of the Scrutiny Committee of the House of Commons on the Mental Health Act 2007 showed that major work needs to be undertaken to ensure that both voluntary and detained patient are receiving

appropriate treatment and care. The UK at the present time is facing changes in its incapacity and disability benefits all of which make the position of the mentally disordered more vulnerable. At the same time, plans to reduce the prison population by keeping drug addicts and the mentally ill out of jail will lead to more patients being treated for their psychiatric disorders and addiction in the community. The challenges facing health professionals and organisations concerned with their care are immense.

Reflection questions

1 Contrast the rights of the informal patient and compare these to the statutory rights of the patient detained under mental health legislation.
2 Analyse the provisions for giving compulsory treatment to those patients detained under the Act.
3 Discuss the new community treatment order and the benefits which it could bring to patients and carers.

Further exercises

1 Study the restraint and seclusion policy in your hospital and consider the extent to which its implementation can remain within the law, in particular the Human Rights Act. (See the website of this book.)
2 Ask to see the latest report of the Care Quality Commission on your hospital.
3 In what ways would informal patients benefit from coming under the jurisdiction of the Care Quality Commission?
4 What is meant by Deprivation of Liberty Safeguards? Find out how they are applied in your hospital, residential home or private clinic. (See chapter 17.)

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Chapter 21

Accident and emergency, outpatients, genito-urinary departments and day surgery

This chapter discusses

- Accident and emergency department
- Outpatients department
- Genito-urinary medicine
- Day surgery

Introduction

This chapter explores non-inpatient facilities which all raise similar legal issues in relation to dealing with workload pressures and confidentiality, and are increasingly becoming the focus of political attention. In particular, the spotlight has been cast over the future of A&E services (also referred to as unscheduled services), which have been at the centre of a number of proposals for reform.

Accident and emergency department

In recent years, the role of the nurse in the A&E department has undergone a fundamental change, not just as a result of the transfer of many activities formerly undertaken by medical staff to nurses, but as a result of the nurse taking on a wider sphere of responsibility and working within new parameters and

developing a new specialty of A&E nursing. The role of the clinical nurse specialist includes the provision of immediate care to patients and the determination of priorities for care (triage). The RCN provided in 1994 a framework for the safe development of A&E nursing at specialist and advanced level,[1] in 2008 case studies for RCN safety reps on issues in A&E nursing[2] and in 2010 guidance on children in A&E departments.[3] In 2003 the RCN in conjunction with the Department of Health published a joint report, *Freedom to Practise: dispelling the myths*.[4] The report aims to dispel the myths about what the nurse and other healthcare professionals can or are entitled to do within their codes of conduct. At the launch of the report, the Health Minister stated that 'the NHS is still not maximising the nursing expertise we have in the health service and this means we are, in effect, wasting NHS resources'. The booklet also provides practical fact sheets about the legal and professional frameworks that support practice and enable the development of practice. The legal implications of the expanded role of the nurse are considered in chapter 24.

Strategy for A&E units

In 2010 the National Audit Office published a highly critical report on deficiencies in the treatment of patients suffering major trauma.[5] It pointed out that hundreds of people who suffer serious injuries are dying because of poor care and that despite the many criticisms of trauma services since 1988 no improvements have taken place.

Major Trauma Networks were introduced in 2010 and this has led to an increase of 20 per cent in the survival rate for patients who have suffered multiple trauma in serious accidents, but there has been criticism that rehabilitation services for civilians have lagged behind in comparison with the resources available for armed service personnel, such as the Help for Heroes Rehabilitation Complex at Headley Court.[6]

Proposals were put forward in November 2013 by the Medical Director of NHS England Sir Bruce Keogh to create two-tier A&E services. About 40–70 units would be designated as Major Emergency Centres, which would treat serious conditions such as heart attacks, major accidents and strokes. These recommendations were made in the light of the fact that 40 per cent of patients do not need A&E care, with 25 per cent visiting A&E because they could not get a GP appointment. These patients could be treated through contact with NHS 111 (replacing NHS Direct), or through contact with pharmacists. Blue light ambulances will ensure that the appropriate patients are transferred to the major emergency centres bypassing local A&E centres.[7] In June 2014 the National Director for Acute Episodes of Care at NHS England, Professor Keith Willett, said that there was resistance to these centralisation changes and thousands of patients have died needlessly because of this damaging reluctance to accept changes in the NHS.[8]

Managing the workload

Many initiatives have been introduced to speed up the treatment of patients and avoid extensive waiting times.

In September 2007 NICE issued a clinical guideline on the triage, assessment, investigation and early management of head injury in infants, children and adults which is available on its website.

The Department of Health published guidance in 2007 prepared by the Urgent Care Pathway Group on best practice for older people with complex needs. This identified best clinical practice in the three areas of falls, confusional states and hip fractures, and provided audit indicators for the ambulance service and for A&E.

The 'See and Treat' initiative from the Modernisation Agency's Emergency Services Collaborative aimed to assess and treat patients with minor complaints as soon as they arrive, rather than asking them to wait. The key principle was that the first clinician to see the patient is able to assess, treat and discharge them safely.[9]

The Department of Health set a target of 4 hours for waiting times for emergency care, but recognised that there were clinical exceptions to this.

The target setting was followed by a joint document prepared by the Royal Colleges of Surgeons and Physicians, the Faculty of Accident and Emergency Departments, the British Association for Emergency Medicine and the Department of Health's Clinical Director for Emergency Access on reforming Emergency Care.[10]

The Coalition government announced in June 2010 that the target waiting time of 4 hours in A&E was to be abolished since it lacked clinical justification. Instead the focus was to be on outcomes and the clinical evidence to identify what directly contributes to delivering the best possible results for patients. However, in December 2013 the 4-hour waiting time was still being used as a target and Dame Barbara Hakin, Chief Operating Officer of NHS England, expressed disappointment that in the biggest A&E units only 92.9 per cent were seen within 4 hours, below the 95 per cent target.[11]

A report published on 5 July 2010 by the Nuffield Trust stated that the NHS was being put under unsustainable pressure by the increase in the number of emergency admissions to hospital. Many patients admitted in an emergency stayed less than a day, suggesting that doctors were admitting people with low clinical need. The Director of the Nuffield Trust said that politicians needed the courage to close beds and increase the focus on primary care services.[12]

In October 2013 the College of Emergency Medicine published the paper *Stretched to the Limits* outlining the challenges faced by emergency consultants. Sixty-two per cent of those who responded stated that their current jobs were unsustainable.[13]

The lack of A&E doctors has led to A&E staff being lured with £40,000 bonuses.[14]

The CQC in its annual report published in November 2013 suggested that 1 in 10 people over 75 have been rushed to hospital needlessly in the past year. More than half a million people over 65 were admitted as an emergency for conditions that could have been treated at home. Avoidable admission rates were up by almost a third over the past five years.[15]

The Medical Director for NHS England warned in January 2014 that NHS funds given to LAs to help older people to stay healthy and therefore reduce the pressure on A&E departments were being diverted to fill potholes. In 2015 £2 billion is to be taken from the NHS budget to be used to help older people stay healthy.[16]

Criticisms have been made about the effect of competition in the NHS on the viability of A&E departments[17] and Professor Keith Willett, who is conducting a review of emergency services, says that the effect of the new NHS pricing policy has led to an adversarial relationship between hospitals. The NHS England review has resulted in plans led by the urgent and emergency care delivery group to help hospitals and A&E departments keep waiting times in check.[18] Further information on the Delivery Group can be found on the NHS website.[19]

In May 2013 the CQC chair, David Prior, urged widespread closure of hospital beds and investment in community care. He stated that too many patients were arriving in hospital as emergencies, when they should have been dealt with by GPs, social care or other services. The leader in *The Times* on 22 May 2013 suggested that the absence of GP services out of hours means that huge pressure is being put on hospital A&E departments by patients who have no need to be there. Then subsequently a further *Times* leader on 25 July 2013 spoke of a looming crisis with the problems in A&E being a harbinger of a struggle to come for the NHS, in the light of a report by the Health Select Committee of the House of Commons that the government's plans to relieve pressure on A&E units in England were not good enough.[20] Only one in six of all hospitals had the recommended level of consultant cover and too many were unable to manage the use of beds and the discharging of patients, the committee reported. In September 2013 the chief executive of the NHS Confederation stated that 'The warning signs are clear; the time for stop-gap solutions has passed . . . As a society, we need to drastically change how we regard hospital-based A&Es.'[21] In June 2013 NHS England commissioned a review of unscheduled care to explore how best to deliver emergency health services in the future.[22] One initiative to ease pressure on A&E departments put forward by the Health Secretary was that healthcare for elderly people should be centralised with the plan being made compulsory from 2014 with the aim of reducing the number of older people being admitted to hospital.[23]

Local initiatives

Since a considerable proportion of A&E patients are there as the result of alcohol abuse another option was to treat such patients outside the A&E unit. A letter to *The Times* from the Professor of Oral and Maxillofacial Surgery at Cardiff University[24] pointed to the experience in Cardiff where using information from A&E patients injured as a result of violence to target locations and times of violence has cut violence-related A&E attendances. This initiative was supported by the opening of a late-night alcohol treatment centre in a city-centre chapel where intoxicated people can be taken by friends, street pastors and ambulances and cared for by nurse practitioners in a place of safety until they have sobered up. This has reduced A&E attendances and waiting times significantly. In addition, the professor noted that the introduction of minimum alcohol prices also has the potential to reduce demands on A&E. The growing trend of underage drinking and their being sent to A&E departments was highlighted in an investigation by BBC Radio 5 Live. There were 293 admissions of under-11s, up a third on 2011 for alcohol-related problems in 2012. Twenty thousand children a year use NHS services to deal with substance addiction, of whom a third are there because of alcoholism.[25]

National Audit Office Report 2013

In October 2013 the National Audit Office published a report on emergency admissions to hospital.[26] This stated that many emergency admissions to hospital are avoidable and many patients stay in hospital longer than is necessary. The NAO recommended both short- and-long-term strategies to address staffing shortages in A&E. The Department of Health and NHS England, the NAO said, should address barriers to seven-day working in hospitals, such as the consultants' contract, which gives consultants the right to refuse to work outside 7 a.m. to 7 p.m. Monday to Friday. They should also explore how key patient information can be shared between health organisations. The DH, NHS England and Monitor should consider how best to align incentives across the health system to reduce emergency admissions. NHS England should review the suitability of the measure for delayed discharge. The report can be accessed on the NAO website.[27]

The Public Accounts Committee reported in March 2014 that there was no clear plan in the NHS to end a chronic shortage of A&E doctors. Nearly one fifth of consultant posts in emergency departments were either vacant or filled by locums in 2012.[28] It made several recommendations including requiring the Department of Health and NHS England to create a strategy to deal with levels of performance; reforming the overall system for funding urgent and emergency care; and considering all available options to address immediate and longer-term shortage of A&E consultants. Figures from the College of Emergency Medicine suggested that 1 in 25 consultants left the NHS in 2013, three times as many as the year before. A spokesman for the DH said that many doctors returned to the NHS with experience which would benefit patients.[29] At the same time a poll by Healthwatch England showed that 1 in 5 people had attended an A&E for non-urgent care. Its chairwoman Anna Bradley suggested that people should not be blamed for going to the wrong place: 'Until the health and care sector offers a more consumer-friendly experience, things are unlikely to improve.'[30] These figures were supported by research at Imperial College London which found that more than 1 in 4 visits to the A&E happen because patients could not see a GP.[31]

NHS 111 Service

An investigation has claimed that local NHS 111 Services, which are currently replacing NHS Direct (see chapter 5), have inadequate numbers of qualified staff and have sent ambulances out for minor ailments such as hangovers, coughs, colds and cat scratches.[32] The Medical Director of NHS England Professor Sir Bruce Keogh suggested that patients should phone the NHS 111 phone line before they went to A&E. This may help divert many of them to out-of-hours services and relieve pressure on A&E departments.[33] Early teething problems beset the early stages of NHS 111 when NHS Direct pulled out of providing urgent care lines in 11 of the 46 areas.[34]

The nurse has a clear role in improving these services and it is essential that the training for expanding the scope of her professional practice should be in place. (The scope of professional practice of the nurse is considered in chapter 24.)

Emergency workers legislation

The Emergency Workers (Obstruction) Act 2006 makes obstructing or hindering certain emergency workers (or those persons assisting emergency workers) from responding to emergency circumstances a criminal offence. The definition of emergency worker includes a person employed by (or by an organisation supplying services to) an NHS body in the provision of ambulance services or of a person providing services for the transport of organs, blood, equipment or personnel made at the request of an NHS body. The Home Office expanded upon categories of persons covered by the Act to include all fire and rescue services and those under contract as well as volunteers who provide an ambulance service on behalf of a Health Service. Further information is available on the government website.[35]

Ambulance services

A CQC report[36] on ambulance services in London found that there were not enough qualified, skilled and experienced staff to meet people's needs, and action was needed on staffing and the safety, availability and suitability of equipment. A 21-year-old woman died after an ambulance crew (unqualified student paramedics) who were dispatched unsupervised by London Ambulance Service, failed to treat her or take her to hospital. The coroner found that there was a gross failure to provide basic medical attention and ruled that neglect contributed to the death of Sarah Mulenga.[37] Data from NHS England in December 2013 showed that ambulances were missing the 999 response target with variations across the country.[38] See the *Kent* v. *Griffiths* case for an illustration of the liability of the ambulance service[39] (see chapter 3 Case 3.1).

Pressure of work – legal issues

Practical Dilemma 21.1 Priorities under pressure

The A&E department was unusually pressurised one weekend: staff shortages due to a flu epidemic and cutbacks because of an attempt to reduce overspending left only a skeleton staff. Unfortunately, there was a particularly horrific pile-up on the motorway in the fog. Twelve people were brought in with varying levels of seriousness. One of them, David Lewis, a boy of 10, appeared to be suffering mainly from shock and bruises. He complained of a sore wrist. His mother was advised to take him home and give him a few paracetamol, a hot drink and, after a good night's sleep, he would be fine. The next day, however, it was learnt that he had died during the night after inhaling vomit.

There is every possibility in this case that the mother will make an official complaint and possibly take legal action. Normally, it is not a successful defence to an action for negligence that the staff were under pressure (see Case 4.10), if it can be established that they failed to follow the approved accepted practice in relation to the care of the patient. Dealing with children is particularly difficult, since they cannot always correctly identify the site of any pain and discomfort. The possibility of head injury does not appear to have been considered in this case and this would be subject to investigation. Was the mother told the correct way of caring for the boy? The legal position is as follows:

1 There is a duty to care for the boy.
2 It must be established by the parents that the staff failed to follow the accepted approved practice.
3 This failure reasonably foreseeably led to the death of the boy.

The workload in an A&E department is extremely erratic. One moment there can be few demands, the next there may be a major incident or a sudden influx of patients and the pressure is on. What is the standard of care in such circumstances? Even though the nurses and doctors are under extreme pressure, each patient is still entitled to expect the appropriate standard of care. Thus it would still be actionable if a fracture remained undiagnosed or if a head injury were to be missed. However, the courts would take into account the pressure on the staff if priorities had to be set over who should be treated first. It would be open to the court to examine the basis of these priorities. In chapter 4, the case of *Deacon* v. *McVicar*[40] (Case 4.11) is considered. In this case, a patient alleged that she should have been seen earlier and the court was prepared to examine the records of other patients who were in the ward at the time to see if they were making demands on the staff at that time. These principles would apply to the policy of triage, i.e. the professional staff have to take all due care in treating the patients and, where priorities have to be decided on, this must be according to approved accepted practice. There is no doubt that, in general, pressure of work does not justify a lower standard of care for the patient. It may, in addition, lead to a successful action against the NHS trust itself if it can be established that the authority failed to provide adequate resources and training for the patients to be cared for safely. It may be necessary in emergencies for staff to undertake tasks that they are not properly trained to do. If so, it is a question of balancing one risk against another, i.e. the risk of not being treated at all against the risk of harm arising because the only available person to treat the patient has not had sufficient training. Inevitably, the only way of coping with wide variations in demand is either to bring in additional staff to meet peaks of demand or for patients with less severe conditions to wait until staff are available to assist. Even though waiting for a long time would probably not result in a successful legal action, the complaints procedure might be used for those who consider that they have waited an unacceptable length of time. To prevent such claims, clear standards of communication with patients must be drawn up and implemented to ensure that patients are fully apprised of the situation.

The parents of a 9-year-old girl alleged that Hull Royal Infirmary failed to diagnose a broken leg and sent her home after six hours with no X-rays and told her to keep trying to walk on it. Subsequently she was given an X-ray and a spiral fracture was diagnosed.[41]

Giving information to patients

Additional precautions must thus be taken to ensure that, where the patient is not detained overnight, he has sufficient information to recognise any signs and symptoms that suggest a return to the hospital or to the general practitioner for further consultation and examination. Most hospitals already have pre-printed leaflets covering warnings in relation to head injuries, care of plaster, the need for anti-tetanus and other potential dangers. There is a need to stress, by word of mouth also, the importance of a patient following these instructions. If a patient ignored the instructions, having had clear advice from the staff, there is unlikely to be any blame on the part of the staff and certainly there may be a large element of contributory negligence on the part of the patient. Where information is given by word of mouth to the patient, one frequent concern of the staff is, 'How can I prove what I said since it is only the patient's word against mine?' This is always a dilemma in negligence cases, since no matter how strong the defendant's case would appear to be on paper, it still has to be proved through witnesses to the satisfaction of the courts. It is here that good record keeping is extremely important. If the nurse notes that the patient was given the relevant information, this does not in itself prove that he was since the records do not necessarily reflect what actually took place, but it does indicate the existence of a system where the nurse is more likely than not to have given the requisite information. In addition, of course, any witness who can recall the events and substantiate what the nurse was saying will undoubtedly help her. An additional precaution where it is essential to emphasise the importance of following the correct advice is for the patient himself to be asked to sign that he has understood the importance of obeying the instructions and has received written instructions (see also chapter 4).

Relationship between the duty of care owed by the GP and by the A&E department

Another difficulty that arises in the A&E department is the extent to which the department is used, inappropriately as far as the operational policy of the A&E department is concerned, as a GP surgery or health centre. The replacement of GP out-of-hours services by deputising services has led to an increase in the use of A&E departments for minor illnesses and injuries and some departments are coping with this by setting up a primary care facility within the A&E department.

Practical Dilemma 21.2 Minor ailments

A patient came into the A&E department complaining of a pain in his ear. He was registered by the admission clerk and seen by a nurse, who then told him to wait to see the doctor. The doctor asked him how long he had had the pain and the man said that he had had it for about three days. He was asked if he had been to see his GP and he said that he was not sure who his GP was. The house officer suggested that he should go to see his GP and that he should not have come to the A&E department which was for emergency treatment of a serious kind. The man was very reluctant to go and very upset. It was subsequently learnt that he was admitted to the district general hospital with mastoid meningitis and an inquiry was established to find out why he had not been diagnosed in the A&E department.

The general principle would appear to be that once a patient comes through the doors, a duty of care is owed and the patient should not be sent away without an adequate examination. The words 'through the doors' are important, since a duty of care is not owed in a vacuum. It is perfectly possible for a hospital to say 'we do not accept A&E patients here' and refuse to treat a patient. However, once a hospital accepts a patient for attention, then a duty of care would arise to ensure that this patient receives the appropriate standard of care, even though it might mean arranging the transfer of the patient to another hospital or advising the patient to see his own GP. The Primary Care Foundation was commissioned by the Department of Health in May 2009 to carry out a study across England of the different models of primary care operating within or alongside emergency departments. It was asked to provide a viable estimate of the number of patients who attend emergency departments with conditions that could be dealt with elsewhere in primary care. It estimated that around half of the services across the country have some form of primary care service working with the emergency department. Its recommendations are particularly important for commissioners and providers of primary care and A&E services. It emphasised the importance of breaking down the barriers between primary care and emergency care clinicians and between the different organisations that employ the staff. Good joint working should be promoted.[42]

Extent of duty of care

Practical Dilemma 21.3 Referral for what?

A patient was referred to the A&E department by the GP for X-ray because she had fallen and sustained a severe injury and considerable bruising to her leg. The house officer arranged for her to be X-rayed and it was found to be negative. The patient mentioned to the doctor that she was very short of breath and thirsty. However, only her leg was examined. She subsequently discovered that she was suffering from diabetes and claimed that the casualty officer should have diagnosed this.

This is another situation that raises the extent of the duty of care owed by the hospital staff to the patient. If the GP refers a patient for a very specific purpose, which is carried out, can it then be said that the patient should have been given a full examination so that other significant defects could have been detected? The answer must obviously depend on the particular circumstances and what the reasonably accepted approved practice is.

The clinical nurse specialist in the A&E department

Increasingly, protocols are being developed for a nurse specialist to work within the A&E department, seeing patients who are not examined by a doctor, prescribing on a limited scale and performing an expanded range of activities. The legal issues arising from this scope of professional practice and the appointment of modern matrons in A&E departments are considered in chapter 24. A significant development in the A&E modernisation programme was the appointment of clinical nurse specialists (see chapter 24). An emergency care practitioner (ECP) report was prepared by the DH which set out the role of the ECP in the management of patients who require emergency (unscheduled) care.[43] Stuart Toulson has edited a book on A&E nursing which includes chapters on the role of the triage nurse and the role of the ECP.[44]

Pressure to disclose confidential information

The basic principles relating to the disclosure of confidential information are discussed in chapter 8. In that chapter, two examples are given of requests for information in A&E departments. Staff are under particular pressure in this respect, since they are likely to be hounded by both the police and the press in order that sensitive and personal information can be disclosed. In very prescribed circumstances, the health professions owe a duty to act in the public interest, and this duty may take precedence over the duty of confidentiality owed to the patient (see chapter 8). Guidance is provided in the NMC Code of professional conduct. The statutory powers of the police under the Police and Criminal Evidence Act enable, in cases of serious arrestable offences, a special procedure to be followed to compel the production of personal information and human tissue which would otherwise be protected from disclosure. Whatever the local policy on disclosure to the police, in the end it must be the individual professional's decision, since that individual may have to justify to the patient why confidentiality was not maintained.

Practical Dilemma 21.4 Road traffic accidents

The police are entitled to know the names and addresses of those who have been involved in a road traffic accident. This does not mean, however, that the media are also entitled to know these names or to know the condition of the patient. If the patient gives consent (and possibly the relatives, although this is more doubtful), then the information can be disclosed. If, however, this consent is refused, the hospital spokesman must remain silent as far as the disclosure of any confidential information is concerned. Once again, practice varies and there is an absence of court cases to settle the issue. For example, some hospitals allow a condition report to be given to the press without obtaining the consent of the patient, e.g. 'Of the ten persons injured in the motorway pile-up on Tuesday, one has since died, three have been discharged, four are comfortable and two are on life support machines.' There are few who would see this as a breach of confidence. Anyone (and this includes medical staff) who is aware of information about people involved in a road accident where personal injuries occurred has a duty to ensure that the police are notified.[45]

Patients' records come under the provisions of the Data Protection Act 1998 and are, of course, subject to close controls over disclosure. NHS trusts and clinical commissioning groups should appoint a Caldicott Guardian to oversee standards of confidentiality within the organisation (see chapter 8). Any concerns could be raised with that person, who should be on the Board.

Aggression and violence in A&E

One major headache for A&E staff is the increasing problem of dealing with aggressive drunken patients and the rights of the staff either to claim compensation from the criminal courts (if there is a successful prosecution of the assailant) or claim from the Criminal Injuries Compensation Authority. These topics are considered in chapter 2 (Criminal injuries compensation) and chapter 12.

Problems relating to the unconscious patient and the patient who has attempted to commit suicide have been considered in chapter 7 on consent to treatment.

Outpatients department

Excessive waiting

Practical Dilemma 21.5 Waiting

Bruce was self-employed and time was money. He had been suffering from a severe pain and his doctor had referred him to the consultant surgeon querying gallstones or cholecystitis. He was sent an appointment to see the surgeon at 9.30 a.m. in outpatients. Because he had an important meeting that afternoon, which could involve him in a lot of valuable work, he phoned the clerk who assured him that the clinic ended at lunchtime. When he got to the clinic, he discovered that 30 people had been booked in for 9.30, most of whom had arrived before him. As he sat chatting, he discovered that others who had been booked in for 12.00 noon had come early, since they were seen in the order of arrival and not according to appointments. He settled down for a long wait and then was told at 1.00 p.m. that the surgeon had had to rush off to theatre to cover for a colleague who had been taken ill, but that if Bruce waited, the doctor would see him when the operation was over. Bruce said that he could not wait as he had a very important meeting. The clerk replied that if he went away he would be treated as a 'did not attend' and would have to take his place in the queue being seen in outpatients. He would not be able to give him an appointment for at least another three months. Bruce insisted on seeing the sister in charge.

Oddly enough, there seems to be no legal grounds for bringing an action against an NHS trust for causing excessive waiting in outpatients or in A&E departments. The Department of Health had set down targets to reduce waiting in A&E departments, but these were enforced through the complaints system, rather than through legal action. In private practice there would be a contract between professional and client, and it could be more clearly argued that there was a breach of contract when a client was kept waiting an unreasonable length of time. However, in NHS care, there is no contract between the patient and the NHS trust or between the patient and the professional, and the patient who is aggrieved at having to wait an unreasonably long time would have to argue that there was a breach of the duty of care owed to the patient under the laws of negligence that has caused him some loss or harm – a loss or harm that is compensatable under the law. There have been actions when patients have waited excessively long periods of time for inpatient treatment. However, no action has been brought in relation to a long wait within the department itself. Such a complaint is more likely to be investigated

by the hospital management and be reviewed by the Health Service Commissioner (i.e. Ombudsman) (see chapter 27). The Health Service Commissioner has investigated many complaints of unreasonable waiting times in A&E, outpatients and other departments. The procedure for handling complaints is considered in chapter 27. The NHS Constitution (see the website of this book) makes the following patient pledge:

> **The NHS also commits: to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution.**

The NHS Handbook to the Constitution sets 18 weeks from the date of referral to starting consultant-led treatment for non-urgent conditions and a maximum of 2 weeks from GP referral to be seen by a cancer specialist where cancer is suspected. Page 29 of the Handbook sets other waiting time targets. Both the NHS Constitution and the Handbook can be downloaded from the government website.[46] The main means of enforcing such a pledge would appear to be through the complaints mechanism.

In Practical Dilemma 21.5, when the sister is confronted by a very disgruntled patient she should ensure that the facts given by the clerk are accurate. It is unlikely, for example, that a patient who has been kept waiting in the way in which Bruce has should be treated as a 'did not attend'. If so, the system is manifestly unjust. The sister should be able, with cooperation from the doctor, to arrange for Bruce to be seen much earlier. In addition, she may be able to arrange a compromise by asking Bruce to attend the meeting and to return that same day. Certainly she should be able to take the heat out of the situation, explain the problems fully to Bruce, work out some acceptable solution and, of course, apologise to him for what has happened. This is not law, but it is good practice. However, there are many such occasions where the patient may or may not have a right of action in law where skilled counselling and cooperation with the patient prevents a situation developing into a court action or Health Service Ombudsman's inquiry. The RCN has provided a guide for competencies for advanced nurse practitioners[47]

The Care Quality Commission published a briefing paper in 2010[48] on a survey of outpatients. In general there was an improvement in waiting times, cleanliness and the information given to patients. However, the results show that there is considerable room for improvement in the service provided. The survey carried out by the CQC in 2011 found that there was an improvement from the results of the 2009 survey.[49]

Mistaken identity

Practical Dilemma 21.6 The wrong notes

Sister Bailey was short staffed in the outpatients department and the situation was made worse by a strike among the coordinators. However, the consultants were adamant that the clinics should continue. She called out for one patient, Handel Thomas, to come to the diabetic clinic. She checked that he was from The Marina, Fish Street, and he said he was. He was asked if he had brought any samples with him and he replied: 'No, no one told me to.' He was then taken in to see the consultant. He was given a very full investigation and was asked how often he injected his insulin. He was a little surprised at this and replied that he had never been told to use insulin.

After considerable confusion, during which time Handel was getting very disturbed, it emerged that there was another Handel Thomas in Fish Street. This Handel James Thomas lived at number 45 and was due to be seen in the eye clinic; the other Handel, Handel David Thomas from 2 Fish Street, should have been seen in the diabetic clinic.

In circumstances like this, there has been clear negligence by the sister in failing to check that she was taking the right patient to be seen and by the doctor who also did not check. However, apart from causing distress to the patient and a breach of confidentiality of information about the other patient,

no harm has been caused to either, so it is not a case that is likely to end up in the courts. However, the potential implications of this type of mistake are terrifying and the tightest control must be kept over patient identification. Unfortunately, one cannot always rely on patients to point out the error since they can become institutionalised and frightened at the prospect of challenging the professionals, and stories abound as to what they are prepared to submit to by mistake. A news item in June 2014 reported that a pensioner died three hours after doctors operated on the wrong lung at the William Harvey Hospital in Kent.[50]

Genito-urinary medicine

Confidentiality

In a genito-urinary department (formerly known as the VD clinic or the 'special clinic'), strict confidentiality must be maintained. This section looks at some of the problems and pitfalls that can arise over confidentiality in this context and also at the statutory provisions.

Practical Dilemma 21.7 A reasonable request

Mr Grey had just visited the GUM clinic and samples had been taken. He was told that the results would be available by the Thursday of the following week. He was naturally anxious and, since he lived some 40 miles from the clinic, he phoned up late Thursday morning to find out the results. He gave his name and the nurse asked for his clinic number. She explained that it was on his card. He said that he had lost his card. She therefore told him that she would be unable to give him the result over the phone. He asked if that meant that the results were positive. She said not at all, but because of the principles of confidentiality, she could neither confirm that someone of that name had attended the clinic nor could she give any results over the phone without the clinic number. He became very angry, pointing out the inconvenience that he would suffer if he had to drive the 40 miles there and back, especially if the results were negative. She told him that she could not change the rules. He threatened to complain about her attitude and report her.

There is no doubt that the nurse is correct in not divulging information without being absolutely certain that she is talking to the patient. There are possible ways out of this dilemma. One would be for the nurse to phone a number that had already been given by the patient to the clinic for the notification of the results. The other would be to ensure that all patients are warned of the strict rules of confidentiality from the outset of their care so that they know the rules are firmly adhered to for their own protection, even in circumstances that cause them great inconvenience such as the one above.

A similar difficulty can be seen in Practical Dilemma 21.8.

Requests for information by a spouse

Practical Dilemma 21.8 Spousely concern

A man phoned the GUM clinic saying that he was the husband of Mrs Robinson, a patient who had an appointment at the clinic that afternoon. He said that she had lost her appointment card and forgotten the time and, since he was giving her a lift, could they let him know the time of the appointment?

This is the sort of request that few staff in a general outpatients department would hesitate to respond to helpfully. Yet, if confidentiality is to be preserved, it is essential that the person answering the phone does not admit to the fact (if this is indeed the case) that there is a patient of such a name attending the clinic.

Tracing

Obviously, it is essential that, as far as possible, any people who have been in contact with someone who is infected should be traced and advised to have tests. It is important that this be done without revealing the name of the contact. A form is completed to assist the clinic. If original contacts can be persuaded to advise their contacts to have a check, this is preferable to their receiving a call out of the blue.

Venereal disease regulations

These regulations (National Health Service (Venereal Diseases) Regulations 1974 Section 1 No. 29 (as amended by SI 1982 No. 288)) ensure that any information about any sexually transmitted disease is kept confidential.

In 2000, Directions[51] were issued for England only, which came into force on 1 April 2001 revoking earlier Directions of 1991. The 2000 Directions require every NHS trust and PCT to take the necessary steps to secure that any information capable of identifying an individual obtained by any of their members or employees with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except:

(a) for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof, and

(b) for the purpose of such treatment or prevention.

The National AIDS Trust (NAT) published in 2009 a booklet on confidentiality in healthcare for people living with HIV which is available on its website.[52]

It was suggested in the case of *X* v. *Y and Another* (1988)[53] that AIDS came within the scope of the VD regulations. See chapter 26 for a consideration of the legal issues in AIDS and infectious diseases.

Sexual health

In 2001, the government published the National Strategy for Sexual Health and HIV.[54] This strategy placed sexual health and HIV firmly on the national agenda and set out a 10-year programme to tackle sexual ill health and to modernise the sexual health services in England. The sexual health strategy aimed to reduce sexually transmitted diseases and unwanted pregnancies. As part of this initiative it published a guide for commissioning and planning.[55] In 2005 the government published a response to the Health Select Committee's Report on New Developments in Sexual Health and HIV/AIDS Policy.[56] It noted that £200,000 had been allocated by the Department of Health to support nurses undertaking a distance learning programme. This would train 2,700 practice nurses in basic sexual health skills and the supply of condoms and emergency contraception. In 2007, the government commissioned the Independent Advisory Group (IAG) on Sexual Health and HIV to undertake a review of the progress made in implementing the national sexual health and HIV strategy. The IAG report was published in 2008 reviewing the progress of the strategy[57] and the government response in 2009 outlined the progress since 2001 and responded to each of the national-level recommendations made in the strategy review.[58] In 2010 the Department of Health published its equality impact assessment for national sexual health policy. It concluded that significant inequalities existed in sexual health in England and set out plans to reduce them. These reports are available on the DH website. In 2013 the Department of Health

published its Framework for sexual health improvement in England. It identified the key principles of best practice in sexual health commissioning which were:

- prioritising the prevention of poor sexual health
- providing strong leadership and joined up working
- focusing on the outcomes
- addressing the wider determinants of sexual health, commissioning high-quality services, with clarity about accountability
- meeting the needs of more vulnerable groups and good-quality intelligence about services and outcomes for monitoring purposes.

Strategies relating to the reduction of teenage pregnancies are considered in chapter 13.

Day surgery

The NHS Plan saw an increase in day surgery as a means of helping the NHS achieve its targets of treating more patients faster and was therefore a key strand of NHS modernisation and predicted that 75 per cent of all elective operations would be carried out as day cases. In 2001 the Audit Commission considered that day surgery units were not being used to their maximum capacity.[59] An operational guide was published by the Department of Health[60] to improve efficiency in day surgery units with funds made available from the NHS Modernisation Programme. Some of the problems identified by the Audit Commission and the British Association of Day Surgery included:

- inappropriate and inefficient use of units (e.g. treating patients who could be cared for in a treatment room or outpatients)
- poor management and organisation, especially in relation to the flow of patients
- clinicians' preference for inpatient surgery
- mixing of inpatients and day cases on the same list, leading to cancellations due to theatre overruns
- failure to recognise day surgery as a priority.

All those areas of law that are the concern of inpatient care also apply to those working in day surgery. However, there are additional problems that can arise from the speed of turnover, the fact that patients are seen for a very short time and that significant decisions have to be made urgently. For example, crucial decisions have to be made about whether an operation is to proceed following the necessary tests; should the patient be admitted after surgery or could he/she be allowed to go home, and what information has to be given to the patient before the patient returns home. The pressure of work, the speed of patient throughput and the risk of harm arising means that clear protocols are necessary to ensure that patients receive a satisfactory standard of care and that they and their carers are given essential information pre- and post-surgery. Practical Dilemma 21.9 is only one of the situations where complaints and litigation can arise. Reference must be made to earlier chapters setting out basic principles of law. Benchmarking tools were introduced in 2004 by the Modernisation Agency in relation to day surgery so that trusts could assess their performance and learn of best practice across the country. Research at Salford University into the psychological impact of conscious day surgery found that more contact with nurses could help reduce patient anxiety. It suggested that if nurses met patients before the surgery and provided information about the operation and the anaesthesia this would help reduce anxiety in the majority of patients.[61] The Healthcare Commission reviewed services for day surgery in 2005 and concluded that there was scope to do much more day surgery within the capacity already available.[62] Figures published by the NHS Institute for Innovation and Improvement (now NHS Improving Quality) showed that only cataract care came anywhere near the potential national day case rate.[63] The use of Better Care, Better Value indicators reveal the potential to make significant cash or resource savings while improving quality by greater use of day surgery.[64] *Converting the Potential into Reality* (2009) sets out 10 steps a provider can take to realise the benefits of Better Care, Better Value indicators.

Practical Dilemma 21.9 Day surgery

Barbara was called for day surgery to have an operation for carpal tunnel syndrome. The operation was to be performed under a local anaesthetic. She was told to arrive by 9.00 a.m. even though she would be the last on the list. She waited for two hours before she was seen by a nurse, who then booked her in and told her that she should not have had any breakfast. Barbara queried this, as a general anaesthetic was not planned. The nurse said it was a precaution in case the operation could not be performed under a local anaesthetic. At 2.30 p.m. she was taken down for surgery and told that she must stay in the ward until 6.00 p.m. She asked for and was given a cup of tea at 4.00 p.m. Apart from that, she had no food or drink. No instructions were given to her for postoperative care. She considers that she has been treated poorly. What rights does she have?

This situation is more likely to lead to a complaint than to litigation. There is the possibility of a claim under Article 3 of the Convention on Human Rights (see chapter 1 and the website of this book) in that she may have been given degrading or inhuman treatment. She is unlikely to benefit from civil litigation for compensation, unless there is long-term harm as a result of the failure to give her post-operative and post-discharge instructions. For example, if she should have been advised not to drive a car after the operation and, as a result of this omission, she was involved in an accident, then there would appear to be a breach of the duty of care owed to her. However, these deplorable circumstances might well be the subject of a complaint and of the argument that the pledges and rights recognised in the NHS Constitution were not respected.

Conclusions

The crises within A&E departments continue to place considerable pressure upon nursing staff. The importance of the nurse practitioner and clinical specialist role assumes greater significance as the shortage of A&E consultant specialists continues. At the same time patient expectations continue to rise. There are likely to be an increasing volume of complaints. There is evidence that the potential for day surgery instead of inpatient care has not yet been fully realised. Current plans put forward by the Chief Executive of NHS England for smaller hospitals to be retained are likely to lead to some imaginative use of Skype and the sharing of doctors and greater cooperation between health service providers.

Reflection questions

1 Does the nurse (or doctor) who works in the A&E department have a duty in law to assess the priority to be given to a patient and could she be held liable in the civil courts for failures in making that assessment?

2 Can a patient be lawfully refused treatment in an A&E department and be referred instead to his GP?

3 What remedy does a patient who has waited an excessive amount of time in the A&E department or the outpatients department have?

4 What precautions might be taken to preserve medical confidentiality in the A&E department in relation to:
   (a) the press
   (b) the police
   (c) other staff?

Further exercises

1 Do you consider that the spouse of a patient suffering from a sexually transmitted disease should have a right to be told of the spouse's medical condition? What is the law on this?

2 What remedies does a member of staff have who has been injured by a drunken patient in the A&E department? (See also chapter 12.)

3 In what way does the duty of staff in A&E departments differ from the duty of those on the wards in relation to the care of the patient's property? (Refer also to chapter 25.)

4 A patient is admitted into the A&E department with severe bleeding. His clothes have to be cut from him and because they are badly soiled they are sent for incineration. He subsequently complains that there was £300 in the pocket of his jacket. What is the liability of the hospital or of the A&E staff? (Refer to chapter 25.)

5 A clinical nurse specialist who works in day surgery is asked if she would like to apply for a nurse consultant post in this speciality. What differences would she anticipate in these two roles? (Refer also to chapter 24.)

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Chapter 22

Human fertility and genetics

This chapter discusses

- Artificial insemination
- Human Fertilisation and Embryology Act 1990 as amended by 2008 Act
- *In vitro* fertilisation
- Embryos
- Confidentiality
- Surrogacy
- Conscientious objection
- Genetics
- Gene therapy and genetic diagnosis
- Gender selection
- Genetic screening and testing
- Cloning

Introduction

Nurses are increasingly likely to be caring for patients in clinics and on the wards who are receiving treatment in connection with problems of fertility. Medical technology has made vast strides in this field and frequently outpaces the law. This chapter provides guidance on the current legislation relating to artificial insemination by donor, embryo implantation, surrogacy and genetic engineering. The legal problems that arise from sterilisation and family planning are considered in chapter 15 and those relating to organ and tissue removal, donation and storage in chapter 16. Genetic research using human

tissue is considered in chapter 18. The Warnock Committee[1] considered the need for legislation across this field and its recommendations led to the Human Fertilisation and Embryology Act 1990 which introduced statutory controls in relation to reproductive medicine. Subsequent scientific developments after 1990 inevitably led to calls for new legislation. A White Paper[2] was published in December 2006 following extended consultation, and a draft Human Tissue and Embryos Bill was published in May 2007 and subjected to scrutiny by a committee of both Houses of Parliament. The government response to the Joint Committee's report was published in October 2007[3] and is shown in Box 22.1. Subsequently, the Human Fertilisation and Embryology Act 2008 was enacted and implemented.

Box 22.1 Government response to Joint Committee on the draft Human Tissue and Embryo Bill

The government:

- accepted the recommendation to retain the two separate authorities (Human Fertilisation and Embryology Authority and Human Tissue Authority), but would look at the scope for the two authorities to streamline legislation;
- welcomed the recommendation that primary care trusts and Foundation trusts implement NICE guidance on minimum levels of IVF treatment, and accepted that although this is not a matter for legislation, the DH was funding a three-year programme of work (being carried out by Infertility Network UK) that aims to reduce inequalities in the provision of IVF;
- agreed that the use of inter-species embryos for research could be put before Parliament, with the power given to the Regulator to permit or refuse licences in relation to all inter-species embryos;
- agreed that a permitted embryo could only be implanted if it was from the genetic material of a woman and a man, and not from two women;
- agreed that selecting for saviour siblings should not be limited to 'life-threatening' conditions, but only to 'serious' conditions;
- sex selection should only be for medical reasons in accordance with current HFEA policy;
- use of an embryo for research involving altering the genetic structure of the embryo could proceed within the 14-day period;
- where embryos have been created using donor gametes, and a woman no longer wished to consent to the storage of the embryo, the clinic would not have to notify the donor;
- whether it was in the best interests of a mentally incapacitated person to take gametes for storage should be left to the professional judgement of the clinicians;
- the need for a father should be removed but the general duty to take account of the welfare of the child should be included in primary legislation;
- there should be a time limit on the period of storage of gametes or embryos and this should be increased from 5 to 10 years but be subject to review;
- people intending to marry or cohabit or enter a civil partnership should be entitled to contact the HFEA to see whether they are related as a result of donor insemination, but the consent of both parties is required for this information to be provided;
- HFEA, which holds a register of all donor treatment since 1990, will be able to run the voluntary contact register which covered donor treatment preceding the 1990 Act;
- those of 16 years and over can obtain non-identifying information from HFEA, but the age limit of 18 years for those wishing to obtain identifying information is to be retained;
- putting the fact of donor conception on a birth certificate involves issues of privacy, human rights and data protection and will be kept under review;
- facilitating counselling for persons seeking donor information from the HFEA is important and will be included in discussions between the government and the HFEA on its annual business plan and priorities;
- the provision in the draft Bill for not allowing sex selection for non-medical purposes in sperm-sorting kits is to be removed since it relates to a potential development and it will be kept under review;
- the possibility of bringing surrogacy within the remit of the HFEA would be considered.

Artificial insemination

Artificial insemination by husband (AIH)

If a married couple require help in conception such that the husband's semen is artificially transferred to the wife, the law would see the outcome of this as being identical with natural conception. As far as such aspects as inheritance, legal guardianship of the child, etc. are concerned, there is no difference between the artificially and the naturally conceived child. However, the involvement of a third person raises the possibility of other legal issues. For example, it is possible that if a pathology laboratory is involved, there could be a mix-up over the semen and the woman could be given semen from someone other than her husband. With genetic coding, it would now be possible to prove that the child is not the husband's, although, of course, it must be remembered that in order to succeed in a negligence action it must be established that there was a causal link between the negligent act and the harm caused (the woman could have had sex with a third person). Some have opposed AIH on moral grounds, since it is an unnatural form of conception, but the Warnock Committee[4] were of the view that it was an acceptable form of treatment except where a widow used semen that had been stored in a semen bank. They felt that insemination after the husband's death could lead to profound psychological problems for the child and the mother. (See the Diana Blood case on page 589.) The Warnock Committee considered that there was no need or even practical possibility of formal regulation of AIH, but recommended that it should be administered by or under the supervision of a medical practitioner.

No licence is required under the 1990 Act for artificial insemination by the husband. Neither is one required for AIP (artificial insemination of an unmarried woman with her partner's sperm). Neither AIH nor AIP requires the use of donated gametes. However, a licence would be required if the sperm is processed or stored. GIFT (gamete intrafallopian transfer) does not require a licence if the egg and sperm come from the woman and her partner/husband. Basic partner treatment services (i.e. treatment services that are provided for a woman and a man together without using (a) the gametes of any other person, or (b) embryos created outside the woman's body), are excluded from the licence and information provisions.

Following amendments made to the 1990 Act by the 2007 regulations,[5] a licence is required under the 1990 Act in respect of non-medical fertility services. Non-medical fertility services are any services that are provided, in the course of a business, for the purpose of assisting women to carry children, but which are not medical, surgical or obstetric services. This would cover internet-based businesses that arrange for donated sperm to be delivered to women at home for self-insemination.

The European Court of Human Rights held that the refusal of access to artificial insemination facilities to a life-term prisoner was a disproportionate action by the state and a breach of his Article 8 rights[6] (see chapter 1).

Artificial insemination by donor (AID)

Where the donor is not the husband, problems over legitimacy, rights to inheritance and the duties of the husband in relation to the child arise. A report from the Archbishop of Canterbury in 1948 recommended that AID should be made a criminal offence. The Feversham Report set up by the government in 1960 recommended that AID should be discouraged. The opposite has happened. In 1973 a panel under the chairmanship of Sir John Peel recommended the setting up of accreditation centres for AID, but this has not taken place. In an early case[7] (preceding the legislation of 1990), regarding the rights of the father, the father and mother had entered into an agreement that the girl would be artificially inseminated by him and then she would hand over the child on payment of £3,000. She refused to hand the child over and the trial judge gave the father limited rights of access. The Court of Appeal, however, gave him no rights of access.

Artificial insemination by donor is not unlawful, but, in contrast to the child born from AIH, the child born as a result of AID is illegitimate and the husband of the mother has no parental rights and duties in relation to the child, unless he accepts the child as a child of the family. The donor could be held responsible for the maintenance of the child and could apply to the court for access or custody. A consultation paper was published by the government in 1986. Following this, a child who is born to a woman as the result of artificial insemination by someone other than her husband is treated as the child of the parties of that marriage. This is enacted by section 27 of the Family Reform Act 1987. The main condition is that the marriage must be in existence at the time. Proof to the satisfaction of the court that the other party to the marriage did not consent to the insemination will prevent this provision arising. This means that the burden is placed on the husband to show that the insemination was performed without his consent. This provision came into force in April 1988 and applies only to children born subsequently. Sections 33 to 38 of the 2008 Act cover the definition of mother and father in cases involving assisted reproduction.

In a significant decision, a gay man who had provided sperm for the artificial insemination of a woman on the basis that they would share in the child's upbringing (neither was in a gay relationship at the time) won his application to have joint parental rights over the child. The mother had denied him access to his son, 2 years old, at the time of the court hearing.[8] In another case where a child was conceived to a partner in a lesbian relationship by having sexual intercourse with a man, the man was given parental responsibility subject to a preamble and specified conditions by the Family Division of the High Court.[9] In a case in 2010 in the Court of Appeal a lesbian mother and the gay father disputed residency rights. (The father wished for shared residency, but the mother argued that the residency order should be made in favour of herself and her partner who had jointly been the children's (a boy of 9 and girl of 7) primary carers since birth.) The CA held the father should have residency rights for 152 days of the year.[10] In a recent case the donor of sperm to a lesbian couple was not to be excluded from the life of his son and the woman failed in her attempt to prevent any contact between the father and son. The judge said that the father had rights of his own and that the baby would benefit from his input.[11] In a case in March 2014 the Court of Appeal overruled a family court decision that the genetic mother could not share residence of twin girls born from artificial insemination. The genetic mother had donated eggs to her lesbian lover but sole residence was awarded to the birth mother. The Court of Appeal upheld the challenge of the genetic mother and said that the case must be sent back to the county court.[12]

In another case in 2013 there was a dispute between the woman and the father of the child as to whether the child was born as a result of sperm donation according to him (Mr F) or sexual intercourse according to her[13]. If the child was the result of sexual intercourse F would be the legal parent of the child and had a duty to provide for the child financially. If F was a sperm donor then the question of parentage depended on the effect of section 35 of the Human Fertility and Embryology Act 2008. (Section 35: the husband of a woman who conceives following embryo or egg and sperm donation, where the sperm is not his, is deemed to be the father of the child unless he did not consent to the fertilisation.) M's husband was 30 years older than M. The judge concluded on the evidence (he found that both M and F had lied) that F was the biological and legal parent of the child. In the dispute over costs (M had paid £300,000) the judge held that the legal father should pay the husband's costs and the mother's costs with a reduction of 25 per cent to take account of her misconduct.

Anonymity of donors

There were two years of consultation on whether donors should be entitled to keep their anonymity or whether the offspring from donated gametes had a right to know the donors. A summary of the public consultation is available on the internet. In July 2003 the HFEA called for the removal of laws protecting the anonymity of all future sperm and egg donors, and acknowledged the fundamental right of donor

offspring to have knowledge of their genetic origins. In a report in *The Times*,[14] Baroness Warnock admitted that she had been wrong to recommend that anonymity should be preserved. Two cases held that Britain was violating Article 8 of the European Convention on Human Rights by depriving children of the right to obtain knowledge of their personal identity. Legislation to give children of sperm, embryo and egg donors the right to find out about their parents was proposed by the government in January 2004[15] and led to new rules[16] to lift anonymity from future donors and allow donor-conceived children to access the identity of their donor when they reach 18 years coming into force on 1 April 2005. As a consequence, those who donated sperm, eggs or embryos after 1 April 2005 are, by law, identifiable. Any person born as a result of donation after this time is entitled to request and receive their donor's name and last known address, once they reach the age of 18. These rules do not have retrospective effect. Neither do they create financial or legal obligations on the donor for the child. The HFEA issued guidance on the disclosure of information relating to gamete donation in 2004 following the new disclosure rules.[17] It lists the disclosures to donors which are permissible as long as the disclosure could not lead to the identification of a person whose identity should be protected. The information which could be disclosed includes telling a donor whether a live birth has resulted from the donation and, if so, the number of such births. Further information is available from the HFEA website. The lifting of anonymity has led to a shortage of donors and the HFEA is considering raising the payment to egg and sperm donors from £250 to £800.[18] Following a consultation paper, the Code of Practice section 13A was amended in April 2012 to cover the payment of donors. Centres may pay sperm donors a fixed sum of £35 per clinic visit and egg donors can be compensated with a fixed sum of £750 per cycle of donation. For further details see the HFEA Code of Practice section 13A interpretation of mandatory requirements.

The laws relating to disclosure of genetic parentage are now contained in section 31ZA added to the 1990 Act by section 24 of the 2008 Act (see page 591, Confidentiality).

Safety of tissue and cells

Concern has been expressed by the HFEA over the purchase of sperm over the internet. It was announced in January 2004 that the first baby had been born to a lesbian couple following conception by sperm obtained via the internet. New rules came into force in July 2007[19] relating to standards on quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of tissues and cells which were set out in an EU Directive in 2004.[20] Internet sperm providers must therefore be licensed by the HFEA or have a third party agreement with a licensed centre to ensure standards of quality and safety of the sperm. The announcement that an IVF clinic was raffling a human egg to promote its new baby profiling service led to understandable concern[21] and a discussion on whether the law should permit a market place in human material.[22] In the UK donors can only receive reasonable expenses for their gifts and fixed sums as set out above.

Human Fertilisation and Embryology Act 1990 as amended by 2008 Act

The 1990 Act was passed to implement the recommendations of the Warnock Committee.[23] A summary of the provisions of the 1990 Act (as amended) is set out in Statute Box 22.1. It covered three main areas of activity:

1. licensed treatments, i.e. any fertility treatment that involves the use of donated eggs or sperm, or embryos created outside the body (i.e. IVF);
2. storage of eggs, sperm and embryos;
3. research on human embryos.

Statute 22.1 Provisions of the Human Fertilisation and Embryology Act 1990 as amended by the 2008 Act

1 Definition of terms 'embryo' and 'gamete' revised in 2008.
2 Specific activities prohibited: some completely; others without a licence (see Statute Box 22.2).
3 Human Fertilisation and Embryology Authority established with the function of:
- reviewing information about embryos and advising Secretary of State
- publicising services provided to public by HFEA or in pursuance of licences
- providing advice and information
- other functions specified in regulations
- monitor committees to grant licences
- giving directions
- providing an annual report
- maintaining a statement of general principles
- promoting compliance with legal provisions and Code of Practice
- carrying out its duties effectively, efficiently and economically.

4 Licences for treatment, storage, research and conditions of holding licence.
5 Code of practice to be issued by HFEA subject to Secretary of State's approval.
6 Definition of 'mother' and 'father'.
7 Register of information to be kept by HFEA with restriction on disclosure.
8 Amendments to Surrogacy Arrangements Act 1985 by providing that no surrogacy arrangement is enforceable by or against any of the persons making it.
9 Changes to Abortion Act 1967 (see chapter 15).
10 Protection of those with conscientious objection (see page 594).
11 Powers of enforcement given to HFEA including power to enter premises.
12 Offences established.

Statute 22.2 Prohibited activities

3 Prohibitions in connection with embryos

(1) No person shall bring about the creation of an embryo except in pursuance of a licence.
(1A) No person shall keep or use an embryo except –
  (a) in pursuance of a licence, or
  (b) in the case of – (i) the keeping, without storage, of an embryo intended for human application, or (ii) the processing, without storage, of such an embryo in pursuance of a third party agreement.
1(B) No person shall procure or distribute an embryo intended for human application except in pursuance of a licence or a third party agreement.
(2) No person shall place in a woman –
  (a) an embryo other than a permitted embryo (as defined by section 3ZA (see Statute Box 22.3)), or
  (b) any gametes other than permitted eggs or permitted sperm (as so defined).
(3) A licence cannot authorise –
  (a) keeping or using an embryo after the appearance of the primitive streak,
  (b) placing an embryo in any animal, or
  (c) keeping or using an embryo in any circumstances in which regulations prohibit its keeping or use.
(4) For the purposes of subsection (3)(a) above, the primitive streak is to be taken to have appeared in an embryo not later than the end of the period of 14 days beginning with the day on which the process of creating the embryo began, not counting any time during which the embryo is stored.

3A Prohibitions in connection with germ cells

(1) No person shall, for the purpose of providing fertility services for any woman, use female germ cells taken or derived from an embryo or a fetus or use embryos created by using such cells.

(2) In this section – 'female germ cells' means cells of the female germ line and includes such cells at any stage of maturity and accordingly includes eggs; and 'fertility services' means medical, surgical or obstetric services provided for the purpose of assisting women to carry children.

4 Prohibitions in connection with gametes

(1) No person shall –
- **(a)** store any gametes, or
- **(b)** in the course of providing treatment services for any woman, use –
  - **(i)** any sperm, other than partner-donated sperm which has been neither processed nor stored,
  - **(ii)** the woman's eggs after processing or storage, or
  - **(iii)** the eggs of any other woman,

  except in pursuance of a licence.

(1A) No person shall procure, test, process or distribute any gametes intended for human application except in pursuance of a licence or a third party agreement.

(2) A licence cannot authorise storing or using gametes in any circumstances in which regulations prohibit their storage or use.

(3) No person shall place sperm and eggs in a woman in any circumstances specified in regulations except in pursuance of a licence.

(4) Regulations made by virtue of subsection (3) above may provide that, in relation to licences only to place sperm and eggs in a woman in such circumstances, sections 12 to 22 of this Act shall have effect with such modifications as may be specified in the regulations.

(5) Activities regulated by this section or section 3 or 4A of this Act are referred to in this Act as 'activities governed by this Act'.

4A Prohibitions in connection with genetic material not of human origin

(1) No person shall place in a woman –
- **(a)** a human admixed embryo,
- **(b)** any other embryo that is not a human embryo, or
- **(c)** any gametes other than human gametes.

(2) No person shall –
- **(a)** mix human gametes with animal gametes,
- **(b)** bring about the creation of a human admixed embryo, or
- **(c)** keep or use a human admixed embryo, except in pursuance of a licence.

(3) A licence cannot authorise keeping or using a human admixed embryo after the earliest of the following –
- **(a)** the appearance of the primitive streak, or
- **(b)** the end of the period of 14 days beginning with the day on which the process of creating the human admixed embryo began, but not counting any time during which the human admixed embryo is stored.

(4) A licence cannot authorise placing a human admixed embryo in an animal.

(5) A licence cannot authorise keeping or using a human admixed embryo in any circumstances in which regulations prohibit its keeping or use.

(6) For the purposes of this Act a human admixed embryo is –
- **(a)** an embryo created by replacing the nucleus of an animal egg or of an animal cell, or two animal pronuclei, with (i) two human pronuclei, (ii) one nucleus of a human gamete or of any other human cell, or (iii) one human gamete or other human cell,
- **(b)** any other embryo created by using – (i) human gametes and animal gametes, or (ii) one human pronucleus and one animal pronucleus,

(c) a human embryo that has been altered by the introduction of any sequence of nuclear or mitochondrial DNA of an animal into one or more cells of the embryo,
(d) a human embryo that has been altered by the introduction of one or more animal cells, or
(e) any embryo not falling within paragraphs (a) to (d) which contains both nuclear or mitochondrial DNA of a human and nuclear or mitochondrial DNA of an animal ('animal DNA') but in which the animal DNA is not predominant.

(7) In subsection (6) –
(a) references to animal cells are to cells of an animal or of an animal embryo, and
(b) references to human cells are to cells of a human or of a human embryo.

(8) For the purposes of this section an 'animal' is an animal other than man.

(9) In this section 'embryo' means a live embryo, including an egg that is in the process of fertilisation or is undergoing any other process capable of resulting in an embryo.

(10) In this section –
(a) references to eggs are to live eggs, including cells of the female germ line at any stage of maturity, but (except in subsection (9)) not including eggs that are in the process of fertilisation or are undergoing any other process capable of resulting in an embryo, and
(b) references to gametes are to eggs (as so defined) or to live sperm, including cells of the male germ line at any stage of maturity.

(11) If it appears to the Secretary of State necessary or desirable to do so in the light of developments in science or medicine, regulations may –
(a) amend (but not repeal) paragraphs (a) to (e) of subsection (6),
(b) provide that in this section 'embryo', 'eggs' or 'gametes' includes things specified in the regulations which would not otherwise fall within the definition.

(12) Regulations made by virtue of subsection (11)(a) may make any amendment of subsection (7) that appears to the Secretary of State to be appropriate in consequence of any amendment of subsection (6).

The definition of permitted eggs, sperm and embryos is shown in Statute Box 22.3.

Statute 22.3 Definition of permitted eggs, sperm and embryos – Section 3ZA

(1) This section has effect for the interpretation of section 3(2).

(2) A permitted egg is one –
(a) which has been produced by or extracted from the ovaries of a woman, and
(b) whose nuclear or mitochondrial DNA has not been altered.

(3) Permitted sperm are sperm –
(a) which have been produced by or extracted from the testes of a man, and
(b) whose nuclear or mitochondrial DNA has not been altered.

(4) An embryo is a permitted embryo if –
(a) it has been created by the fertilisation of a permitted egg by permitted sperm,
(b) no nuclear or mitochondrial DNA of any cell of the embryo has been altered, and
(c) no cell has been added to it other than by division of the embryo's own cells.

(5) Regulations may provide that –
(a) an egg can be a permitted egg, or
(b) an embryo can be a permitted embryo, even though the egg or embryo has had applied to it in prescribed circumstances a prescribed process designed to prevent the transmission of serious mitochondrial disease.

(6) In this section –
(a) 'woman' and 'man' include respectively a girl and a boy (from birth), and
(b) 'prescribed' means prescribed by regulations.

In vitro fertilisation (IVF)

The Human Fertilisation and Embryology Act 1990 (as amended) provides a framework for the control of the external fertilisation of an egg, extracted from the ovary, with semen. It covers the disposal of unwanted embryos, their ownership, authorisation to undertake research on these embryos, embryo donation to another woman or genetic engineering to prevent hereditary disorders or to create a super-human. It also covers human admixed embryos. Fertilisation outside the body coupled with transfer of the embryo into the uterus is, in its most simple form, a means of overcoming a fertility problem in a married couple. However, because of the possibility of egg and semen donation and subsequent transfer to a woman other than the provider of the egg, a complex situation can arise. In addition, it can be coupled with a surrogacy arrangement whereby a couple for whom the woman is unable to carry a child arrange for an embryo created from their egg and semen to be inserted into a host woman who will return the child to the genetic parents after birth. The surrogacy arrangements are considered below (see (see pages 591–4)). This part will deal with IVF and ET (embryo transfer) to the uterus.

The majority of the Warnock Committee recommended a time limit of 14 days on research on an embryo because at about the 15th day after conception the formation of the primitive streak can be identified. This is the first of several identifiable features that develop in and from the embryonic disc during the succeeding days. Information about the process of approving research proposals can be obtained from the HFEA website. It involves five stages: contacting HFEA; applying for a licence or renewal; undergoing peer review; inspection; and presentation to the research licence committee. Regulations relating to the disclosure of protected information for the purposes of research came into force on 6 April 2010.[24] The HFEA decided to publish details of the success rates of individual IVF clinics on an improved website. Couples would be able to assess the 'predicted chance' of a live birth after treatment at individual clinics.[25]

Refusal to permit IVF

In a case in 1987[26] the High Court refused an application for judicial review of decisions by consultants who decided that a woman should be refused IVF treatment, on the grounds of past convictions and her prostitution. Section 13(5) of the 1990 Act made it a condition of any licence that treatment services are not to be provided unless account had been taken of the welfare of the child who may be born as a result of the treatment (including the need of that child for a father) and of any other child who may be affected by the birth. The 2008 Act amended this provision to substitute 'supportive parenting' for 'father'. The Code of Practice issued by the HFEA gives further advice on how the licensed centres should assess these welfare issues and its guidance was updated in 2010.[27] HFEA issued new guidance in 2013 on how clinics should make an assessment of the welfare of any child who may be born as a result of treatment services.[28] In 1994 a 37-year-old woman was refused IVF treatment through the NHS on the grounds of her age.[29] Her application to the High Court to quash the health authority's decision failed on the grounds that, in the light of its limited resources, a health authority policy to set an age limit was not unreasonable. The HFEA Code of Practice does not stipulate any age limitation and paragraph 8.7 advises centres to assess applicants in a non-discriminatory way and not discriminate on the grounds of gender, race, disability, sexual orientation, religious belief or age. However, under the amended section 13(5) of the Act, cited above, it could be decided that the welfare of the child would be adversely affected by an elderly applicant.

The Court of Appeal overthrew the decision of the High Court in a case where a couple had agreed to have IVF treatment that was unsuccessful on the first attempt. The couple then separated, but the woman did not tell the clinic and then, on the next attempt, became pregnant. Her former partner sought a declaration that he was the child's legal father and wished to establish contact. The High Court ruled that he was the legal father of the 3-year-old girl. However, the woman's appeal succeeded. The Court of Appeal held that the wording of the 1990 Act meant that the partner of a woman receiving treatment

with donor sperm will be the father of any resulting child only if the couple are receiving that treatment together, at the time that the sperm or embryo is placed in the womb. The House of Lords dismissed the appeal.[30]

A summary of the provisions of the Human Fertilisation and Embryology Act 1990 as amended by the 2008 Act on IVF is set out in Statute Box 22.1.

On 20 July 1994, the HFEA ruled that eggs from aborted fetuses could not be used in fertility treatment, but they could be used in research. The same ruling applies to the eggs of a dead woman, even though she is carrying a donor card. Guidance on the donation of sperm, eggs and embryos was published by the HFEA in January 2006 and implemented on 1 April 2006.[31] The report of the Sperm, Egg and Embryo Donation (SEED) review covers the adoption of professional standards for donor screening, greater clarity around the number of families that may be created using each donor and new guidance to help centres avoid exceeding this limit, new directions on the reimbursement of donors' expenses and compensation for loss of earnings, guidance on egg sharing and HFEA's policy on authorising imports and exports of gametes and embryos. The SEED Report can be downloaded from the HFEA website.[32]

In 2010 the HFEA commenced a review on many of its policies, including:

- the number of families to which donors can donate;
- expenses and compensation that donors can receive for donation;
- donation between family members;
- the restrictions which donors can place on the use of their gametes or embryos.

A new edition of the Code was published in 2010 following the implementation of the Human Fertilisation and Embryology Act 2008 and was updated on 1 October 2013 to reflect recent developments.

An infertile man who attempted to become a legal father to a sperm-donor baby simply by signing his partner's IVF consent form failed when the Court of Appeal overruled a paternity declaration in his favour by a High Court judge.[33]

Obtaining fertility treatment within the NHS has varied from health authority to health authority, with some couples having to pay as much as £3,000 to obtain each private fertility treatment, while others are able to obtain the treatment on the NHS. In November 2000 the Secretary of State for Health asked NICE (see chapter 5) to review the various fertility treatments with a view to ending the post-code lottery and to draw up national guidelines for the provision of fertility treatment within the NHS. NICE reported in August 2003 and recommended that women between 23 and 29 should be entitled to free IVF treatment under the NHS. NICE guidelines on IVF were published in February 2004 and recommended that all women between the ages of 23 and 39 should be offered three cycles of IVF. Following this, the Department of Health recommended that initially women under 40 years who had been unable to conceive after two years should have one course of IVF treatment, if appropriate, under the NHS. In its response to the Joint Committee scrutiny of the draft Human Tissue and Embryos Bill, the government stated that legislation was not an option to enforce NICE guidelines covering IVF treatment on primary care trusts and foundation trusts but the DH was funding a three-year programme of work that aimed to reduce inequalities in the provision of IVF. In 2009 NICE reported an increase in the number of centres which were offering the recommended three cycles of IVF. New guidance was issued by NICE in 2013 which suggests that women aged under 40 years should be offered three full cycles of IVF, women over 40 years one full cycle.[34] However, in July 2014 Mid Essex CCG stated that financial problems had resulted in IVF treatments only being available to HIV positive men and cancer patients (see chapter 5). The RCN published a policy briefing on the provision of infertility treatment in England.[35] It noted that around 1 in 6 couples in the UK have problems conceiving and over three million babies have been born worldwide as a result of IVF. This new policy briefing states that full implementation of the NICE guidelines on IVF treatment would help many couples who are unable to conceive naturally. The briefing discusses how patient safety would be improved by implementing the NICE guidelines. It also highlights the key role that specialist nurses play in IVF, as they care for and inform the patient during what can be a highly emotional and stressful treatment. A lesbian couple won

the right to have IVF on the NHS following a legal fight.[36] They were supported by the Equality and Human Rights Commission.

A new cheaper method of IVF known as the 'Alka-Seltzer IVF' is being promoted and is thought to be able to end the postcode lottery which currently exists in the NHS over obtaining IVF treatment.[37] Recent scientific developments have improved the chances of IVF succeeding.[38]

Embryos

The 1990 Act prohibits certain actions in relation to the use of embryos (see Statute Box 22.2). However, there were doubts as to whether the Act and therefore the HFEA prevented the use of embryos for stem cell research or human cloning. The definition of embryo has been the subject of dispute. Section 1 of the 1990 Act stated that '(a) an embryo means a live human embryo where fertilisation is complete and (b) references to an embryo include an egg in the process of fertilisation'. The House of Lords held that organisms created by cell nuclear replacement (CNR) came within the definition of 'embryo' in section 1(1) of the 1990 Act and accordingly were subject to regulation by the HFEA.[39] In the High Court[40] it had been held that live human embryos created outside the body by CNR were not 'embryos' within section 1 and accordingly were not subject to regulation under the Act. The Court of Appeal[41] allowed the appeal against this decision and the House of Lords dismissed the appeal against the decision of the Court of Appeal. In the light of the High Court decision (which meant that embryos created by CNR were not subject to the 1990 Act and therefore could be cloned) the Human Reproductive Cloning Act 2001 was passed and came into force on 4 December 2001 to prohibit the placing in a woman of a human embryo which has been created otherwise than by fertilisation. Proceedings could only be brought with the consent of the Director of Public Prosecutions. The 2001 Act was repealed by the 2008 Act since it was superseded by the provisions of section 3. Regulations to enable research on stem cells to take place within the provisions of the 1990 Act[42] were enacted and subsequently re-enacted in the 2008 Act (see page 582–4). These enabled a licence to be issued for research for the purposes of increasing the knowledge about the development of embryos, increasing knowledge about serious disease or enabling any such knowledge to be applied in developing treatments for serious disease. The UK Stem Cell Bank has issued a Code of Practice on the use of stem cells but this has no legal force. Proposals to prevent research using hybrid embryos (formed from human and animal cells) which were to be included in new legislation were dropped following pressure from the scientific community.

A new section 3A was added to the 1990 Act (by the Criminal Justice and Public Order Act 1994) which prohibited the use of female germ cells derived from an embryo or fetus for the provision of treatment services for any woman.

Three-parent embryos

Draft regulations were published in 2014 to enable the procedure whereby diseased mitochondria is removed from one egg and replaced by healthy mitochondria from another egg and then fertilised and implanted in the woman who carries the genetic mitochondrial defect. In February 2015 the House of Commons passed the draft regulations which are expected to be approved by the House of Lords and be in force by the end of 2015.

Criminal offences and civil wrongs relating to embryos

There have been several cases where mistakes have been made in the implantation of embryos. In one case a woman was told that her embryo had been thawed and unfortunately implanted in another woman's womb.[43] When the other woman found out that the embryo was not hers, she had an abortion. The Cardiff and Vale NHS Trust paid out compensation. In another case at the same hospital an embryo was lost when the tube and needle transferring them to the woman's womb became disconnected.[44] The

Court had to rule in a case where, at the assisted conception unit of Leeds General Infirmary, eggs were inadvertently fertilised by the wrong man's sperm and as a result mixed race twins were born to white parents, Mr and Mrs A. Both couples, Mr and Mrs A and Mr and Mrs B, were having IVF treatment. The biological father Mr B wished to be declared the legal father of the twins. Dame Elizabeth Butler-Sloss, President of the Family Division, held that Mr B was the twins' legal father. The husband of a mother whose child is born after treatment with another man's sperm is the child's legal father, providing the husband consented to the treatment. Although Mr A had consented to his wife's treatment, he had not consented to the use of another man's sperm. The judge held that the twins' rights to respect for their family life with their mother and Mr A could be met by appropriate family or adoption orders and those orders would be proportionate to the infringements of those rights.[45] Another mishap occurred in Bristol when frozen sperm from 28 cancer patients whose treatment may have left them sterile was destroyed when a freezer unit broke down. An inquiry was set up[46] and subsequently six patients were successful in a claim against the North Bristol NHS Trust. The Court of Appeal allowed the appeal against the dismissal of the case holding that the sperm was property belonging to the men and they had a claim in tort and bailment and could recover for psychiatric injury or mental distress.[47] In a criminal case an embryologist was jailed for 18 months for deceiving couples by giving them test tubes containing saline solution instead of embryos.[48]

In July 2014 the HFEA admitted that about 550 incidents a year were reported, less than 1 per cent of the 60,000 cycles of IVF carried out. Of these only three fell into category A: the most serious. These included a family being given the wrong donor sperm, frozen sperm being destroyed and the third involved 11 embryos contaminated with cellular debris.[49]

Could donors be sued for any reason? A donor-conceived person born with an abnormality could sue their donor for damages if it is proven that the donor had not told the clinic relevant facts about their or their families' medical history when they donated.

Human Fertilisation and Embryology Authority (HFEA)

The HFEA was established under the provisions of the 1990 Act. It has the power to issue licences for centres to carry out IVF treatment and inspect them. It also issues a Code of Practice for the centres and provides guidance to the government on new areas for litigation and control.[50] The Human Genetics Advisory Commission (HGAC) operated from December 1996 to December 1999, providing the government with independent advice on issues arising from developments in human genetics. It published papers on: insurance and genetic testing (December 1997); cloning (December 1998); and employment and genetic testing (July 1999). It was replaced by the Human Genetics Commission (HGC) in December 1999, which also replaced the Advisory Committee on Genetic Testing and the Advisory Group on Scientific Advances in Genetics. The HGC had the remit of advising on necessary changes to the advisory and regulatory framework, of providing information and guidance to the minister on general issues in human genetics. Other non-statutory bodies advising in this area were: Gene Therapy Advisory Committee; Genetics and Insurance Committee; and the Nuffield Council on Bioethics, an independent body established by the trustees of the Nuffield Foundation in 1991 to consider the ethical issues arising from developments in medicine and biology.

The powers of the HFEA to refuse to authorise the implantation of more than three embryos in a particular patient were challenged by a clinic.[51] The court refused the application, holding that the court had no authority to intervene to quash the decision of the HFEA in circumstances where careful and thorough consideration had been given to the matter and opinion provided that was plainly rational. While the decisions of the authority were open to judicial review, they were only amenable to such scrutiny in circumstances where the authority had either exceeded or abused its powers. The Expert Group of the HFEA published the *One Child at a Time* report in October 2006, following which HFEA issued a public consultation on the issue of multiple births after IVF in October 2007. Following the consultation, the HFEA decided to adopt an outcome-based policy, which allowed centres the flexibility to develop their own elective single embryo transfer (eSET) strategy that is appropriate for them and

the patients they treat. In 2009 (Year 1) the maximum multiple birth rate was 24 per cent (the national average at the time). This meant that no more than 24 per cent of a centre's annual live birth rate should be multiple births. In Year 2 from 6 April 2010 no more than 20 per cent of a centre's annual live birth rate from treatment started from this date should be multiples. The overall aim is to reduce the UK IVF multiple birth rate to 10 per cent in stages over a period of years. However, from 1 January 2014 HFEA no longer requires IVF clinics to keep their multiple birth rate below the HFEA target as one of the conditions for their licence. The decision followed a legal challenge by two clinics and a reduction of multiple births from 1 in 4 to 1 in 6.[52] The HFEA has set up a 'One at a time' website, warning of the dangers of multiple births.[53]

Consent provisions for retrieval, storage and use of human gametes under the Human Fertilisation and Embryology Acts 1990 and 2008

Diane Blood was refused permission by the HFEA to use the stored sperm from her dead husband on the grounds that the husband had not given written consent for this use as required by the 1990 Act. She brought a case seeking judicial review of the Authority's refusal to license the infertility treatment. The sperm had been taken from her husband as he lay in a coma as a result of meningitis. The Court of Appeal[54] held that, as a result of the restrictions under the 1990 Act, she could not be lawfully treated with the sperm in this country. However, she would be permitted to receive treatment in Belgium according to Article 59 of the EC Treaty. She subsequently became pregnant and gave birth. Following this case, the Minister of Health appointed a committee under the chairmanship of Professor Sheila McLean to review the consent provisions in the Human Fertilisation and Embryology Act 1990. The committee sent out a questionnaire for public consultation and published its report in December 1998. In August 2000, the government published its response to the McLean Report.[55] It accepted all the recommendations of the report and went further, suggesting a retrospective effect.

1. The father's name should be allowed to appear on birth certificates where his sperm has been used after his death.
2. The legal position on consent and removal of gametes should remain unchanged: gametes can be taken from an incapacitated person who is likely to recover, if the removal of gametes is in their best interests.
3. The HFEA should have the power to permit the storage of gametes where consent has not been given, so long as the gametes have been lawfully removed. This will also benefit children who are about to undergo treatment that will affect their future fertility.
4. Families will be able to make these birth certificate changes retrospectively.
5. The best practice is for written consent to be obtained, since this most clearly constitutes effective consent. Where there is doubt over whether an effective consent has been obtained, this should be a matter for the courts.

Subsequently, Diane Blood won her claim to have her late husband legally recognised as the father of her two sons, when the Department of Health dropped its opposition.[56] The judge accepted that her inability to name her deceased husband as the father of her children was contrary to her human rights and he ordered the Department of Health to pay Mrs Blood's £20,000 legal costs. The Human Fertilisation and Embryology (Deceased Fathers) Act 2003, which came into force on 1 December 2003, specifies the circumstances in which a deceased father can be recorded on the birth certificate. The father must have given a written consent before his death. The 2008 Act replaced the provisions in the 1990 Act by section 39. Where a man's sperm is used after his death, the man may be treated as the child's father, for the purposes of birth registration only, if various conditions are met. The man must have consented, in writing, to the use of the sperm or embryo after his death and to being treated as the child's father for the purposes of birth registration. The woman must elect that he should be treated in this way within 42 days (or 21 days in Scotland) of the child's birth.

The strict wording of the 1990 Act in relation to consent by both parties to the use of the gametes was applied by the High Court in a case[57] where couples who had agreed that embryos could be created and stored then disagreed over their later disposal. One woman placed six frozen embryos into storage before she had cancer treatment. The judge held that the court had no power to override the unconditional statutory right of either party to withdraw or vary consent to the use of embryos in connection with *in vitro* fertilisation treatment at any time before the fertilised embryo was implanted in the woman. In addition, where consent for treatment had originally been given for treatment together with a named partner, that consent remained neither effective nor valid once the parties ceased to be together. Ms Evans lost her appeal to the Court of Appeal in June 2004.[58] Her application to the ECHR for breach of Articles 2, 8 and 14 failed but a dissenting judgment held that there had been a breach of Article 8 and Article 14 in conjunction with Article 8.[59]

In another case,[60] a woman appealed against the decision of the High Court that sperm of her deceased husband should be allowed to perish or be destroyed. The Court of Appeal held, in applying the provisions relating to consent to the storage and use of gametes under sections 4(1)(a) and 11 and Schedule 3 of the 1990 Act, that the centre was entitled to rely on a form that gave consent to the perishing of the sperm and embryos in the event of death or mental incapacities. The Court of Appeal held that there was no evidence of undue influence by the centre and, without an effective consent by the husband, the continued storage and later use of his sperm by the centre would be unlawful. The husband had initially agreed that the sperm could be used after his death, but subsequently withdrew this consent at the request of a specialist nursing sister.

The 2008 Act extended the storage period for embryos from 5 to 10 years. The provision came into force in October 2009. This would have been too late for some women whose embryos had to be destroyed and amendments were made to allow these embryos to be retained.[61]

In a recent case, Beth Warren challenged the deadline of April 2015 after which her dead husband's sperm would be destroyed.[62] The husband, who had died of a brain tumour, had agreed that his sperm could be used after his death but he signed a two-year cut-off clause. The HFEA had informed the widow that it had no power to extend the storage period beyond that to which her husband had given written consent. The High Court held on 6 March 2014 that it was her human right under Article 3 and 8 to be allowed to store his sperm for the next 55 years. She criticised the Care Fertility Clinic in Northampton for not ensuring that the necessary consent arrangements were in place. HFEA decided not to appeal against the ruling because the likelihood of future problems was not strong enough to warrant appealing in this case. The husband's wishes were clearly set out and if it weren't for the clinic's failings Mrs Warren would not have needed to seek a declaration from the court.[63]

Another recent case is that of AB whose husband was in a vegetative state but was given an emergency order for sperm to be removed. The Family Court ruled in the week beginning 16 January 2014 that that order should not have been granted.[64] It was reported that AB was appealing against this and the case was due to be heard in February 2014.[65] However, she has subsequently abandoned the case.

Counselling and consent

The provisions of the 1990 Act in relation to counselling and consent were extended by the 2008 Act. The requirement under the 1990 Act that a woman may not be provided with any treatment services involving donated gametes or embryos, or the use of an embryo which has been created *in vitro*, unless she and any man with whom she is being treated have been provided with relevant information and offered counselling is now extended to same-sex couples. Before proceeding with embryo transfer or donor insemination, clinics are required to offer counselling and provide relevant information to couples who have given notice that they consent to the intended mother's partner being treated as the parent of a child who is conceived using donor sperm. A new Schedule 3ZA (see Statute Box 22.3) was added to the 1990 Act to cover the circumstances in which the offer of counselling is required as a condition of a licence to provide treatment. Part one covers the kinds of treatment in relation to which counselling must be offered and part two covers the events in connection with which counselling must be offered.

Confidentiality

Section 33 of the 1990 Act placed tight restrictions on the disclosure of information held by the HFEA or a licensing authority. The few exceptions to these restrictions were considered to be inadequate and the Human Fertilisation and Embryology (Disclosure of Information) Act 1992 was passed, amending section 33 as follows: to enable the patient to give specific and general consent to disclosure; for information to be disclosed by a clinician to his legal adviser in relation to legal proceedings (the 1990 Act had permitted disclosures only in relation to action under the Congenital Disabilities (Civil Liability) Act 1976); and for a couple to obtain information about the legal parentage of a child born to a surrogate mother. The 1992 Act was repealed by the Human Fertilisation and Embryology Act 2008 and its provisions incorporated into the 2008 Act in a revised section 33A.

The following sections in the 1990 Act as amended by the 2008 Act cover the keeping and disclosing of information.

31. Register of information
31ZA. Request for information as to genetic parentage, etc.
31ZB. Request for information as to intended spouse, etc.
31ZC. Power of Authority to inform donor of request for information
31ZD. Provision to donor of information about resulting children
31ZE. Provision of information about donor-conceived genetic siblings
31ZF. Power of Authority to keep voluntary contact register
31ZG. Financial assistance for person setting up or keeping voluntary contact register
31A. The Authority's register of licences
31B. The Authority's register of serious adverse events and serious adverse reactions
32. Information to be provided to Registrar General
33A. Disclosure of information
33B. Power to provide for additional exceptions from section 33A(1)
33C. Disclosure for the purposes of medical or other research
34. Disclosure in interests of justice
35. Disclosure in interests of justice: congenital disabilities, etc.

Section 33A prevents the disclosure of information specified in section 31(2) (identifiable treatment services, gametes, embryos, etc.) unless it comes under one of the exceptions set out in sections 31ZA–E. The legislation can be downloaded from the legislation website.[66]

A person of 18 or over has the right to obtain information from the HFEA if that person was born in consequence of treatment services, but an opportunity for proper counselling must be provided before disclosure. Section 31ZA inserted by the 2008 Act enables those over 16 years to obtain non-identifying information from the HFEA.

Surrogacy

This might be thought, like IVF, to be a result of the recent developments in medical technology. However, the biblical story of Abraham resorting to the servant who could bear a child for him because Sarah was barren is an early example of one form of surrogacy. The possibility of embryo implantation has, however, increased the number of ways in which surrogacy can take place. The child that is born might have no genetic relationship with the ultimate parents, but be the natural child of the bearing mother or even an embryo from two donors. More likely, however, is the situation where the child is genetically related to the father as a result of artificial insemination, but not to the adopting mother. Prior to the Warnock Report, the only legislation that covered a surrogacy situation was the childcare legislation and rules relating to adoption. Section 50, for example, of the Adoption Act 1958 prohibits any payment in connection with adoption. Such surrogate cases as Baby Cotton[67] revealed the gaps in the law and the

uncertainties surrounding basic questions. Is a contract for surrogacy enforceable by either party, neither party or only by the mother? What are the legal implications if the child is handicapped? What controls do the contracting couple have over the standard of life of the mother during the pregnancy, e.g. what if she smokes or drinks heavily? If she changes her mind and has an abortion, are damages then payable?

Case 22.1 *In re An Adoption (Surrogacy)* (1987)

A surrogacy dispute[68]

Mr and Mrs A were unable to have children and, because of their age, had been refused as adoptive parents. They entered into a surrogacy arrangement with Mrs B who wished to help the childless couple. Under the arrangement, it was agreed that Mr and Mrs A would pay £10,000 to Mrs B who would give up her job to have the child. In due course, a child was conceived, but in the event Mrs B accepted only £5,000 and refused the balance. It was clear that the amount did not cover Mrs B's loss of earnings and expenses. After the birth, Mr and Mrs A applied to court for an adoption order. The question arose (a) whether the payment of money had been a payment of reward for adoption within the meaning of the Adoption Act section 50(1) and (b) if there had been a contravention of the section, whether the court could make a retrospective authorisation in respect of the payment under section 50(3) of the Act and grant an adoption order.

In Case 22.1 it was held that a payment to the mother in a surrogacy arrangement did not contravene the Act if payments made by those others to the natural mother did not include an element of profit or financial reward. Even if they were made for reward, the court had a discretion under the Act to authorise the payments retrospectively. The court granted the adoption order.

The Surrogacy Arrangements Act 1985 prohibits the making of surrogacy arrangements on a commercial basis. Those companies that had come over from the USA and started to arrange surrogacy contracts were thus forced out of business in the UK. This approach had been recommended by the Warnock Committee, whose recommendations, however, went further and suggested that both profit- and non-profit-making organisations should be made illegal and also that any professional who knowingly assisted in the establishment of a surrogacy pregnancy should be criminally liable. They recommended that all surrogacy arrangements should be held illegal and unenforceable in the courts. Section 36(i) of the Human Fertilisation and Embryology Act 1990 amended the 1985 Act to make a surrogacy arrangement unenforceable. It did not make it illegal.

The 1990 Act section 30 enabled a court to order a child to be treated as a child to the parties of the marriage where another woman has acted as surrogate, provided that certain conditions are met. In a case in 1996,[69] a couple applied under section 30 for a parental order in respect of a child who was born following a surrogacy arrangement. It was agreed that the unmarried woman would receive £8,280 to cover her expenses and loss of earnings. The High Court judge was satisfied that the requirements of section 30 were met. In particular, the mother had given consent (although she admitted to tearing her copy in half) and the payments were reasonable and could be granted retrospectively. In this case, there was no man who was to be treated as the father and whose consent was required. Section 30 of the 1990 Act was repealed by the 2008 Act since its provisions were incorporated in sections 54, 55 and Schedule 6 (see page 593 – Parental orders and surrogacy). In a case in 2007 a couple, Mr and Mrs J, agreed a surrogacy arrangement whereby Mrs P was fertilised by Mr J's sperm. However, Mrs P refused to hand over the child and brought him up as her own child. At the time of the hearing the child was 17 months old. The court awarded custody to the couple and ordered Mrs P to hand over the boy to them. The judge found that Mrs P was motivated by a compulsive desire to bear further children and never intended to let Mr J have the child. The Court of Appeal dismissed Mrs P's appeal. A collection order was made by the Court of Appeal empowering High Court staff to travel to Bristol with Mr J to oversee the handover of the child.[70]

(See also the case of *Re T* where it was feared that harm would be caused to the child.)[71]

In 1997, Professor Margaret Brazier was appointed by the Department of Health to review the existing law relating to surrogacy arrangements. The terms of reference included whether payments for expenses should continue to be allowed; whether there was a case for the regulation of surrogacy arrangements through a recognised body and to advise on whether any changes were necessary to the 1985 Act and section 30 of the Human Fertilisation and Embryology Act 1990. An extensive consultation exercise was undertaken and subsequently the Brazier Report recommended that the Surrogacy Arrangements Act 1985 and section 30 of the 1990 Act should be replaced by new legislation and a code of practice on surrogacy should be drawn up by the Department of Health.

The Joint Parliamentary Scrutiny Committee reviewing the draft HFEA Bill recommended that it be amended to bring the regulation of surrogacy within the remit of the HFEA. Eventually the 1985 Act was retained but significant changes were made to the laws relating to surrogacy by section 59 of the 2008 Act. Not-for-profit bodies are permitted to receive payment for carrying out activities in initiating negotiations with a view to the making of a surrogacy arrangement and in compiling information about surrogacy on that basis. However, only reasonable payment can be made (i.e. it does not exceed the costs reasonably attributed to the activity). Not-for-profit bodies will not be permitted to receive payment for offering to negotiate a surrogacy arrangement or for taking part in negotiations about a surrogacy arrangement. These activities are not unlawful if there is no charge. Section 59 also makes changes in relation to advertising by non-profit-making bodies. Under the 1985 Act, it is an offence to publish or distribute an advertisement that someone may be willing to enter into a surrogacy arrangement, or that anyone is looking for a surrogate mother, or that anyone is willing to facilitate or negotiate such an arrangement. This is amended to enable a non-profit-making body to advertise about activities which may legally be undertaken on a commercial basis: for example, that it keeps a list of people seeking surrogate mothers.

Parental orders and surrogacy

Section 54 of the 2008 Act replaces section 30 of the 1990 Act and maintains the same criteria for a parental order as section 30 of the 1990 Act with the exception of the eligibility criteria that now permits civil partners and couples in an enduring family relationship to apply for a parental order, in addition to married couples.

Under section 55 of the 2008 Act regulations have been drawn up which enable specified adoption legislation to be applied, with modifications, to parental orders[72] which came into force on 6 April 2010. For England, Schedule 1 of the regulations apply (with modifications) to the Adoption and Children Act 2002 to a parental order. Thus, principles such as the welfare of the child is the paramount consideration and a checklist for determining the welfare of the child will apply to a parental order.

Compensation amounts and surrogacy

In a case in 2000,[73] a woman claimed compensation as a result of medical negligence that led to a stillborn child and a subtotal hysterectomy. The defendant health authority accepted liability, but damages were disputed. She claimed in addition to damages for pain, suffering and loss of amenity, compensation for the post-traumatic stress disorder as a result of the stillbirth and hysterectomy, loss of earnings and the cost of surrogacy. The court held that she would be awarded £66,000 for the infertility and the accompanying psychological condition. It refused, however, to compensate her for loss of earnings, since it held that regardless of the stillbirth and hysterectomy, she would not have been able to start her training as a teacher earlier. The court also refused the cost of surrogacy, which the claimant was arranging in the USA. The judge held that, under the present UK law, surrogacy arrangements were unenforceable and, if commercial, illegal. It would therefore be wrong, and contrary to public policy, that damages should be awarded to enable an unenforceable and unlawful contract to be entered into. The judge did not conclude that it would always be wrong to award damages for the cost of surrogacy, but in the claimant's particular circumstances, she could not succeed.

The law relating to surrogacy is as follows:

- The surrogate has the legal right to keep the child, even if it is not genetically related to her (unless she would pose a risk to the child).
- Surrogacy arrangements are not legally enforceable, even if a contract has been signed and the expenses of the surrogate have been paid.
- The surrogate will be the legal mother of the child unless or until parenthood is transferred to the intended mother through a parental order or adoption after the birth of the child.
- The surrogate has the legal right to change her mind and keep the child, even when the baby she gave birth to is not genetically related to her.
- The child's legal father or second parent is the surrogate's husband, civil partner (unless it is shown that husband/civil partner did not consent to the treatment) or partner (if the partner consented to being the father/second parent).
- If treatment was performed in a licensed clinic and the surrogate mother has no partner, the child will have no legal father or second parent.
- If the intended parents wish to become the legal parents of the child, they may either apply to adopt the child, or apply for a parental order. A parental order transfers the rights and obligations of parentage to the intended parents, providing certain conditions are met (section 54 of the 2008 Act).
- Applications for a parental order must generally be made to the court within six months of the birth of the child.
- To obtain a parental order, at least one of the commissioning couple must be genetically related to the baby, i.e. be the egg or sperm provider. Couples must be husband and wife, civil partners or two persons who are living as partners.
- If the commissioning couple cannot apply for a parental order because neither of them are genetically related to the baby (i.e. donor egg and donor sperm or donor embryos were used), then adoption of the baby is the only option available to them.
- A registered adoption agency must be involved in the surrogacy process if adoption is required.

The dangers of informal surrogacy arrangements were highlighted in March 2014 when a High Court judge held that turkey baster-style insemination left a mother with no parental rights over the baby. The judge warned against illegal private surrogacy arrangements. The woman had done a deal with a friend who was artificially inseminated with her husband's sperm. The marriage broke down shortly after the birth of the boy but the woman, being neither the boy's legal or biological parent had no parental rights. The birth certificate contained the names of the boy's father and the surrogate mother. The judge granted the woman a residency order to care for the child. The surrogate mother was banned from exercising her parental rights without permission from the court.[74]

In August 2013[75] the HFEA amended its requirements to allow one of the intended parents commissioning a surrogacy arrangement to be recognised as the legal parent when the child is born, if certain conditions are met and the relevant consents are in place.

Conscientious objection

The nurse's personal moral beliefs are taken into account by section 38 of the Human Fertilisation and Embryology Act 1990, which provides a conscientious objection clause as follows:

1 No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so.
2 In any legal proceedings, the burden of proof of conscientious objection shall rest on the person claiming to rely on it.
3 In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in a particular activity governed by the Act shall

be sufficient evidence of that fact for the purpose of discharging the burden of proof imposed by subsection (2) above.

Genetics

Considerable progress has been made in the science of gene identification. The Human Genome Project was an international collaboration by the US government and the Wellcome Trust that started in 1990. It aimed to identify every gene in the human body. At the same time, a private company, Celera Genomics Corp., headed by Craig Venter, was pursuing the same object. The project was completed on 26 July 2000 when a dead heat was claimed between the two rival organisations. The mapping of the human genome was declared complete in April 2003, two years ahead of schedule,[76] producing a 'book of life' containing 2.9 billion 'letters' of human DNA. Genes linked with some specific hereditary diseases have now been identified. One of the first genes to be linked with a specific disease was that of cystic fibrosis. Subsequently, there have been claims of genetic links with a wide range of medical conditions and human qualities and characteristics. For example, claims have been made for genetic links for sleeplessness,[77] for heart disease,[78] for dyslexia,[79,80] for hibernation,[81] for diseases of old age,[82] for autism,[83] for early menopause,[84] for asthma[85] and many other disorders and characteristics. These discoveries present many ethical and legal issues: to what extent should parents have the right to modify the genetic inheritance of their children? What controls should there be over individuals purchasing commercial testing kits? Should insurers have the right to compel those seeking insurance to be tested? Baroness Kennedy was appointed by the government to head an inquiry into the implications of the mapping of the human genetic code and a White Paper on genetics was published in June 2003.[86] Its aim was to set out a vision of how patients could benefit in future from advances in genetics in healthcare. It presented a comprehensive plan for preparing the NHS, including the investment of £50 million over three years, to realise the benefits of genetics in healthcare. Initiatives included the upgrading of laboratories and increase in the numbers of health professionals involved in genetics, including counsellors, consultants and scientists; a new genetics education and development centre and new research programmes in pharmacogenetics, gene therapy and health services research. The Human Genetics Commission (HGC) and the National Screening Committee studied the ethical, social, scientific, economic and practical considerations of screening, and its report[87] *Choosing the Future* was published in 2004. In November 2007 the HGC began preparation for a citizen's inquiry into the use of DNA, details of which are available on its website. In August 2010 the HGC published a new Code of Practice. It expressed concerns about parental consent for DNA testing of their children. Such tests should be confined to cases where there is an immediate and compelling medical reason.[88] The HGC stated that such tests could infringe the rights of the child to take health decisions for themselves when they are adults. The HGC Code of Practice is for guidance only. It recommended that counselling should be offered before and after tests for serious genetic mutations such as those causing Huntington's disease and some forms of breast cancer. (See chapter 8 for discussion on DNA databases and acquittals in the criminal courts.) Following a review of quangos, the HGC published its final paper in 2012. It has been reconstituted as a Departmental Expert Committee. The implications of genetic knowledge for the treatment of diseases and the personalisation of medicines is considered in chapter 28.

Genetic testing for pregnant women

Which pregnant women should be offered genetic testing? The HGC[89] has issued guidance for consultation on behalf of the former Advisory Committee on Genetic Testing, whose work it has taken over. The guidance suggests that a woman should have access to prenatal genetic tests and the expertise she requires appropriate to her risk. There should be resources in primary care and hospitals for referral and subsequent care of the patient. Prenatal genetic testing for rare disorders should be arranged on a supra-regional or national level.

Gene therapy and genetic diagnosis

The Clothier Committee[90] recommended that research should continue for somatic cell gene therapy where treatment is given to an individual patient to alleviate disease (e.g. cystic fibrosis). However, germ-line gene therapy, where future generations are affected, should not as yet be lawful. It recommended the establishment of a supervisory body, the Gene Therapy Advisory Committee (GTAC). In its ninth annual report (which is available online)[91] the GTAC reviewed the use of gene therapy in treating children with X-linked severe combined immunodeficiency (leukaemia had developed in two of the children treated with gene therapy) and recommended that recruitment into the trials should only be on a case-by-case basis. The United Kingdom Ethics Committee Authority recognised GTAC as the UK research ethics committee for all gene trials under the new legislation governing clinical trials (see chapter 18, pages 493–4). The GTAC issued guidance in 2004 on gene therapy. It must be approved by GTAC, must not interfere with the germ-line and must not put patients at disproportionate risk.[92] In its 13th annual report it stated that it considered 14 applications for gene therapy clinical trials and they were all approved or conditionally approved. Around 1,300 patients had been enrolled on to UK gene therapy trials by December 2006. GTAC has worked with the Department of Health, along with other regulators of stem cell research, to develop an online resource for researchers called the 'UK stem cell tool kit'. The website allows stem cell researchers to build a customised map outlining all of the regulatory steps to take their ideas for a new treatment from the laboratory to patients. In October 2010 the government announced that, following the Advisory Non-Departmental Public Bodies (ANDPB) Review, GTAC no longer needed to report and provide advice directly to Ministers, and that responsibility for supporting its Research Ethics Committee (REC) statutory functions should be transferred to the National Research Ethics Service (NRES) (see chapter 18).

Pre-implantation genetic diagnosis (PGD)

The HFEA and the Advisory Committee on Genetic Testing established in 1998 a joint working group to prepare a consultation paper on pre-implantation genetic diagnosis (PGD). This paper was published in November 1999.[93] PGD refers to the two-stage process in which IVF is used to create embryos that are then tested for a particular genetic disorder or to establish their sex (where the disorder is sex-linked). Embryos that do not carry the genetic disorder or are not of the potentially affected sex can then be transferred to the uterus in the hope that a pregnancy of a child without the hereditary condition will develop. Four centres in the UK are licensed to carry out PGD. Testing for cystic fibrosis is the most common reason for PGD for a single gene defect. However, there were concerns about the range of conditions for which PGD should be licensed, at the seriousness of the condition to be checked for, whether the late onset of a condition should be taken into account and what the nature of the regulation should be.

PGD has also been used in circumstances where parents wish to have a child who would be compatible with and therefore of life-saving assistance for a sibling who is suffering from a genetic disease. Several cases have been contested.

Case 22.2 *R (Quintavalle) v. HFEA* (2002–5)

Tissue typing for the benefit of a sibling[94]

Raj and Shahana Hashmi wished to bear a child who would be free of the genetic blood disorder, beta thalassaemia major, and whose tissue type would match that of their young son Zain, who suffered from the life-threatening disorder. They hoped that stem cells from blood taken from the umbilical cord of a newborn baby with matching tissue would cure their son. They applied to the

HFEA for a licence for PGD. HFEA decided that tissue typing would only be permitted where PGD was already necessary to avoid the passing on of a serious genetic disorder and that licences would be granted on a case-by-case basis and on certain conditions. HFEA granted a licence permitting PGD and tissue typing as part of the couple's *in vitro* fertilisation treatment. The granting of the licence was challenged by Josephine Quintavalle on behalf of Comment on Reproductive Ethics who succeeded in an application for judicial review of the lawfulness of HFEA actions. HFEA appealed to the Court of Appeal.

The Court of Appeal held that the HFEA had the power to grant a licence to permit simultaneous tests to be carried out on an embryo for the purpose not only of identifying genetic defects in the embryo but also of ascertaining whether the tissue type of the embryo would match that of an existing child. The House of Lords dismissed the appeal against the Court of Appeal ruling and held that HFEA's discretion to award a licence for tissue typing of an embryo was not limited to its testing for defects in the embryo.

In a case that contrasts with Case 22.2, the HFEA turned down the application from the Witakers to use IVF techniques to select a baby who would be a perfect tissue match for Charlie, aged 3, who had a rare blood disorder and required a bone marrow transplant. The HFEA refused the application because embryos may be screened only if they might carry a serious genetic risk[95]. The Witakers subsequently obtained treatment in the USA.

These issues were the subject of an extensive consultation by the HFEA, which published its report in July 2004.[96] It concluded that balancing the likely benefit of pre-implantation tissue typing – to the sick sibling, the new baby and the family as a whole – against a better understanding of the possible physical and psychological risk to the child to be born, pre-implantation tissue typing should be available subject to appropriate safeguards, in cases in which there is a genuine need for potential life-saving tissue and a likelihood of therapeutic benefit for an affected child. In January 2006 the Human Genetics Commission published *Making Babies*,[97] an overview of reproductive decisions and genetic technologies. One of its many significant recommendations and conclusions was that the anxiety that PGD lies on the slippery slope leading to the possibility of a wide range of potential enhancements, such as intelligence or beauty, is misplaced. The HFEA has published a list of over 100 conditions which could justify the fertility clinic, using PGD, to screen out without seeking special permission. These include conditions which are not life-threatening[98] and are therefore controversial. Using PGD to reveal the sex of the embryo is not permissible unless it is related to a genetic disease (e.g. haemophilia). A New York clinic is offering sex prediction services on embryos to couples from the UK.[99]

A trial is taking place at Birmingham's Children's Hospital, linked to centres in eight other countries to test newborn babies with suspected liver disease for 92 genetic conditions.[100] Embryo testing for genetic disease or sex selection now comes under Schedule 2 of the 2008 Act: activities which may be licensed under the 1990 Act. Under section 1ZA of Schedule 2 a licence cannot authorise the testing of an embryo except for one or more specified purposes. These purposes include establishing whether there is a genetic abnormality, establishing the sex where there is a particular risk that the child be seriously physically or mentally ill as a result of a gender-related abnormality. The purposes also include a situation where a sibling suffers from a serious medical condition which could be treated by umbilical cord blood stem cells, bone marrow or other tissue of any resulting child, establishing whether the tissue of any resulting child would be compatible with that of the sibling.

Gender selection

To what extent should parents be able to select the sex of their children? Certainly in some cultures, parental selection could lead to an oversupply of boys and very few girls, but there may be justification

for it when hereditary diseases, such as haemophilia, are sex-linked. A commercial organisation has been set up to assist couples in obtaining the gender of their choice for their child. Where this does not involve gametes of other persons, it does not come under the provision of the 1990 Act as amended. Some consider, however, that there should be controls in this field. A public consultation paper was issued by the HFEA in January 1993.[101] In November 2003 the HFEA announced its recommendations on sex selection.[102] It found from its survey that public opposition to sex selection for non-medical reasons was clear and consistent. As a result of the Tissue and Cells Directive, which came into force in July 2007 (see page 581),[103] sperm-sorting services are now subject to regulation. Schedule 2 as amended covers the testing of embryos for sex selection and is shown in Statute Box 22.4.

Statute 22.4 Schedule 2 Activities that may be licensed under the 1990 Act

Sex selection

(1) A licence under paragraph 1 cannot authorise any practice designed to secure that any resulting child will be of one sex rather than the other.
(2) Sub-paragraph (1) does not prevent the authorisation of any testing of embryos that is capable of being authorised under paragraph 1ZA.
(3) Sub-paragraph (1) does not prevent the authorisation of any other practices designed to secure that any resulting child will be of one sex rather than the other in a case where there is a particular risk that a woman will give birth to a child who will have or develop –
  (a) a gender-related serious physical or mental disability,
  (b) a gender-related serious illness, or
  (c) any other gender-related serious medical condition.
(4) For the purposes of sub-paragraph (3), a physical or mental disability, illness or other medical condition is gender-related if the Authority is satisfied that –
  (a) it affects only one sex, or
  (b) it affects one sex significantly more than the other.

Genetic screening and testing

Concern at the possibility that insurers and employers would require compulsory genetic screening led to the Nuffield Council on Bioethics reporting on the ethical issues involved in genetic screening. It recommended safeguards in relation to consent, confidentiality and monitoring of genetic screening programmes.[104] A moratorium has been agreed between the government and the Association of British Insurers (ABI) on the use of predictive genetic test results.

Commercial screening kits

Do-it-yourself genetic screening test kits are now available and have raised considerable ethical concerns. *A Code of Practice and Guidance on Human Genetic Testing* was published on 23 September 1997 by the health departments of the United Kingdom.[105] It was put forward by the Advisory Committee on Genetic Testing (ACGT) on the basis of proposals prepared by a subgroup (chaired by Professor Marcus Pembrey). It recommended that a voluntary system of compliance and monitoring should be established rather than a statutory scheme. The Code of Practice and Guidance was intended to be used by those who supply genetic testing services direct to the public. The Code itself covered the following areas: testing laboratories, equipment and reagents; confidentiality and storage of samples and records; proposed tests should be cleared with the ACGT and comply with the Code; tests should not be available to those under 16 years or to those unable to make a competent decision regarding testing; specified

information should be provided to the customer; pre- and post-test genetic consultation should be available without additional charge; and the involvement of medical practitioners. This voluntary code could work, given suppliers who have goodwill and purchasers who are well informed, without the necessity of statutory controls and criminal sanctions. The ACGT required companies selling the kits to submit them for prior approval, but it had no statutory powers and its guidelines were not enforceable. The ACGT was subsumed into the HGC in December 1999 and the HCG was replaced by an expert committee in 2012. On 20 January 2014 the *Daily Mail* announced that there were 38 British websites offering home testing kits costing up to £300; the most popular of which were paternity and genetic tests, while requests for tests to reveal genetic vulnerability to diseases were increasing.

Code of Practice on genetic tests from the insurers

The ABI published a Code of Practice in 1997. It made further revisions to it in 1999.[106] It is a voluntary code for insurers over genetic tests and gives the following guidance:

1. It should not require a person to take a genetic test to obtain insurance cover.
2. If the results of a genetic test are in a person's medical records, they can be taken into account only if they apply to one of seven conditions for which the tests are deemed reliable. (These conditions include breast cancer, Alzheimer's and Huntington's chorea.)
3. If the test is later found to be unreliable, the person is entitled to a refund of overpaid premiums and cheaper future payments.
4. A person is obliged to tell an insurance company if he has had a genetic test and disclose the results.
5. Anyone refused insurance cover or who wishes to complain can contact the ABI.[107]

Some evidence emerged that, contrary to the assertion of the ABI, some people were being refused insurance cover on the grounds that they have a genetic disorder.[108,109] It was thought that either statutory intervention or some form of state insurance cover may be necessary to protect those who are vulnerable. In October 2000, new guidelines were recommended by a genetics and insurance committee established by the Department of Health.[110] The committee recommended that the reliability and relevance of the genetic test for Huntington's chorea is sufficient for insurance companies to use the result when assessing applications for life insurance. Insurers will not be able to require prospective clients to take the test, but they will be able to ask clients if they have taken tests for Huntington's chorea and to ask for the results to be given. The recommendations have been criticised, for example by the National Consumer Council, on the grounds that they will create a genetic underclass and will dissuade people from taking the tests.[111] In addition, scientists are fearful that potential volunteers for genetic tests will refuse to cooperate in this country. Thus, many scientists would have no option but to work outside this country, where potential research subjects would not have to disclose results to insurance companies.[112] The HGC has endorsed a regime of self-regulation for companies supplying genetic tests to the public, but their recommendations were criticised by Human Genetics Alert and GeneWatch UK.[113] In April 2003 the HGC issued a report saying that direct sales of such tests raised serious questions and that a 'robust but flexible' regulatory system needed to be established to control them. The HGC did not recommend an outright ban as people have the right to information about themselves, but they did want to ensure proper protection. They recommended that genetic tests should be carried out under the supervision of a doctor within the NHS.[114]

In 2005 the Department of Health and the ABI agreed a moratorium on the use of predictive genetic test results (unless the test has been approved), which has been extended to 2014. The moratorium applies to life insurance policies up to £500,000 and critical illness, long-term care and income protection up to £300,000. The only test which has been approved and would therefore have to be disclosed is that for Huntingdon's disease. The House of Lords Scientific and Technology Committee recommended that the moratorium should be kept until 2014 but should be tightened to make it clear that people who have had tests do not have to inform insurers. It also recommended that a White Paper on genomics should be prepared[115] (see chapter 28). The moratorium was subsequently extended to 2017. The ABI stated

that it had proved to work well, enabling people to insure themselves and their families, even if they have had an adverse result from a predictive genetic test.[116] There are reviews at three-year intervals.

Genetics and confidentiality

The identification of genes linked to disabilities has raised serious legal and ethical issues, as Practical Dilemma 22.1 illustrates.

Practical Dilemma 22.1 Concealing information

Mavis undergoes a genetic test and discovers that she is carrying a gene that is linked with Huntington's chorea. Her sister, Rachel, has just got married and Mavis knows her sister intends having children and that both her sister and any children could be at risk of suffering from that disease. Mavis decides that she will keep this information to herself.

In this situation, the ordinary laws of confidentiality (see chapter 8) apply. There are no specific statutes that require the testers to disclose the results to any members of the family. If Rachel were unaware that there is a family risk of Huntington's chorea, she would not have the grounds to have herself tested or to seek a disclosure of the results of the test on Mavis. By the time Rachel has had her children and maybe finds that she is suffering from or is a carrier of the disease, it is too late to take preventive action. Had she known of the risk, she could have opted for the testing of embryos before implantation (see pages 596–7). New guidance from the GMC suggests that there may be circumstances where the confidentiality of patients with genetic diseases may not be kept in order to protect their families. Paragraph 69 of the GMC guidelines on confidentiality published in 2009[117] states:

> **However, a patient might refuse to consent to the disclosure of information that would benefit others, for example, where family relationships have broken down, or if their natural children have been adopted. In these circumstances, disclosure might still be justified in the public interest (see paragraphs 36 to 56). If a patient refuses consent to disclosure, you will need to balance your duty to make the care of your patient your first concern against your duty to help protect the other person from serious harm. If practicable, you should not disclose the patient's identity in contacting and advising others of the risks they face.**

Huntingdon's disease is the only predictive genetic test which has to be reported to insurers under the terms of the Moratorium outlined above.

Cloning

In 1997 Dolly the sheep became the first vertebrate cloned from a cell of an adult animal. Because of the immense significance of this scientific development, the Human Genetics Advisory Commission set up a working group and held a consultation exercise on cloning. It issued a consultation paper in 1998.[118] Following this exercise, HFEA recommended that research should continue into creating cloned tissue that can be transplanted, but that cloning for reproductive purposes should continue to be illegal.[119]

Following the report of the Chief Medical Officer's expert group on therapeutic cloning,[120] the government accepted its recommendations (press announcement, 16 August 2000) and agreed that:

1 The currently permitted grounds for embryo research will include treatment for a range of human diseases and research on human embryonic stem cells should be permitted. (At present research on embryos is restricted to the first 14 days and is permitted for five specific purposes relating to

infertility, congenital disease, gene or chromosomal abnormalities, miscarriage or contraception. Additional purposes can be added by Statutory Instrument.)

2 Research involving cell nuclear replacement (so-called 'therapeutic cloning') should be allowed to help understand the biological mechanisms involved in the growth and development of human cells.

3 Specific consent must be given before early embryos can be donated for stem cell research.

On 19 December 2000 the House of Commons passed secondary legislation legalising research on the stem cells of embryos and the House of Lords approved the changes in 2001. A Statutory Instrument was enacted in 2001.[121] (This was subsequently repealed and replaced by Schedule 2 of the 2008 Act.) This means that it is possible for stem cells to be used in the research for illnesses such as cancer, Parkinson's disease, diabetes, osteoporosis, spinal cord injuries, Alzheimer's, leukaemia and multiple sclerosis. A licence is required from the HFEA and the cloning of human beings for reproductive purposes remains illegal (see page 600).

Human cloning has been used to create embryonic stem cells from adult skin cells which could be used to grow new tissues or even organs that would be genetically identical to a patient's own cells thus overcoming the risk of rejection.[122]

Children over 16 years can give stem cells and in November it was reported that a girl of 17 had made medical history by giving stem cells to a stranger. She had signed up to the Anthony Nolan Register.[123,124] See Code of Practice No 6 on the donation of allogeneic bone marrow and peripheral blood stem cells for transplantation issued by the Human Tissue Authority.[125]

The United Nations voted in November 2003 not to ban all forms of cloning. This led to a statement by the Department of Health[126] that welcomed the United Nations' decision, seeing it as a victory for the UK position. The UK is firmly against reproductive cloning but it believed that therapeutic cloning research offers enormous potential to develop cures for serious diseases such as Alzheimer's, Parkinson's and heart disease, and this therapeutic cloning is strictly controlled under licence from the HFEA. In January 2004 a claim was made by Dr Zavos, an American scientist, that he had implanted a cloned embryo in a woman's womb. This led to the president of the Royal Society and other top scientists appealing for a world-wide ban on human reproductive cloning.[127] Under the 2008 Act the use of inter-species embryos for research is permitted, with the HFEA having the power to authorise or refuse licences.

Personalised medication

The sequencing of the human genome has enabled an entire genetic code to be profiled with an ever-decreasing cost (now about £3,000). Saudi Arabia has announced that it is to sequence the genomes of 100,000 citizens to facilitate personalised medicine which should prove more effective and cheaper.[128] The Royal Marsden Hospital is looking at dangerous mutations of 100 genes covering many types of cancer in order to provide the most suitable drugs to cancer patients.[129] The 100,000 Genomes Project was announced by the Prime Minister on 31 July 2014. The project will sequence the genomes of 75,000 sick children and their parents in order to target medicines and is due to last three years.[130]

The speed in the identification of disease-related genes would suggest that personalised medication will develop extensively, for instance: it is suggested that children should be tested for the ovarian cancer gene;[131] the possibilities of a genetic treatment for Down's syndrome are now known;[132] cold sores have been blamed on a mutant gene;[133] survival rates of leukaemia have improved greatly as a result of new treatment which genetically modifies the patient's own white blood cells;[134] a gene linked to intelligence which may assist in the treatment and diagnosis of schizophrenia and autism has been identified;[135] and it has been found that using a gene present in babies, but which is later switched off, may assist burns victims.[136]

The Personal Genome Project UK was launched on 7 November 2013 seeking 100,000 volunteers who agree to undergo genetic screening to identify their genome sequence. The aim is to assist in the development of personalised treatments. It cautions that there is no promise of confidentiality.[137] (See chapter 28 on personalised medicine.)

Conclusions

It is inevitable that as science progresses further, amendments to legislation in this field will be required. However, for the time being the 2008 Act has filled a gap. Many issues are still ongoing. The decision not to amalgamate the Human Fertilisation and Embryology Authority with the Human Tissue Authority has now been revised as a result of the arm's-length bodies review.[138] The review suggests that while both the HFEA and HTA should initially be retained, eventually their research licensing functions should be transferred to a new research regulator, their inspection and control functions should be transferred to the Care Quality Commission, and their information and collection functions to the Social Care Information Centre. The new regulations relating to the three-parent child due to be in force by the end of 2015 indicate the extent to which changes to the law are required to keep pace with new technology in this field.

The government stated in response to the House of Lords Science and Technology Committee Inquiry into Regenerative Medicine that it remains committed to the field of regenerative medicine which is recognised as one of the UK's Eight Great Technologies and is supporting ongoing research through funding and the National Institute for Health Research which funds infrastructure in the NHS for translational research in regenerative medicine.[139]

Reflection questions

1 Where a child is born as the result of a surrogacy arrangement so that an embryo from a woman and her husband is transplanted into the uterus of another woman, what legal rights do you believe that the woman giving birth to the child should have over the genetic mother? What legal rights does she have?

2 To what extent do you think that couples should have the legal right to obtain treatment for their infertility?

3 Can experimentation on an embryo and its replacement in the uterus to develop as a human being be justified?

Further exercises

1 Look at the daily papers and journals over the next month and collect details on the cases, debates and articles on the topics discussed in this chapter.

2 To what extent do you think the law is an appropriate machinery to determine the choices of parents and professionals in the topics discussed in this chapter?

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Chapter 23

Community and primary care nursing

This chapter discusses

- NHS and social services provision
- Funding of long-term care
- Care Act 2014
- Human rights and care homes
- Delayed discharges
- Carers
- Negligence
- Safety of the community professional
- Consent to treatment
- Protection of property
- Disclosure of information
- Criminal suspicion
- Standards: care homes
- Community matrons
- The specialist community public health nurse
- The school nurse
- The clinic nurse
- The practice nurse
- Developments in technology and structure

Introduction

This chapter covers the law relating to nurses who work in the community and in primary care, including community/district nurses, health visitors (known after 2004 as **specialist community public health nurses**), practice nurses and specialist nurses. Community psychiatric nurses (CPNs) will also find chapter 20 on mental healthcare of relevance, and for health visitors and school nurses chapter 26 provides information on the law relating to public health.

The development of community care and the earlier establishment of primary care trusts (PCTs) meant that the focus for many health professionals switched from the institution to the community and to primary care, and those who have always been community workers, such as the health visitor and the district nurse, felt the increased pressure from the implications of the policy to transfer patients from the institution to the community. Recent developments have seen an increase in specialist posts in the community. Community nurses for those with learning disabilities and CPNs are increasing in number and specialist posts for stoma care, incontinence, asthma, diabetes, terminal illness and other specialist areas have been established. Many liaison nurses are now seeking specialist training. There are increased appointments in the community for occupational therapists, physiotherapists and paediatricians. These organisational changes have continued with the creation of Clinical Commissioning Groups (see chapter 5) under the Health and Social Care Act 2012. Box 23.1 illustrates some of the particular difficulties with which these workers are faced.

Box 23.1 Difficulties faced by the nurse in the community

1 Isolation
2 Vulnerability
3 Sole responsibility
4 Pressure to go beyond job description: definitions of the scope of professional practice
5 Health and safety hazard and occupier's liability
6 Variable facilities and resources.

NHS and social services provision

Considerable problems have arisen in the provision of a seamless service between NHS and social services because NHS care is free at the point of delivery whereas most social services provision is means tested. The NHS and Community Care Act 1990 placed responsibility upon local authorities for funding, on a means-tested basis, the residential care costs of its residents. Local criteria for the eligibility for NHS continuing care were drawn up in each area and those who disagreed with the decisions could use the complaints procedures established by the strategic health authority and local authority. From 2010 there has been a uniform complaints procedure between health and social services (see chapter 27).

Disputes over eligibility for continuing care have been the concern of the Health Service Commission. Cases 23.1, 23.2 and 23.3 illustrate concerns about the system of means testing for those in residential care.

Case 23.1 *R v. N and E Devon Health Authority ex parte Coughlan* (2000)

NHS or means-tested care?[1]

Pamela Coughlan brought an action against the health authority in 1999 when she was told that she would have to leave the nursing home she was living in at NHS expense and move to another home that would be means-tested. She had been grievously injured in a road traffic accident in 1971. She was tetraplegic, doubly incontinent and partially paralysed in the respiratory tract. She had been promised by the health authority that she would be able to stay in Mardon House for life, the costs of her care being met by the NHS.

The Court of Appeal held that nursing care for the chronically sick was not always the sole responsibility of the NHS, but could, in appropriate circumstances, be provided by a local authority as a social service and the patient could, depending on her means, be liable to meet the cost of that care. However, there was no overriding public interest in the health authority breaking its promise to her that she could stay in that home for her life.

There was no appeal against the Court of Appeal's decision. Pamela Coughlan was able to continue to have NHS funding of her care, but the court had accepted the principle that nursing care did not always have to be funded by the NHS, so in that sense both parties won their case. However, the principle that nursing and other personal care should be funded by the NHS was put forward by the majority recommendations in the Royal Commission Report on the long-term care of the elderly[2] (see page 612). The National Framework for continuing care is considered below.

Following the Coughlan judgment,[3] the Ombudsman issued a report on continuing care on 20 February 2003 after which the Department of Health issued instructions[4] that strategic health authorities should agree with local councils one set of criteria for continuing care in keeping with the Coughlan judgment.

Subsequently, in 2007, the DH announced that a National Framework for continuing care would be implemented in October 2007. Assessments for continuing NHS care were to be carried out by a multidisciplinary team using the concept of 'a primary health' need as the criteria for the receipt of continuing healthcare.[5] This initiative was intended to resolve the issues which were raised by the High Court decision in the Grogan case[6] (see Case 23.3).

A dispute arose in relation to the provision of services to disabled people under the Chronic Sick and Disabled Persons Act 1970 and the extent to which the local authority could take into account its financial resources.

Case 23.2 *R v. Gloucester CC and Another ex parte Barry* (1997)

Assessment of disabled persons[7]

A man of 79 with severe disabilities brought an action in Gloucester when the local authority informed him that it was going to withdraw his cleaning and laundry services. He obtained judicial review of the local authority's decision on the grounds that they had not reassessed his needs prior to withdrawing the services. The High Court judge refused to grant a declaration that, in carrying out the reassessment, the local authority was not entitled to take into account the resources available to it. The Court of Appeal allowed his appeal, on the grounds that the local authority was not entitled to take into account the resources available to it. The local authority appealed to the House of Lords.

The House of Lords allowed the appeal holding that, for the purposes of section 2(1) of the 1970 Act, a chronically sick or disabled person's needs were to be assessed in the context of, and by reference to, the provision of certain types of assistance for promoting the welfare of disabled people using eligibility criteria. These criteria had to be set taking into account current acceptable standards of living, the nature and extent of the disability and the relative cost balanced against the relative benefit and the relative need for that benefit. Its impact on its resources had to be evaluated and therefore its financial position was relevant. The authority could not make the decision in a vacuum from which all considerations of costs were expelled. In another significant court decision the Court of Appeal[8] allowed the application for judicial review and held that Sefton Borough Council had behaved unlawfully[9] when it set up a scheme whereby those who were entitled to be provided with accommodation under section 21 could have their capital taken into account unless it was or fell below £1,500 (this figure was chosen since it would usually leave sufficient for a funeral). Subsequently the Community Care (Residential Accommodation) Act 1998 was passed to put the decision of the Court of Appeal on a statutory basis. Section 1 of the 1998 Act states that in determining whether care and attention are otherwise available to a person, a local authority shall disregard so much of the person's capital as does not exceed the capital limit for the purposes of section 22 of the National Assistance Act 1948. The regulations on capital disregard must be followed by local authorities in means testing.[10]

In July 2001 the Department of Health published a consultation document, 'Guidance on Fair Access to Care Services', to ensure greater consistency in the use of eligibility criteria for access to care services.

Case 23.3 *R (on the application of Grogan) v. Bexley NHS Care Trust (2006)*

Continuing care[11]

G applied for judicial review of a decision by an NHS trust that she did not qualify for continuing NHS healthcare. If the NHS provided care, it would be free; if it were the social services, she would be means tested. The High Court held that an NHS trust should apply a primary health need test to determine whether accommodation should be provided by the NHS or social services. The criteria of the NHS trust for determining whether the patient had continuing care needs were fatally flawed and it failed to give reasons why it considered that the patient's continuing care needs were neither complex nor intense. The Court ordered the trust's decision to be set aside and remitted for fresh consideration.

Following the decision in the Grogan case the DH announced that a national framework for continuing care would be implemented in October 2007 and gave interim guidance.[12] Assessments for continuing NHS care were to be carried out by a multidisciplinary team using the concept of 'a primary health' need as the criteria for the receipt of continuing healthcare.[13]

The *National Framework on NHS Continuing Healthcare and NHS-funded Nursing Care*, published in October 2007[14] revised in 2009 and 2012 and updated in 2013, set out the national framework, the legal framework, the primary health need, core values, and principles, eligibility considerations, links to other policies, care planning and provision, review, dispute resolution and governance. It stated that primary health need should be assessed by looking at all of the care needs and relating them to four key indicators:

- **Nature** – the type of condition or treatment required and its quality and quantity
- **Complexity** – symptoms that interact, making them difficult to manage or control

- **Intensity** – one or more needs which are so severe that they require regular interventions
- **Unpredictability** – unexpected changes in condition that are difficult to manage and present a risk to the patient or to others.

To be eligible for continuing healthcare the person must be assessed as having a primary health need and have a complex medical condition and substantial and ongoing care needs.[15]

The NHS would make decisions on eligibility for NHS continuing healthcare in collaboration with the local authority through a multidisciplinary team and with the full and active involvement of the patient and carers. Further information on the national framework on continuing care is available on the government website. Answers to frequently asked questions on continuing care are also incorporated in the guidance.

Information on the right to receive continuing healthcare can be found online at NHS CHC Checklist; decision support tool for NHS CHC; and national framework for NHS CHC and NHS-funded nursing care.

In 2008 the government initiated a consultation on the future of care and support. It set up a care and support website (now archived)[16] which could be accessed to take part in the debate. It pointed out that given the longer life expectancy, the cost of disability benefits could increase by 50 per cent in the next 20 years and there could be a £6 billion funding gap for social care. Since the proportion of people of working age in the population would decline, the government would not be able to raise enough money through tax alone to meet the costs of care and support. A new insurance-based system was seen as a means of funding care for the elderly which was forecast to reach £4 billion in the next 20 years. Feedback was invited in its efforts to find an affordable, fair and sustainable way of delivering and funding a first-class care and support system for the twenty-first century. In a letter to *The Times*[17] from representatives of 12 organisations involved with the care of older and disabled people and their carers, it was highlighted that disabled and older people were being forced to end their support services because they could not afford them, and they called on the government to conduct a thorough review of the impact of care charges and for these issues to be addressed in adult care reform.

There was also concern and inconsistency about relatives paying top-up fees.[18] Councils should only ask for top-up fees from relatives if the family has requested a particular care home for their relative other than the one chosen by the local authority. Otherwise the local authority should pay the fees in full where the assets of the old person are less than £13,500. Where the elderly person has assets of between £13,500 and £22,250 then there is a sliding scale of contribution.

In August 2009 the NHS was ordered to pay £100,000 to the family of an Alzheimer's sufferer to cover care home fees which the local NHS trust had refused to pay. Judith Roe died aged 74 in October 2008. The NHS trust had ruled that she did not qualify for NHS funding because her condition was deemed to be a social rather than a health problem. The Ombudsman said that the fees should have been met by Worcester PCT and ordered NHS Worcestershire (which replaced the PCT) to pay the family more than £100,000. Disputes have also arisen between local authorities over the responsibility to fund an individual's community care package. In one case in 2009 the Court of Appeal held that once the Secretary of State had determined that a person was ordinarily resident in a particular area then that local authority had a responsibility to fund a care package, even though another local authority had set up the package.[19]

Rationing care

Many local authorities have tightened their criteria for providing social care and are offering help only in critical cases. A legal challenge was brought against Harrow Council by several claimants, who were in receipt of community care services. Harrow had proposed that owing to financial constraints it would limit provision of care services to people with need categorised as critical under the Fair Access to Care Services guidance issued by the Secretary of State. The judge decided that there was a general duty under section 49A of the Disability Discrimination Act 1995 to have due regard to considerations

listed therein. Those were important duties which included the need to promote equality of opportunity and to take account of disabilities, even where that involved treating the disabled more favourably than others. There was no evidence that the legal duty and its implications were drawn to the attention of the decision makers who should have been informed, not just of the disabled as an issue, but of the particular obligations that the law imposed. Harrow Council's decision-making process had not complied with section 49A of the Act.[20]

Funding of long-term care

With Respect to Old Age,[21] the Royal Commission's 1999 report into long-term care, made radical recommendations for the future care of older people. It suggested that:

> **The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation; the rest should be subject to a co-payment according to means.**

A minority of two members of the Royal Commission, in a note of dissent, stated that they could not support the majority view that personal care should be provided free of charge, paid for from general taxation, on the basis of need. The government did not accept the Royal Commission's recommendation that personal care should be met from public funds, although it made various recommendations to reduce the hardship of means-tested payment of fees. The disputes between the demarcation of NHS-funded care (and therefore free at the point of delivery) and means-tested social services care continued to give rise to many concerns and complaints.

The Court of Appeal held that a local authority was entitled to consider what an individual's needs were as the starting point for the calculation of a person budget and had to give reasons for its decision.[22]

Green paper on the funding of long-term care in the future

In July 2009 the long awaited Green Paper[23] was published. It identified six features that everyone was entitled to expect. These were:

1. The right support to help you stay independent and well for as long as possible and to stop your care and support needs getting worse.
2. Wherever you are in England, you will have the right to have your care and support needs assessed in the same way and you will have a right to have the same proportion of your care and support costs paid for wherever you live.
3. All the services that you need will work together smoothly, particularly when your needs are assessed . . . You will only need to have one assessment of your needs to gain access to a whole range of care and support services.
4. You can understand and find your way through the care and support system easily.
5. The services you use will be based on your personal circumstances and need. Your care and support will be designed and delivered around your individual needs. As part of your care and support plan, you will have much greater choice over how and where you receive support, and the possibility of controlling your own budget wherever appropriate.
6. Your money will be spent wisely and everyone who qualifies for care and support from the state will get some help meeting the cost of care and support needs.

The aim was to build a National Care Service that was fair, simple and affordable. Everyone who qualified for care and support from the state should get some help with paying for it. Any new system must therefore be

- fair
- simple and easy to understand
- affordable
- universal, underpinned by national rights and entitlements, and helping everyone who needs care to pay for it
- personalised to individual needs, and flexible enough to support people to live their lives in the ways in which they want.

Three funding options were put forward for consultation:

1 Partnership – in this system, everyone who qualified for care and support from the state would be entitled to have a set proportion – for example, a quarter or a third – of their basic care and support costs paid for by the state. People who were less well-off would have more care and support paid for – for example, two-thirds – while the least well-off people would continue to get all their care and support for free.
2 Insurance – in this system, everyone would be entitled to have a share of their care and support costs met, just as in the Partnership model. But this system would go further to help people cover the additional costs of their care and support through insurance, if they wanted to.
3 Comprehensive – in this system, everyone over retirement age who had the resources to do so would be required to pay into a state insurance scheme. Everyone who was able to pay would pay their contribution, and then everyone whose needs meant that they qualified for care and support from the state would get all of their basic care and support for free when they needed it.

Three systems were ruled out.

1 The current system with some getting their social care paid for but others receiving no help at all.
2 A tax funded system where people would pay tax throughout their lives, which would be used to pay for all the people who currently need care. When, in turn, people needed care themselves, they would get all their basic care free. This option was ruled out because it places a heavy burden on people of working age.
3 Pay for Yourself – in which everybody would be responsible for paying for their own basic care and support, when they needed it; they could take out insurance to cover some of these costs, or use their income and savings. This was ruled out because it would leave many people without the care and support they need, and is fundamentally unfair because people cannot predict what care and support they will need.

Following the Green Paper a White Paper was published in March 2010.

White Paper on social care[24]

The White Paper recommended a National Care Service which would be free at the point of delivery to be set up within five years. There would be three stages:

1 free care at home for the elderly and the infirm with critical needs;
2 a guarantee by 2014 that residential care will be free after the first two years; and
3 a universal system free at the point of delivery with the necessary legislative changes contained in a Personal Care at Home Bill.

Criticisms of the White Paper included the absence of a clear plan on meeting the costs and timescale.[25] The Personal Care at Home Act 2010 was passed and was seen as the first stage in the development towards a National Care Service. It would have amended the Community Care (Delayed Discharges) Act of 2003 to include the provision of free personal care at home and would have provided free personal care for 280,000 people with the highest needs – including those with serious dementia or Parkinson's disease. However, the Coalition government stated on 20 May 2010 that it did not intend

to implement the provision of free personal care and instead appointed Andrew Dilnot to chair a Commission to review the funding of care for the elderly.

The Dilnot Report on Social Care[26]

In 2011 the Independent Commission chaired by Andrew Dilnot reported on the funding of social care. It found that the current system is confusing, unfair and unsustainable and made the following recommendations:

- Capping lifetime individual contributions to care at £35,000
- Providing free care for those who develop needs before they reach 40
- Raising the means-tested threshold for savings below which people become eligible for state-funded residential care from £23,250 to £100,000
- Standardising contributions to board and lodging costs in residential care at between £7,000 to £10,000 a year
- Introducing a national system of assessment and eligibility, initially set at substantial need
- Giving free state support to people who enter adulthood with a care and support need immediately rather than being subjected to a means test.

In December 2013 research by the London School of Economics showed that nearly half a million elderly and disabled people had been denied social care due to a squeeze on council funding over the past five years.[27] The LSE found that 86 per cent of English councils responsible for social services offered care to only those with needs deemed 'critical' or 'substantial'. The Care and Support Minister Norman Lamb stated that from 2015 a new minimum eligibility threshold would provide clarity and consistency on whether a person was eligible for care and support. He also stated that the government was investing £3.8 million through the Better Care Fund to join up health and social services so that people can live as independently as possible. Concerns over the repercussions of this transfer on NHS funding led to a modified plan with at least £1 billion of the Better Care Fund having to be spent on the NHS.[28]

A daughter won her case against Worcester County Council which wished to assess the family home to pay for her mother's care home fees. She claimed that she rented a property and regarded her mother's home as her only real home and she intended to retire to it. The Court held that the council had erred in law by

1. conflating the concept of occupation as a home with that of permanent residence, and
2. wrongly considering that the application of the exemption could only be determined on a once-and-for-all basis at the time of the resident's admission into care.[29]

Caring for our future: reforming care and support

A White Paper[30] on social care and funding was published by the government in 2012. It can be accessed on the government website[31] and sets out the key actions which it intended to take to reform the provision and payment for social care. The Law Commission, which had conducted a three-year review into adult social care law, published its final report in May 2011[32] (accessible on the Law Commission website[33]). It recommended a single, clear, modern statute and code of practice paving the way for a coherent social care system. The government response was published in July 2012.[34] The Care and Support Bill (enacted in 2014 as the Care Act) was published to implement the White Paper recommendations, (including modified Dilnot recommendations), those of the Law Commission and also some of the recommendations of the Francis Inquiry into Mid Staffordshire NHS Trust (see chapter 5). The Dilnot cap was raised to £75,000 but led to controversy over the deferred payment scheme, since people would not be eligible for a deferred payment if they had more than £23,000 in assets excluding the value of their home. The deferred payment scheme required LAs to pay care fees up front, to be reimbursed later

from the estate, thus freeing families from the burden of paying care home fees until after their loved ones had died. As a result of the Care Act 2014, in April 2016 the threshold for self-funding will increase to £118,000 and lifetime care costs will be capped at £72,000.

Care Act 2014

The Act has been described as the most significant reform of care and support in more than 60 years. Earlier legislation is repealed for England including section 47 of the National Assistance Act 1948 (which gave local authorities the power to remove a person in need of care to a place of safety). The Care Act 2014 is in the main focused on England since social care is a devolved matter. However, there are exceptions to this and the explanatory memorandum to the Act (available on the legislation website[35]) provides fuller information on territorial extent.

Statute Box 23.1 sets out the main provisions of the Care Act 2014.

The following are some of the Act's key features:

1. The local authority has a statutory duty to promote people's well-being not only of the users of the services but also of the carers. Well-being includes physical, mental and emotional needs. Users and carers have a right to receive support once it has been determined that they have eligible needs (sections 1, 18 and 20) (see Statute box 23.2).
2. A local authority also has a statutory duty to provide preventative services to maintain people's health (section 2) (see Statute box 23.3).
3. A local authority has a statutory duty to ensure the integration of care and support provision with health provision and health-related provision in performing its functions (section 3) (see Statute box 23.4). This is comparable to the reciprocal duty placed upon NHS England and the clinical commissioning groups under sections 13N and 14Z1 of the amended NHS ACT 2006.
4. A minimum eligibility threshold is introduced – a set of criteria that makes it clear when local authorities have to provide support (section 13).
5. People can appeal against council decisions on eligibility and funding for care and support (section 72 and regulations).
6. Local authorities will be required to provide information and advice (section 4). A new website for NHS Choices will give information on provider profiles to help people choose, compare and comment on care homes and other care services.
7. All those receiving care and support, whether in residential care or home, are now covered by the Human Rights Act, except those who pay for their own care (section 73).
8. There will be a cap of £72,000 on reasonable care costs and financial support (not including accommodation) enabling people to plan their finances. Councils must offer a deferred payment scheme so that people do not have to sell their home in their lifetime (sections 24–30 and 34–36).
9. Legal right for those with a care and support plan to have a personal budget which can be received as a direct payment (sections 28 and 31–33).
10. Moving to a different authority will not lead to loss of care and support (section 37 and 38).
11. Greater independence for the CQC (see chapter 5).
12. Health Education England to be the first ever non-departmental public body with responsibility for training and education of staff in the NHS (sections 96–102) (see chapter 18).
13. A duty of candour on healthcare organisations to be introduced through regulations (section 81) (see chapter 5).

A memorandum of understanding sent by the government to every council in England in May 2014 recommended that each council should appoint a senior responsible officer (SRO) to be accountable for local implementation of the Act. Each local authority is required to agree a completed Better Care Fund plan (pooling health and social care funds) with its partner Clinical Commissioning Group and the plan must be signed off by the local Health and Wellbeing Board.

Statute 23.1 Care Act 2014

Part 1 Care and Support

General responsibilities of local authorities:

1 Promoting individual well-being
2 Preventing needs for care and support
3 Promoting integration of care and support with health services, etc.
4 Providing information and advice
5 Promoting diversity and quality in provision of services
6 Cooperating generally
7 Cooperating in specific cases

Meeting needs for care, etc.

8 How to meet needs

Assessing needs:

9 Assessment of an adult's needs for care and support
10 Assessment of a carer's needs for support
11 Refusal of assessment
12 Assessments under sections 9 and 10: further provision
13 The eligibility criteria

Charging and assessing financial resources:

14 Power of local authority to charge
15 Cap on care costs
16 Cap on care costs: annual adjustment
17 Assessment of financial resources

Duties and powers to meet needs:

18 Duty to meet needs for care and support
19 Power to meet needs for care and support
20 Duty and power to meet a carer's needs for support
21 Exception for persons subject to immigration control
22 Exception for provision of health services
23 Exception for provision of housing, etc.

Next steps after assessments

24 The steps for the local authority to take
25 Care and support plan, support plan
26 Personal budget
27 Review of care and support plan or of support plan
28 Independent personal budget
29 Care account
30 Cases where adult expresses preference for particular accommodation

Direct payments:

31 Adults with capacity to request direct payments
32 Adults without capacity to request direct payments
33 Direct payments: further provision

Deferred payment agreements, etc.:

34 Deferred payment agreements and loans
35 Deferred payment agreements and loans: further provision
36 Alternative financial arrangements

Continuity of care and support when adult moves:

37 Notification, assessment, etc.
38 Case where assessments not complete on day of move

Establishing where a person lives, etc.:

39 Where a person's ordinary residence is
40 Disputes about ordinary residence or continuity of care
41 Financial adjustments between local authorities
Safeguarding adults at risk of abuse or neglect:
42 Enquiry by local authority
43 Safeguarding Adults Boards
44 Safeguarding adults reviews
45 Supply of information
46 Abolition of local authority's power to remove persons in need of care
47 Protecting property of adults being cared for away from home
48–80 Provider Failure; market oversight; transition for children to adult care; independent advocacy and miscellaneous

Part 2 Care Standards

Part 3 Health: Health Education England and Health Research Authority

Part 4 Health and Social Care; Better Care Fund established

Part 5 General

The general responsibilities of local authorities are shown in Statute Box 23.2.

Statute 23.2 General responsibilities of local authorities under the Care Act 2014 section 1

Promoting individual well-being

1(1) The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being.

(2) 'Well-being', in relation to an individual, means that individual's well-being so far as relating to any of the following –

- (a) personal dignity (including treatment of the individual with respect);
- (b) physical and mental health and emotional well-being;
- (c) protection from abuse and neglect;
- (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
- (e) participation in work, education, training or recreation;
- (f) social and economic well-being;
- (g) domestic, family and personal relationships;
- (h) suitability of living accommodation;
- (i) the individual's contribution to society.

(3) In exercising a function under this Part in the case of an individual, a local authority must have regard to the following matters in particular –

- (a) the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being;
- (b) the individual's views, wishes, feelings and beliefs;
- (c) the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist;
- (d) the need to ensure that decisions about the individual are made having regard to all the individual's circumstances (and are not based only on the individual's age or appearance or any condition of the individual's or aspect of the individual's behaviour which might lead others to make unjustified assumptions about the individual's well-being);

(e) the importance of the individual participating as fully as possible in decisions relating to the exercise of the function concerned and being provided with the information and support necessary to enable the individual to participate;
(f) the importance of achieving a balance between the individual's well-being and that of any friends or relatives who are involved in caring for the individual;
(g) the need to protect people from abuse and neglect;
(h) the need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

Statute 23.3 General responsibilities of local authorities under the Care Act 2014 section 2

Preventing needs for care and support

2(1) A local authority must provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will –
(a) contribute towards preventing or delaying the development by adults in its area of needs for care and support;
(b) contribute towards preventing or delaying the development by carers in its area of needs for support;
(c) reduce the needs for care and support of adults in its area;
(d) reduce the needs for support of carers in its area.
(2) In performing that duty, a local authority must have regard to –
(a) the importance of identifying services, facilities and resources already available in the authority's area and the extent to which the authority could involve or make use of them in performing that duty;
(b) the importance of identifying adults in the authority's area with needs for care and support which are not being met (by the authority or otherwise);
(c) the importance of identifying carers in the authority's area with needs for support which are not being met (by the authority or otherwise).

Regulations may make provision for local authority charging.

Statute 23.4 Care Act 2014 section 3

Promoting integration of care and support with health services, etc.

3(1) A local authority must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would –
(a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,
(b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or
(c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

Care and support provision means provision to meet adults' needs, carers' needs and provision of services, facilities or resources, or the taking of other steps, under section 2 (see Statute box 23.3).

The local authority also has a duty to ensure that it establishes and maintains a service for giving advice and information (section 4), promotes diversity and equality in the provision of services (section 5), and cooperates both generally and specifically with the relevant partners as defined in the Act (sections 6 and 7). Under section 8, examples are given as to how it meets the needs under sections 18 and 19. They are shown in Statute Box 23.5.

Statute 23.5 Care Act 2014 section 8

How to meet needs

8(1) The following are examples of what may be provided to meet needs under sections 18 to 20 –
- **(a)** accommodation in a care home or in premises of some other type;
- **(b)** care and support at home or in the community;
- **(c)** counselling and other types of social work;
- **(d)** goods and facilities;
- **(e)** information, advice and advocacy.

(2) The following are examples of the ways in which a local authority may meet needs under sections 18 to 20 –
- **(a)** by arranging for a person other than it to provide a service;
- **(b)** by itself providing a service;
- **(c)** by making direct payments.

Sections 9 and 10 set out details for making an assessment of the person and of the carer. If the person refuses an assessment then section 11 relieves the LA from carrying out that assessment, but if (a) the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or (b) the adult is experiencing, or is at risk of, abuse or neglect, then the assessment must be carried out. Regulations are to make further provisions for assessments for both clients and carers. The LA is required to give a written record of the assessment to the adult, the carer and any other person to whom the adult requests a copy to be given.

Eligibility criteria

Under section 13 where a local authority is satisfied on the basis of a needs or carer's assessment that an adult has needs for care and support or that a carer has needs for support, it must determine whether any of the needs meet the eligibility criteria. The provisions of section 13 are shown in Statute Box 23.6.

Statute 23.6 Care Act 2014 section 13

Eligibility criteria

13 The eligibility criteria

(1) Where a local authority is satisfied on the basis of a needs or carer's assessment that an adult has needs for care and support or that a carer has needs for support, it must determine whether any of the needs meet the eligibility criteria (see subsection (7)).

(2) Having made a determination under subsection (1), the local authority must give the adult concerned a written record of the determination and the reasons for it.
(3) Where at least some of an adult's needs for care and support meet the eligibility criteria, the local authority must –
  (a) consider what could be done to meet those needs that do,
  (b) ascertain whether the adult wants to have those needs met by the local authority in accordance with this Part, and
  (c) establish whether the adult is ordinarily resident in the local authority's area.
(4) Where at least some of a carer's needs for support meet the eligibility criteria, the local authority must –
  (a) consider what could be done to meet those needs that do, and
  (b) establish whether the adult needing care is ordinarily resident in the local authority's area.
(5) Where none of the needs of the adult concerned meet the eligibility criteria, the local authority must give him or her written advice and information about –
  (a) what can be done to meet or reduce the needs;
  (b) what can be done to prevent or delay the development of needs for care and support, or the development of needs for support, in the future.
(6) Regulations may make provision about the making of the determination under subsection (1).
(7) Needs meet the eligibility criteria if –
  (a) they are of a description specified in regulations, or
  (b) they form part of a combination of needs of a description so specified.
(8) The regulations may, in particular, describe needs by reference to –
  (a) the effect that the needs have on the adult concerned;
  (b) the adult's circumstances.

Section 18 and 19 set out the duty (s. 18) and power (s. 19) of the LA to meet the needs for care and support. Section 20 sets out the LA duty and power to meet the needs for support for a carer.

At the time of writing, regulations on eligibility criteria were under consultation.

The next steps for the local authority to take

Care and support plan

Statute Box 23.7 sets out the provisions of section 24 and the steps a local authority must take in relation to the preparation of a care and support plan which is defined in section 25 as shown in Statute Box 23.8.

Statute 23.7 Care Act 2014 section 24

24 The steps for the local authority to take

(1) Where a local authority is required to meet needs under section 18 or 20(1), or decides to do so under section 19(1) or (2) or 20(6), it must –
  (a) prepare a care and support plan or a support plan for the adult concerned,
  (b) tell the adult which (if any) of the needs that it is going to meet may be met by direct payments, and
  (c) help the adult with deciding how to have the needs met.
(2) Where a local authority has carried out a needs or carer's assessment but is not required to meet needs under section 18 or 20(1), and does not decide to do so under section 19(1) or (2) or 20(6), it must give the adult concerned –

(a) its written reasons for not meeting the needs, and
(b) (unless it has already done so under section 13(5)) advice and information about –
  (i) what can be done to meet or reduce the needs;
  (ii) what can be done to prevent or delay the development by the adult concerned of needs for care and support or of needs for support in the future.

(3) Where a local authority is not going to meet an adult's needs for care and support, it must nonetheless prepare an independent personal budget for the adult (see section 28) if –
(a) the needs meet the eligibility criteria,
(b) at least some of the needs are not being met by a carer, and
(c) the adult is ordinarily resident in the authority's area or is present in its area but of no settled residence.

Statute 23.8 Care Act 2014 section 25

Care and support plan

(1) A care and support plan or, in the case of a carer, a support plan is a document prepared by a local authority which –
(a) specifies the needs identified by the needs assessment or carer's assessment,
(b) specifies whether, and if so to what extent, the needs meet the eligibility criteria,
(c) specifies the needs that the local authority is going to meet and how it is going to meet them,
(d) specifies to which of the matters referred to in section 9(4) the provision of care and support could be relevant or to which of the matters referred to in section 10(5) and (6) the provision of support could be relevant,
(e) includes the personal budget for the adult concerned (see section 26), and
(f) includes advice and information about –
  (i) what can be done to meet or reduce the needs in question;
  (ii) what can be done to prevent or delay the development of needs for care and support or of needs for support in the future.

(2) Where some or all of the needs are to be met by making direct payments, the plan must also specify –
(a) the needs which are to be so met, and
(b) the amount and frequency of the direct payments.

(3) In preparing a care and support plan, the local authority must involve –
(a) the adult for whom it is being prepared,
(b) any carer that the adult has, and
(c) any person whom the adult asks the authority to involve or, where the adult lacks capacity to ask the authority to do that, any person who appears to the authority to be interested in the adult's welfare.

(4) In preparing a support plan, the local authority must involve –
(a) the carer for whom it is being prepared,
(b) the adult needing care, if the carer asks the authority to do so, and
(c) any other person whom the carer asks the authority to involve.

(5) In performing the duty under subsection (3)(a) or (4)(a), the local authority must take all reasonable steps to reach agreement with the adult or carer for whom the plan is being prepared about how the authority should meet the needs in question.

(6) In seeking to ensure that the plan is proportionate to the needs to be met, the local authority must have regard in particular –
(a) in the case of a care and support plan, to the matters referred to in section 9(4),
(b) in the case of a support plan, to the matters referred to in section 10(5) and (6).

(7) The local authority may authorise a person (including the person for whom the plan is to be prepared) to prepare the plan jointly with the authority.

(8) The local authority may do things to facilitate the preparation of the plan in a case within subsection (7); it may, for example, provide a person authorised under that subsection with –

(a) in the case of a care and support plan, information about the adult for whom the plan is being prepared;

(b) in the case of a support plan, information about the carer and the adult needing care;

(c) in either case, whatever resources, or access to whatever facilities, the authority thinks are required to prepare the plan.

(9) The local authority must give a copy of a care and support plan to –

(a) the adult for whom it has been prepared,

(b) any carer that the adult has, if the adult asks the authority to do so, and

(c) any other person to whom the adult asks the authority to give a copy.

(10) The local authority must give a copy of a support plan to –

(a) the carer for whom it has been prepared,

(b) the adult needing care, if the carer asks the authority to do so, and

(c) any other person to whom the carer asks the authority to give a copy.

(11) A local authority may combine a care and support plan or a support plan with a plan (whether or not prepared by it and whether or not under this Part) relating to another person only if the adult for whom the care and support plan or the support plan is being prepared agrees and –

(a) where the combination would include a plan prepared for another adult, that other adult agrees;

(b) where the combination would include a plan prepared for a child (including a young carer), the consent condition is met in relation to the child.

(12) The consent condition is met in relation to a child if –

(a) the child has capacity or is competent to agree to the plans being combined and does so agree, or

(b) the child lacks capacity or is not competent so to agree but the local authority is satisfied that the combining the plans would be in the child's best interests.

(13) Regulations may specify cases or circumstances in which such of paragraphs (a) to (f) of subsection (1) and paragraphs (a) and (b) of subsection (2) as are specified do not apply.

(14) The regulations may in particular specify that the paragraphs in question do not apply as regards specified needs or matters.

26 Personal budget

(1) A personal budget for an adult is a statement which specifies –

(a) the cost to the local authority of meeting those of the adult's needs which it is required or decides to meet as mentioned in section 24(1),

(b) the amount which, on the basis of the financial assessment, the adult must pay towards that cost, and

(c) if on that basis the local authority must itself pay towards that cost, the amount which it must pay.

(2) In the case of an adult with needs for care and support which the local authority is required to meet under section 18, the personal budget must also specify –

(a) the cost to the local authority of meeting the adult's needs under that section, and

(b) where that cost includes daily living costs –

(i) the amount attributable to those daily living costs, and

(ii) the balance of the cost referred to in paragraph (a).

(3) A personal budget for an adult may also specify other amounts of public money that are available in the adult's case including, for example, amounts available for spending on matters relating to housing, healthcare or welfare.

27 Review of care and support plan or of support plan

(1) A local authority must –

(a) keep under review generally care and support plans, and support plans, that it has prepared, and

(b) on a reasonable request by or on behalf of the adult to whom a care and support plan relates or the carer to whom a support plan relates, review the plan.

28 Independent personal budget

(1) An independent personal budget is a statement which specifies what the cost would be to the local authority concerned (see section 24(3)) of meeting the adult's eligible needs for care and support.

(2) Where the amount referred to in subsection (1) includes daily living costs, the independent personal budget for the adult must specify –

(a) the amount attributable to those daily living costs, and

(b) the balance of the amount referred to in subsection (1).

(3) An adult's needs are 'eligible needs' if, at the time they were met –

(a) they met the eligibility criteria,

(b) they were not being met by a carer, and

(c) the adult was ordinarily resident or present in the area of the local authority.

(4) A local authority must –

(a) keep under review generally independent personal budgets that it has prepared, and

(b) on a reasonable request by or on behalf of the adult to whom an independent personal budget relates, review the independent personal budget.

(5) A local authority may revise an independent personal budget; and in deciding whether or how to do so, it must, in so far as it is feasible to do so, involve –

(a) the adult to whom the independent personal budget relates,

(b) any carer that the adult has, and

(c) any other person whom the adult asks the authority to involve or, where the adult lacks capacity to ask the authority to do that, any person who appears to the authority to be interested in the adult's welfare.

(6) Where a local authority is satisfied that the circumstances of the adult to whom an independent personal budget applies have changed in a way that affects the independent personal budget, the authority must –

(a) to the extent it thinks appropriate, carry out a needs assessment and make a determination under section 13(1), and

(b) revise the independent personal budget accordingly.

(7) Where, in a case within subsection (6), an adult refuses a needs assessment and the local authority thinks that the adult's refusal is unreasonable, it need no longer keep an up-to-date care account in the adult's case.

(8) Having reviewed an independent personal budget, a local authority must –

(a) if it revises the independent personal budget, notify the adult to whom the independent personal budget relates of the revisions and provide an explanation of the effect of each revision, or

(b) if it does not revise the independent personal budget, notify the adult accordingly.

29 Care account

(1) Where an adult has needs for care and support which meet the eligibility criteria, the local authority in whose area the adult is ordinarily resident or, if the adult is of no settled residence, in whose area the adult is present –

(a) must keep an up-to-date record of the adult's accrued costs (a 'care account'), and

(b) once those costs exceed the cap on care costs, must inform the adult.

(2) Where a local authority which has been keeping a care account is no longer required to do so, it must nonetheless retain the account that it has kept so far until –

(a) the end of the period of 99 years beginning with the day on which it last updated the account, or

(b) where the adult dies, the local authority becomes aware of the death.

(3) A care account must specify such amount as is attributable to the adult's daily living costs.

(4) A local authority which is keeping a care account must, at such times as regulations may specify, provide the adult concerned with a statement which –

(a) sets out the adult's accrued costs, and

(b) includes such other matters as regulations may specify.

(5) Regulations may specify circumstances in which the duty under subsection (4) does not apply.

Deferred payments

Sections 35 to 37 of the Care Act 2014 set out the terms of the 'deferred payment agreement' under which a local authority agrees not to require payment until the specified time. Regulations may, in such cases or circumstances and subject to such conditions as may be specified, require or permit a local authority to enter into a deferred payment agreement with an adult. The regulations may, in particular, prohibit a local authority from entering into, or permit it to refuse to enter into, a deferred payment agreement unless it obtains adequate security (as defined in the regulations) for the payment of the adult's deferred amount. The regulations will also specify interest, costs and other payments which have to be made. 'Alternative financial arrangements' can also be set up which equate in substance to a deferred payment agreement but achieve a similar effect to an agreement of the kind in question without including provision for the payment of interest.

Criticism of the new scheme for deferred payments was made in a study by the Institute and Faculty of Actuaries which found that the average pensioner will spend an average of £140,000 of their own savings on the cost of elderly care. Only 1 in 10 of those entering care in 2016 will reach a new cap designed to prevent older people from being forced to sell their homes to fund the cost of care. The cap which comes into force in 2016 is set at £72,000 because it only applies to care costs set by local authorities. It does not include the cost of housing and living expenses.[36]

Independent advocate

Under section 67(4) of the Care Act 2014 the local authority is required to ensure that an independent advocate is appointed to speak on behalf of a person where, in the absence of such an advocate, the individual would experience substantial difficulty in doing one or more of the following:

(a) understanding relevant information
(b) retaining that information
(c) using or weighing that information as part of the process of being involved
(d) communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means).

This applies where the LA is:

- carrying out needs assessment (section 9(5)(a) and (b))
- carrying out carer's assessment (section 10(7)(a)
- preparing a care and support plan (section 25(3)(a) and (b))
- preparing a support plan (section 25(4)(a) and (b))
- revising the care and support plan (section 27(2)(b)(i) and (ii))
- revising the support plan (section 27(3)(b)(i) and (ii))
- carrying out child's needs assessment (section 59(2)(a) and (b))
- carrying out child's carer's assessment (section 61(3)(a))
- carrying out young carer's assessment (section 64(3)(a) and (b)).

Community equipment

In 2000 the Audit Commission published its findings on the provision of equipment for older and disabled people.[37] It found that users were not asked basic questions about the sort of help they needed; they had to wait for long periods of time for their equipment; the equipment was not always suitable or of a high quality; and the current organisation of equipment services is a recipe for inequality and inefficiency. Among its many significant recommendations are suggestions for involving users, restructuring of mobility services, the integration of health and social services provision for community equipment under the powers of the Health Act 1999, and the introduction of policy reviews and dissemination of good practice. Care trusts have now been set up to ensure integration of health and social

service provision. Brian Donnelly has carried out an independent review of the delivery of community equipment services across England and Wales.[38] He estimated that there are approximately 10 million pieces of community equipment delivered to 3.5 million clients every year in England and Wales. He proposed National Minimum Standards to reduce risks, improve quality and safety, and save public funds.[39] The CQC has published details of the Community Equipment Code of Practice Scheme (CECOPS), which is a social enterprise set up to manage registration, training and accreditation of users of the code of practice for community equipment. The Code sets out a quality framework for procurement and provision of services. CECOPS aims to assist all public and private sector providers and commissioners. Further details can be found on the CQC website.[40]

Human rights and care homes

The Human Rights Act 1998 applies to public authorities and organisations exercising functions of a public nature. How far does it apply to the private sector? In a case brought against the Leonard Cheshire Foundation,[41] the Court of Appeal held that on the particular facts before it (the redeveloping of the home), the charity had not carried out the functions of a public authority. In June 2007 the House of Lords held in a majority decision (in keeping with an earlier decision by the Court of Appeal)[42] that a private care home, which was under contract with a local authority to provide care and accommodation for elderly persons, was not an organisation exercising functions of a public nature.[43] An 84-year-old resident who suffered from Alzheimer's disease was therefore unable to make a claim under Article 8 of the European Convention on Human Rights in respect of her removal from the care home. This decision led to a campaign for legislation to bring private care homes under the auspices of the Human Rights Act 1998. The campaign was given added momentum following the report of the Parliamentary Joint Committee on Human Rights in August 2007.[44] This report found that more than a fifth of care homes have been found to be failing basic standards of care for privacy and dignity. The report considered that elder abuse is a serious and severe human rights abuse which is perpetrated on vulnerable older people who often depend on their abusers to provide them with care. The Joint Committee criticised the Department of Health and Ministry of Justice for failing to provide proper leadership and guidance on the Human Rights Act to providers of health and residential care. It recommended that care standards regulations should be amended so that all care homes are brought under the Human Rights Act and that eventually the Human Rights Act should be amended to ensure that private care homes came under its remit. It also recognised the importance of the role of staff in protecting human rights and made specific recommendation on the training of staff and suggested that there should be a duty specified in the care standards requiring staff to report abuse, with protection for whistleblowing and confidentiality.

As a consequence of the reaction to these court decisions, section 145 of the Health and Social Care Act 2008 was enacted to define the provision of certain social care as a public function. Section 145 states that:

> **(1) A person ('P') who provides accommodation, together with nursing or personal care, in a care home for an individual under arrangements made with P under the relevant statutory provisions is to be taken for the purposes of subsection (3)(b) of section 6 of the Human Rights Act 1998 (c. 42) (acts of public authorities) to be exercising a function of a public nature in doing so.**

The relevant statutory provisions include:

(a) in relation to England and Wales, sections 21(1)(a) and 26 of the National Assistance Act 1948 (c. 29),
(b) in relation to Scotland, section 12 or 13A of the Social Work (Scotland) Act 1968 (c. 49), and
(c) in relation to Northern Ireland, Articles 15 and 36 of the Health and Personal Social Services (Northern Ireland) Order 1972 (SI 1972/1265 (NI 14)).

This provision is not retrospective and does not apply to cases prior to the coming into force of section 145.

Section 73 of the Care Act 2014 extends this provision so that the provider of care and support is exercising functions of a public nature if:

(a) the care or support is arranged by an authority specified in the Act, and
(b) the authority arranges or pays for the care or support under specified legislation.

For England the specified authorities are local authorities (under s. 2, 18, 19, 20, 38 and 48 of the Care Act 2014) and Health and Social Care Trusts (under s. 51 of the Care Act 2014). The provision extends across the UK.

Those funding their own care cannot claim the protection of the Human Rights Act.

An allegation that a local authority was in breach of Article 5 of the European Convention on Human Rights succeeded in 2006.[45] The local authority had placed the claimant's husband in a care home, justifying the placement on grounds that any restriction on his liberty was in his best interests and he was not being deprived of his liberty within the meaning of Article 5. The court held that the crucial issue was whether the person was free to leave and concluded that he was not. Since October 2007 the provisions of the Mental Capacity Act 2005 would apply to this situation – see the Deprivation of Liberty Safeguards (DoLS) and the Supreme Court judgment in the Cheshire case[46] (see chapter 17).

In another successful action alleging a breach of Article 8, the claimant, who was blind, suffered from diabetes and had suffered several strokes, obtained judicial review of a primary care trust's refusal to provide 24-hour nursing care in her own home (her parents ceasing to be able to provide hands-on care). The court held that removing her from her home into residential care would interfere with her right to respect for her family life within Article 8.[47]

In contrast with the previous two cases, the challenge of a wife whose husband was transferred from a nursing home to a hospital because of his health and behavioural problems failed in her claim.[48] The judge held that the without notice application for the transfer by the local authority was justified and there was no breach of Article 8. The injunctions to forbid the wife to interfere with her husband's transfer or his care at the hospital or attempting to see him at the hospital except as agreed and supervised by the local authority were justified.

Case 23.4 *R (McDonald) v. Kensington and Chelsea Royal London Borough Council (ECHR)* (2014)[49]

The Supreme Court[50] had held that there was no breach of Article 8 rights when an LA withdrew the provision of a night-time carer to assist a disabled person to use a commode when required and instead provided her with incontinence pads to wear at night (Baroness Hale dissented). The ECHR held that there was a breach of Article 8 for part of the time. However, where the withdrawal had been made after a proper assessment, the interference with her right to respect for her private life had been both proportionate and justified as necessary in a democratic society and there was no breach of Article 8.

The implications of this ECHR decision is that failure by the local authority to carry out an appropriate assessment before removing any assistance from or refusing to provide a service to a community client could be seen as a breach of Article 8 rights.

In 2013 a strengthened CQC announced that it would consider using CCTV in care homes to check whether there was abuse. Details of the new regime of inspections introduced from 2012 are available from the CQC website.[51] In July 2014 the CQC chief inspector for adult social care announced that from 2015 the CQC would introduce placing non-performing care homes in special measures as part of a new inspection system for care home and care agencies, comparable to the special measures used for hospitals. The CQC was recruiting a team of 700 inspectors.[52]

A serious case review into the deaths of five elderly people at Orchid View in West Sussex was highly critical of the role of the CQC in failing to alert prospective residents and families to concern about conditions at the home. It called for more stringent regulation. After reviewing the deaths of 19 residents between 2009 and 2011 the coroner concluded that all had suffered from sub-optimal care and five had died from natural causes contributed to by neglect.[53] The CQC's chief inspector of adult social care promised an overhaul into how care homes are inspected.[54]

A cosmetic surgeon who used a basement to carry out cosmetic surgery was held to be in breach of the registration provisions since he had carried on an independent hospital without being registered. He failed in his appeal.[55]

In March 2014 the House of Lords published its post-legislative scrutiny on the Mental Capacity Act 2005[56] which stated that patients were being drugged or locked up and deprived of their liberty without protection of the law. See also the case of Steven Neary[57] which illustrated the problems in using the Deprivation of Liberty Safeguards (see chapter 17).

Delayed discharges

Problems in bed blocking because accommodation was not found in the community for patients ready for discharge from NHS beds were met by the Community Care (Delayed Discharges etc.) Act 2003, which made provision for social services authorities to make payments in cases where the discharge of patients is delayed for reasons relating to the provision of community care services or services for carers. Regulations published in 2003 made provisions for the details of the delayed discharges scheme.[58] They set out the type of care which a patient must be receiving to come within the provisions of the Act; set out the details of the notice which the relevant NHS body must give to the local social services authority to inform it that there is a patient who is likely to need community care services on discharge and also set the time limits for notice and the amounts which the local authority must pay. The regulations also provide for resolution of a dispute. Failure by the social services authority to comply with these statutory duties can lead to the authority being liable to make a payment of the amount prescribed in the regulations for each day of the delayed discharge.

Where a patient refuses to be discharged to a residential care home and no longer requires medical or nursing care in hospital, the patient is not entitled to occupy the bed and the NHS trust is entitled to reclaim possession of its hospital premises from the patient.[59]

In 2012 the government launched the Hospital 2 Home resource pack designed to support older people who are returning to their homes after a stay in hospital. The pack indicates that the NHS spends about £600 million each year treating people in healthcare settings when they are well enough to go home but poor housing delays their discharge.[60] The pack contains information, suggestions for action, case studies and checklists for considering older patients' housing situations in hospital discharge and transfer of care. In June 2013 £1 billion was transferred from the NHS budget to social care to enable frail elderly to be looked after better in their own homes. It will be part of a £3.8 billion pot in 2015–6 to be used for schemes commissioned jointly by local health and social care chiefs.[61]

In October 2013 the Department of Health issued Directions[62] requiring NHS trusts to take reasonable steps to ensure that an assessment of eligibility for NHS Continuing Healthcare is carried out in all cases where it appears to the trust that the patient may have a need for such care, in consultation, where appropriate, with the relevant local social services authority. The Directions are accessible on the government website.[63]

Duty of local authority on discharge of hospital patients with care and support needs

The Care Act 2014 has re-enacted the provisions of the Community Care (Delayed Discharges etc.) Act 2003. Under Schedule 3 of the Care Act (brought into effect by section 74), where the NHS body

responsible for a hospital patient considers that it is not likely to be safe to discharge the patient unless arrangements for meeting the patient's needs for care and support are in place, the body must give an assessment notice to

(a) the local authority in whose area the patient is ordinarily resident, or
(b) if it appears to the body that the patient is of no settled residence, the local authority in whose area the hospital is situated.

An assessment notice

(a) must describe itself as such, and
(b) may not be given more than seven days before the day on which the patient is expected to be admitted to hospital.

Before giving an assessment notice, the NHS body responsible for the patient must consult

(a) the patient, and
(b) where it is feasible to do so, any carer that the patient has.

An assessment notice remains in force until

(a) the patient is discharged (whether by the NHS body responsible for the patient or by the patient himself or herself),
(b) the patient dies, or
(c) the NHS body responsible for the patient withdraws the notice by giving a notice (a 'withdrawal notice') to the relevant authority.

A reference to a hospital patient includes a reference to a person who it is reasonable to expect is about to become one.

The NHS body responsible for a hospital patient, having given the relevant authority an assessment notice, must

(a) consult the authority before deciding what it will do for the patient in order for discharge to be safe, and
(b) give the authority notice of the day on which it proposes to discharge the patient.

This is known as a 'discharge notice'. A discharge notice must specify

(a) whether the NHS body responsible for the patient will be providing or arranging for the provision of services under the National Health Service Act 2006 to the patient after discharge, and
(b) if it will, what those services are.

A discharge notice remains in force until

(a) the end of the relevant day, i.e. the later of
  (i) the day specified in the discharge notice, and
  (ii) the last day of such period as regulations may specify), or
(b) the NHS body responsible for the patient withdraws the notice by giving a withdrawal notice to the relevant authority.

The relevant local authority, having received an assessment notice and having in light of it carried out a needs assessment and (where applicable) a carer's assessment, must inform the NHS body responsible for the patient

(a) whether the patient has needs for care and support,
(b) (where applicable) whether a carer has needs for support,
(c) whether any of the needs referred to in paragraphs (a) and (b) meet the eligibility criteria, and
(d) how the authority plans to meet such of those needs as meet the eligibility criteria.

Where, having carried out a needs assessment or carer's assessment in a case within section 27(4), the relevant authority considers that the patient's needs for care and support or (as the case may be) the carer's needs for support have changed, it must inform the NHS body responsible for the patient of the change.

Cases where discharge of the patient is delayed

If the relevant authority, having received an assessment notice and a discharge notice, has not carried out a needs or (where applicable) carer's assessment and the patient has not been discharged by the end of the relevant day, the NHS body responsible for the patient may require the relevant authority to pay the specified amount for each day of the specified period.

If the relevant authority has not put in place arrangements for meeting some or all of those of the needs under sections 18 to 20 (Care Act 2014) that it proposes to meet in the case of the patient or (where applicable) a carer, and the patient has for that reason alone not been discharged by the end of the relevant day, the NHS body responsible for the patient may require the relevant authority to pay the specified amount for each day of the specified period.

Carers

It has been estimated that Great Britain has 5.7 million carers and 1 in 6 households contains a carer.[64] The Carers (Recognition and Services) Act 1995 required local authorities to carry out an assessment of the carer's ability to provide and to continue to provide care for the person receiving community care services, but it did not give local authorities the power to offer carers services to support them in their caring role.

In 1999 the government published a Carer's National Strategy Document[65] highlighting the need for legislation to enable local authorities to provide services direct to carers. The Carers and Disabled Children Act 2000 had four main purposes:

1 It gave local authorities the power to supply certain services direct to carers.
2 It enabled local authorities to make direct payments to carers, including 16- and 17-year-olds, to persons with parental responsibility for disabled children and to the disabled children. These direct payments can then be used for a provider for those services chosen by the carer.
3 Local authorities could provide short-term break voucher schemes, which would give carers flexibility in the timing and choice of breaks.
4 The local authorities were given power to charge carers for the services they receive. In its assessment, the LA can take into account any assessment made under the 1995 Act. The 2000 Act does not apply if the carer is an employee or a volunteer for a voluntary organisation. The LA must consider the assessment and decide:
   - whether the carer has needs in relation to the care that he provides or intends to provide
   - if so, whether they could be satisfied (wholly or partly) by services which the LA may provide
   - if they could be so satisfied, whether or not to provide services to the carer.

Direct payments are considered in chapter 17.

Under the Care Act 2014 the local authority has a duty to assess a carer's needs for support (section 10) and a duty and power to meet those needs.

Liability of client for carer

A carer won a payout from a widower who had employed her to care for his wife. Following the death of his wife the widower cut her hours from 30 to 16 a week and the carer, Jayne Wakefield, claimed that she had been unfairly dismissed and was awarded, by the employment appeal tribunal, £3,569 for constructive and unfair dismissal and breach of contract.[66]

Negligence

Standard of care

Practical Dilemma 23.1 Key worker

The Roger Park Community NHS Trust set up a series of location managers and teams of multidisciplinary professionals for clients. Each client was assigned a key worker who would discuss with the team that particular client's difficulties and try to resolve them as far as possible on his own, thus preventing the client from being visited by a whole host of different professionals. This key worker could be any one of a variety of professionals, but as far as possible it was one whose training was most relevant to the client's needs.

Margaret Downs lived on her own and was recovering from a stroke. With the help of the physiotherapist she was making good progress and the community nurse, Angela Hide, was visiting her twice a week to dress a leg ulcer and also to give her a bath. The community nurse was Margaret's key worker. After a few weeks, Angela decided that Margaret would be able to manage to bath herself on her own if she had a bath rail and support. She got in touch with the local authority department that provided home aids and ordered the appropriate devices to be fitted. She told Margaret that once they were installed she would not need any assistance to bath, but that if she got into any difficulties she should let Angela know. A few days later Margaret, who had not been seen by neighbours for a few days, was found dead in the bath. A post mortem showed that she had slipped while trying to get out of the bath, that the hand rail was not in a suitable position and that she had probably died of exposure. The coroner held an inquest and Angela was asked to provide a statement, as was the occupational therapist in the team, since the task of assessment for bath aids was normally that of the occupational therapist.

In Practical Dilemma 23.1 it is possible that the relatives will be present and probably represented by a solicitor or barrister at the inquest. The inquest might well be followed by a civil claim against the NHS trust on the basis of its direct liability for the death of Margaret in failing to lay down an appropriate procedure for caring for patients in the community and also on the basis of its indirect or vicarious liability for Angela's negligence. Was Angela negligent? Obviously, there are very few facts given here on which the answer to such a question could be determined, but at the heart of the negligence action will be the question: did Angela follow the accepted approved practice in making those recommendations about the bath aids? Or, if she did not follow the approved practice, was there justification for her not doing so and would that justification be supported by competent professional opinion? The question of whether such a decision was within her competence or whether she should have brought in the occupational therapist, whose training includes that type of assessment, will be crucial. It does not, of course, follow that the mere fact that Angela strayed outside her competence will automatically mean that she failed to follow a reasonable standard of care. In addition, the relatives will also have to establish that there was a causal link between the breach of duty by Angela and the harm caused to Margaret and that that harm was reasonably foreseeable.

The most important feature in any team approach and key worker system is that each should know the limits of their competence and the point at which the patient's safety demands that another person be brought in to advise. In the Wilsher case (considered in detail in chapter 4), the court has held that there is no concept of team liability. It is a question of individual liability and/or the liability of the NHS trust. (The legal issues arising from the scope of professional practice are considered in chapter 24.) A salutary lesson on the importance of training individual nurses is seen in the account of a tetraplegic patient dependent on a ventilator at home whose agency nurse accidentally switched off his life support,

causing him to suffer serious brain damage.[6] His family indicated their intention to sue the PCT, which had carried out an investigation which found that the nurse was not qualified in the use of ventilators even though that was one of the requirements for the job. The patient had complained of poor standards of care and set up a camera which recorded the incident.

To whom is the nurse responsible?

Practical Dilemma 23.2 A clash of duties

Community nurses in the Roger Park Unit had been given instructions that they should not carry drugs in their cars, neither should they personally arrange for drugs on prescriptions to be collected from the chemists. Ruth Green was caring for a terminally ill patient who was being nursed by her husband at home. The GP had left a prescription on his last visit and the husband asked her if she would be kind enough to bring the drugs back from the chemist. He said that he did not have any transport or any neighbours who could help and he did not want to leave his wife on her own. Ruth said that she was not allowed to collect drugs from the chemist for patients. He was clearly distressed and offered to come with her if she could provide the transport, but it would still mean leaving his wife on her own. She agreed to this and took him to the chemist and then home again – a round trip of about seven miles that took 20 minutes. The husband could not understand why he had to go with her, leaving his wife for such a long time and obviously in danger. Ruth herself felt that the rules were not appropriate to that situation and wondered whether there was any law that covered her duties.

Practical Dilemma 23.2, in which there is a clash between what the nurse is told to do and what she feels is her duty to the patient, is not unusual, neither is it confined to the community. Other situations, for example where the nurse is told not to take patients in her car or where she is given instructions about lifting that she cannot carry out because the facilities or staff are not available, place the nurse in a dilemma. Is she to fulfil what she believes to be her duty to the patient or should she obey the NHS trust's or nurse manager's instructions? The clash can be seen as a conflict between the Code of Professional Conduct set down by the NMC and her employer's orders. She has a contractual duty to obey the latter, since it is an implied term of her contract of employment that she obey the reasonable orders of her employer; contrariwise, she has a professional duty to follow the Code of Professional Conduct. If provisions of the Code are included in the contract of employment, then there should in theory be no clash between the two. Instructions by the employer must be reasonable and it can be argued that any instructions that clash with the professional obligations of the registered practitioner cannot be reasonable.

The first task for Ruth Green in a situation like this is for the nurse management to be given the full facts of any potential hardship suffered by the patient as a result of their instructions and procedures. Examples of the difficulties that have and will arise from following these instructions must be provided in detail. It may so happen that, when presented with this evidence, management might well feel that either the whole policy should be revised or that certain exceptions can be made in circumstances where the patient is likely to suffer harm.

Alternatively, it may be possible for other arrangements to be made that will ensure the safety and well-being of the patient. For example, in rural areas, pharmacists sometimes provide a home delivery service for medicines and oxygen. If the management is adamant that the procedures must be followed without any exception, the nurse has a duty to undertake those unless there is likely to be such harm to the patient that it is clearly contrary to her duty of care to the patient. In such a situation, her records would have to be very comprehensive to justify her action. In serious situations, the nurse should raise concerns with senior levels of management in accordance with the Public Interest Disclosure Act (see chapter 4).

In the following case, the fact that a GP relied heavily upon the role of community nurses was the subject of disciplinary action.

Case 23.5 *R v. FHS Appeal Authority ex p Muralidhar* (1999)

Medical treatment: reasonableness of doctor relying on nurses[68]

A GP applied for judicial review of a finding by the chief executive of a family health services authority that he was in breach of his terms of service by relying on district nurses who had visited the patient daily to treat a patient's bedsores. The patient suffered from senile dementia, incontinence and was bedridden. The doctor visited her, prescribed antibiotics for infected bedsores, leaving instructions with staff that he should be contacted if there were any deterioration. He was not contacted, but subsequently the patient was removed to hospital where criticism of her previous nursing care was made. The judge, in granting the application, held that the chief executive had failed to consider whether the doctor had behaved in accordance with his terms of service and had taken irrelevant considerations into account. There was also procedural unfairness in that the chief executive had not alerted the doctor to the importance he attached to these considerations so that the doctor could make relevant representations.

There are clear lessons for nursing staff from this case. If they are concerned about a patient's condition they should ensure that the doctor is called in to examine the patient.

Examples of serious breaches of the duty of care

It was reported that two council workers (a social worker and a team leader) were suspended after the death of an elderly woman who was left alone for nine days after her care agency was shut.[69] Carefirst 24 was contracted to care for her and provide daily visits.

Abele View Ltd which ran a care home near Stourbridge was fined £133,000 and ordered to pay £122,412 in costs following the death of a resident in the garden. The resident died of hypothermia and his disappearance went unnoticed. The prosecution was brought under health and safety legislation[70] (see chapter 12).

Three staff were suspended from an old people's home after a local authority started an investigation into standards at the BUPA owned St Mark's Nursing Centre, Maidenhead.[71]

Giving advice

One of the most important tasks of many registered practitioners, and in particular the specialist community public health nurse (SCPHN), is giving advice to clients, young and old, on all aspects of their health and ways of keeping healthy. For example, one of the vexed questions these days is the extent to which the SCPHN should encourage a mother to have her child vaccinated and the possibility of the SCPHN herself being held liable for giving advice that turns out to cause harm. The topic of liability for communications was discussed in chapter 4, where it was stated that exactly the same principles of liability apply in giving advice as apply in using skills. Thus if a health visitor, knowing that a child has a history of convulsions, fails to take this into account in advising the mother to have the child vaccinated and also fails to ensure that the doctor is advised of this fact, the health visitor may well share some responsibility for any harm that befalls the child as a result of undergoing the vaccination. (Vaccinations are considered in chapter 26.)

Safety of the community professional

Entering other people's homes can be dangerous. Unlike the NHS trust, the occupiers have no obligations under the Health and Safety at Work Act 1974, but they do have obligations under the Occupiers' Liability Act 1957. This is discussed in detail in chapter 12. The community worker faces problems in relation to both the standard of the structure and the fixtures and fittings. In addition, she might find difficulties caused by the client or the relatives.

Practical Dilemma 23.3 Defective premises

Pam Hughes, a health visitor, had a large caseload in one of the poorer parts of the city. In one council house, conditions were very bad: the wallpaper was peeling off the walls and there were piles of empty milk bottles in the kitchen and a miscellaneous assortment of carpet pieces on the concrete floor. The local authority had been notified of certain defects to the roof and the fittings, but had said that, because of the backlog of maintenance work and staff cuts, it would be several weeks before they could repair the property. The occupiers, Mr and Mrs James and their seven children, could not cope with the situation. Mr James was unemployed and attempted to rectify some of the defects, including putting a new piece of glass in the front door to replace the pane that had been broken when the door was slammed shut. The door had swollen owing to the guttering leaking onto it. Pam Hughes was well used to the family and had been visiting regularly because of her concern over the two youngest children. After one visit, she let herself out – as was her usual custom – and had to pull hard on the front door to open it. As she pulled, the new pane fell out onto her hand, cutting her severely across the wrist. After medical treatment and the advice of a specialist, it appeared that the tendons were severed and she would have very little movement in the four fingers of her right hand. It is certainly questionable whether she will be able to continue her work as a health visitor. Since she is unmarried, and the sole breadwinner, caring for her elderly mother, she is frightened at the prospect of losing her job. She is therefore anxious to recover financial compensation for the injuries.

This particular situation may be unique but it represents the many dangers with which a community worker is faced.

What are the practicalities of obtaining compensation? Is the NHS trust liable? The answer is probably no, unless it can be shown that it was aware of the danger that an employee was in and failed to take reasonable precautions to safeguard her. There is no evidence that this was so in this case. However, the employers may be prepared to ensure that compensation is paid to her on an ex gratia basis since she was injured in the course of her employment. Mr and Mrs James are possibly liable. As occupiers, they failed to ensure that the premises were safe for the visitor. Mr James may well have repaired the door negligently. However, unless they are insured, the question is academic, since they are unlikely to be able to pay any compensation.

Since it is a council house, it may be that Pam could establish a case against the council in its capacity as landlord and therefore occupier of the building. However, to succeed it would be important to show that, from the obligations under the lease, the landlord had a duty to carry out repairs and his failure to do so had reasonably foreseeably caused the injury to Pam's arm. However, Mr James's repair work makes a break in this chain of causation. If Pam fails against all three potential defendants, then all she can do is fall back on her own insurance cover. Some household insurance schemes also cover for personal injuries or she may have her own personal accident cover. If not, she is unlikely to obtain any compensation other than the usual statutory sick pay scheme and the DSS injury benefits, which are considerably smaller than the level of compensation awarded in the civil courts.

The lesson is clear: because of the dangers of working in variable conditions, it is probably essential that community workers have some form of insurance cover for personal accidents. Some local authorities, professional associations and trade unions have negotiated group schemes of cover. It is, however, the policy of the NHS not to take out insurance cover. If the professional is working on NHS trust premises all the time, then the authority as occupier has a duty to ensure that she is safe, and if it fails in this duty then it could be held liable under the Occupiers' Liability Act.

Case 23.6 *R* v. *Hillingdon Health Authority ex parte Wyatt* (1977)

Aggression in the community[72]

Mrs Wyatt suffered from multiple sclerosis, could do nothing for herself and needed nursing assistance. The health authority had the duty to provide a home nursing service under section 25 of the NHS Act 1946 (as amended by the 1973 Reorganisation Act). The husband, who was also an invalid, abused the nursing staff when they visited his wife and was aggressive and threatening. He was asked to give an assurance that he would cease to behave so, but he refused. The authority told Mrs Wyatt's solicitors that because of Mr Wyatt's behaviour they could not continue the nursing service.

The Court of Appeal held that the authority was doing all that could be reasonably expected of it and the application to compel the authority to provide the service would be dismissed.

The principle established in the Wyatt case can be applied to other situations, including the dangerous nature of the premises. However, before any service can be justifiably withdrawn, the threat to the safety of the community worker must have reached a serious level and every possible precaution must have been taken. For example, it might be necessary for some nurses to be sent in pairs to clients where they face danger. One question that a community nurse sometimes asks is: Can I refuse to go if I consider that I am in personal danger? If the employer's instruction to go to a particular place is unreasonable with regard to the danger with which the worker is faced and the lack of precautions that the employer has taken for the employee's safety, then the employee can refuse to obey them. What is meant by unreasonable? This is a matter of balancing all the options available, including other precautions that it is reasonable for the employer to take against the risks involved and the needs of the client. Where the danger to the professional is the neighbourhood itself, it might, for example, be reasonable for the employer to arrange for an alarm/warning system to be carried by the employee or to ensure that they visit homes in pairs. Where the danger comes from aggressive clients or their relatives, then it might be sufficient if a senior nursing officer accompanies the nurse to ensure her safety. A similar situation of a conflict between patients/carers and the health professionals has arisen in manual handling, where the patient refuses to be lifted by a hoist. This issue is considered in chapter 12. The Health and Safety Executive (HSE) has developed a pack for violence management training in healthcare settings which could be applied to work in the community.[73]

Practical Dilemma 23.4 Community dangers

Albert was a man of 32 with learning disabilities who had been living in a community home for about six weeks. He had settled down well and, provided that he took his medication, he coped quite well, taking his share of the household chores. He was due for an injection, but to the surprise of the community nurse, he said that he was not going to take it. She pleaded with him, but to no avail. She said she would return that night, but he again refused the injection. She offered to provide it in tablet form, but he said that he would not take it in any form. The nurse tried to give the injection to him again, but he lost his temper, striking out and severely injuring her.

Several problems emerge from this: one is the issue of consent to treatment in the community, to which we shall return later; the other is the question of the safety of community nurses for the mentally ill and those with learning disabilities.

It is the employer's duty to take reasonable care of the health, safety and welfare of his employee. If it is known that a particular patient is a danger to nursing staff, then the employer has a duty to take reasonable precautions to see that they will be safe. These precautions might mean ensuring that a female nurse never visits the patient on her own. There is quite likely to be a need for refuge to be provided so that, if a client is particularly disturbed, he can leave the community or family house and make use of a respite bed, i.e. providing respite for the family. In the situation above, in deciding whether the NHS trust is liable for the injuries suffered by the community nurse, account would have to be taken of whether it was known that the patient was aggressive and, if so, whether the appropriate precautions had been taken, whether the community nurse followed approved accepted practice in her dealings with the patient or whether she provoked the patient by what she did and was therefore, to some extent, to blame for what happened. (See further discussion on health and safety in chapter 12.)

Official advice on violence

The Health and Safety Commission (now merged with the Health and Safety Executive) published guidance on the assessment and management of risks of violence and aggression to staff in health services.[74] This includes, in Appendix 3, a home visiting checklist. The three Vs of visiting are 'vet – verify – vigilance'. The checklist for staff is shown in Box 23.2. Another checklist is provided for managers.

Box 23.2 Checklist for staff who make home visits

Have you:

- had all the relevant training about violence to staff?
- a sound grasp of your unit's safety policy for visitors?
- a clear idea about the area into which you are going?
- carefully previewed today's cases? Any 'PVs' (potentially violent clients/patients)?
- asked to double up, take an escort or use a taxi if unsure?
- made appointments?
- left your itinerary and expected departure/arrival times?
- told colleagues, manager about possible changes of plans?
- arranged for contact if your return is overdue?

Do you have:

- forms on which to record and report incidents?
- a personal alarm or radio? Does it work? Is it handy?
- a bag/briefcase, wear an outer uniform or car stickers that suggest you have money or drugs with you? Is this wise where you are going today/tonight?
- out of hours telephone numbers to summon help?

Can you:

- be certain your attitudes, body language, etc. won't cause trouble?
- defuse potential problems and manage aggression?

Consent to treatment

Mental capacity

If a person is mentally capable, he or she is entitled to make their own decisions.[75] A person who has the necessary mental capacity can refuse treatment for a good reason, a bad reason or no reason at all.[76,77] (This is considered further in chapter 7.) However, it is essential that the capacity of the individual to make decisions is assessed by the health professional since if the person lacks the mental capacity then action has to be taken in their best interests.[78,79] The Mental Capacity Act 2005 applies where a person lacks the requisite mental capacity to make decisions (see chapters 7 and 17). In Practical Dilemma 23.4 it may be that Albert lacks the mental capacity to decide whether or not to take his medication and therefore action must be taken in his best interests in accordance with the Mental Capacity Act 2005. The principles and basic provisions of the Act are considered in chapter 7 and the provisions relating to the loss of liberty for those incapable of giving consent, but who are not detained under the Mental Health Act 1983 (known as the Deprivation of Liberty Safeguards (DoLS)), are considered in chapter 17. Alternatively, if the treatment is for mental disorder, then the provisions of the Mental Health Act 1983 as amended may apply (see chapter 20).

Mentally disordered

In chapter 20, which deals with the psychiatric nurse, the problem of giving drugs in the community is discussed. Medication can only be given without consent if it comes within the provisions of the Mental Health Act 1983 as amended by the Mental Health Act 2007 or under the provisions of the Mental Capacity Act 2005 where a person lacks the requisite mental capacity and action is taken in his or her best interests. The Mental Health Act 2007 has introduced a new community treatment order which replaces the provision for aftercare under supervision. In Practical Dilemma 23.4, if the treatment is for mental disorder and Albert continues to refuse to take it, he could be admitted to a mental hospital as an inpatient in order to be treated compulsorily.

Forcible entry

Another point that often concerns the community nurse and the health visitor is whether they have any rights of entry. As far as the statutory law is concerned, the answer is no. There may be a power of entry at common law where it is feared that an old person is in need of help, but it exists only in an emergency to save life.

Practical Dilemma 23.5 A row of bottles

Neighbours drew the attention of the community nurse to a row of bottles outside the house of an elderly recluse. They feared for her safety and suggested that they should break into the house to check that all was well. The community nurse was hesitant.

In a case like this, it is preferable from the practical, as well as the theoretical, point of view for the police to be summoned. Their involvement would provide legal justification (under the Police and Criminal Evidence Act 1984 s. 17(e)) as well as facilitating physical entry to the premises. Social workers have statutory powers of entry under specific conditions, but health workers do not.

Compulsory removal

Under the Mental Health Act 1983

Practical Dilemma 23.6 Refusal to leave

Laura Thomas, a community nurse for the mentally ill, was notified that two sisters who were regarded as recluses had not been seen for several days. Neighbours reported that a number of cats were howling around their home and that the curtains had not been drawn for three days. Laura was also informed that of the two sisters, Annie, the younger one, was considered to be a manic-depressive. Laura went to the house and the door was answered by Agnes. She was abrupt and unwelcoming. When asked about her sister, she said they did not want nosey-parkers and they were quite happy. From the doorway, Laura could see that the house was in a dirty condition and Agnes herself was in a dishevelled state. She feared for the physical and mental well-being of Annie. What could she do?

As a community nurse, Laura has no power to enter the house. However, powers do exist: under section 115 of the Mental Health Act 1983 as amended by the Mental Health Act 2007, an approved mental health professional (AMHP) (replacing the approved social worker under the 1983 Act) may, at all reasonable times after producing, if asked to do so, some duly authenticated document showing that he is such an AMHP, enter and inspect any premises (not being a hospital) in the area of that authority in which a mentally disordered patient is living, if he has reasonable cause to believe that the patient is not receiving care. This power enables the AMHP to inspect premises, other than hospitals, where a mentally disordered person is living. It does not, however, give the right to enforce entry, but refusal to permit the inspection could constitute an offence under section 129 of the Mental Health Act 1983. Premises are not defined, but could include private premises, provided a mentally disordered person is living there and provided there is reasonable cause to believe the patient is not under proper care. Laura would therefore have to arrange for an AMHP to visit the home. If entry were obstructed under section 115, the AMHP would have to make use of her power to apply to the justice of the peace for a warrant to search and remove patients under section 135 (see page 552). The AMHP would have to give information on oath that there is reasonable cause to suspect that a person believed to be suffering from mental disorder:

(a) has been, or is being, ill-treated, neglected, or kept otherwise than under proper control, in any place within the jurisdiction of the justice; or
(b) being unable to care for himself, is living alone in any such place.

The justice may then issue a warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be and if it is thought fit to remove him to a place of safety with a view to the making of an application for his care and treatment. An AMHP must accompany a constable. If it is thought fit, Annie could be removed to a place of safety and kept there for up to 72 hours under section 135(3). (See chapter 20.)

Under the National Assistance Act 1948

The provision of the Mental Health Act described in the last paragraph can be used only in the case of a person believed within the meaning of the Act to be suffering from mental disorder. There are occasionally cases where those powers are not appropriate. In the above situation, it may well be that, although Annie suffers from learning disabilities and may well come within the definition of suffering from mental disorder, Agnes might not, but she might equally be in need of help.

Section 47 of the 1948 Act which authorised the removal to suitable premises of persons in need of care and control to secure the necessary care and attention is abolished for England by section 46 of the Care Act 2014. The Law Commission which had recommended the repeal also suggested that the situation should be reviewed to see if any statutory emergency powers were required.[80]

The coroner urged the government to issue new guidelines on how to interpret legislation. Mayan Coomeraswamy, a 51-year-old suffering from schizophrenia, was found dead in a damp, freezing, squalid flat, with mould growing on the floor and exposed electrical wires. The bathroom ceiling had collapsed, the boiler broken down and neighbours were complaining about the smell. The LA staff felt that they had to respect his right of choice because he was considered to have sufficient mental capacity.[81] The case illustrates the apparent conflict between human rights legislation and the powers under section 135 of the Mental Health Act 1983 and section 47 of the National Assistance Act 1948 (now repealed under section 46 of the Care Act 2014).

Protection of property

If both Annie and Agnes were removed from the house, what happens to their home?

Under section 48 of the National Assistance Act 1948, the council had a duty to provide temporary protection for the property of persons admitted to hospitals. This section is now replaced by section 47 of Care Act 2014 which places upon the local authority a duty in relation to the property of those transferred to hospital or residential care home. The care of patients' and residents' property is considered in chapter 25.

Disclosure of information

This topic is discussed in chapter 8 where an example of the problems faced by community staff is considered (see Practical Dilemma 8.6). The specialist community public health nurse is more likely to be required to give evidence in court than any other community worker and should refer to chapter 9 on giving evidence in court. The policy that she should wait to be subpoenaed before giving evidence in cases involving children has changed because of her duty to the child under the Children Act 1989.

Criminal suspicion

Community nurses often work alone and if they are charged with theft it is one professional's word against that of the client or relative. In a case like Practical Dilemma 23.7, Kate could well have been accused of theft by the old lady herself if she was at all absent-minded and had forgotten what she had done. The safest rule is therefore never to accept gifts, even though this might distress the client.

If the client is insistent and wishes to make a generous gift, then a health service manager could be called in to give advice, but the client should be represented, since if there were any evidence of undue influence the gift would be voidable. The NMC in its Code of Practice[82] under the heading 'Maintain professional boundaries' states that:

> **You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment.**

The legal issue of gifts and favours is considered in chapter 25.

Practical Dilemma 23.7 Suspected

Kate Giles was a community nurse who had long been visiting an elderly widow who appeared to have no family apart from two grandchildren, who rarely visited, and few other visitors. One of Kate's tasks was to dress the client's leg. On one occasion, the client was anxious to point out some of her treasures to Kate. They included some very fine pieces of bone china. It was suggested to Kate that she might like to have a tiny cat as a small gift. Kate protested that she was not allowed to receive gifts from clients. Her protests were ignored and the old lady wrapped the gift up in an old paper bag and gave it to Kate. Kate forgot to mention it to her nursing officer the next day and after that it seemed too small a matter to be of any concern. Shortly after this the old lady died. The grandchildren discovered that a piece of Spode was missing. They made some enquiries and Kate stated that she had been given it by the elderly lady, but that they would, of course, be entitled to have it back. Kate was severely reprimanded and the grandchildren said they did not believe her story, since the old lady had never been known to give anything away; they suggested that Kate had, in fact, stolen the china.

Standards: care homes

The Health and Social Care Act 2008 and Health and Social Care Act Regulations 2009 amended the Care Standards Act 2000 so that from April 2010 regulated health and from October 2010 adult social care providers have been required to register with the Care Quality Commission and comply with new essential common quality standards. From April 2011 GP and dental health practices have also been required to register with the CQC. The CQC has issued guidance which makes the registration requirements clear to providers. The guidance signals an important shift away from measuring systems and processes towards measuring outcomes for people who use services. The CQC can enforce compliance with the registration requirements and the guidance by imposing conditions on the registration, fines and ultimately cancellation of the registration. Further information can be obtained from the CQC website.[83] See also chapter 5.

It was reported in March 2014 that the NHS is investigating that GPs are charging residential homes for visits to their clients which should be free. Ministers are working with CQC and NHS England to prevent abuses.

Prosecutions against care home managers and owners can also be brought under section 44(2) of the Mental Capacity Act 2005 which came into force in April 2007 and which creates a criminal offence of ill-treating or wilfully neglecting a person who lacks capacity. Cases brought under section 44(2) are discussed in chapter 19 (see pages 524–5).[84]

In May 2010 the manager of a care home was jailed for 10 years after the death of an elderly resident.[85] She was found guilty of manslaughter. Evidence showed that she had stolen patients' drugs, forged medical records and lied to investigators who were investigating suspicious deaths at the care home.

In 2013 the Chief Inspector of Social Care stated that care services will have to satisfy a test of 'good enough for my Mum' and announced that inspections by the CQC will be done by specialist inspectors and accompanied by residents and carers. Every home and agency will be graded on a four-point rating system.[86]

A report from the International Longevity Centre and Anchor in February 2014 suggested that a million extra care workers will be needed to meet the needs of the ageing population by 2025 and more men must be prepared to work in the care sector.[87]

A narrative verdict was recorded by a coroner holding an inquest into the death of a woman who died of malnutrition a day after being admitted to hospital from a care home. The coroner said that he would write to the local health authorities and police to raise his concerns about the care that Mrs Willits, who had been categorised as a high-risk patient, received at Ashbourne Nursing Home in Rochdale.

NICE methods and processes are to be used by the NICE Collaborating Centre for Social Care to develop social care quality standards.

Case 23.7 illustrates the means of enforcement of the duty of the local authority has to make an assessment of community care needs.

Case 23.7 *R (on the application of Ireneschild) v. Lambeth* (2006)

Rehousing request refused[88]

A claimant, X, succeeded in an application for judicial review of a community care assessment by Lambeth LBC which had refused a rehousing request. X was incontinent and unable to stand or walk unsupported following an accident and lived in a flat. An assessment in 1999 noted that there were concerns about her accommodation and in 2003 an occupational therapist recommended that she be rehoused. However, in 2006 an assessment held that there was no eligible need arising from her accommodation. The judge held that the local authority had failed to take into account the history of her falls and issues relating to manual handling in her two sons, her carers, having to take her upstairs; had failed to follow the relevant guidance; and had failed to give her an opportunity to participate in the assessment process.

Community matrons

The NHS Improvement Plan for 2004 envisaged the use of community matrons to provide case management of people with long-term conditions. Community matrons would be experienced, skilled nurses who would have the following functions:

- Use data to actively seek out patients who will benefit from the case management approach
- Combine high-level assessment of physical, mental and social care needs
- Review medication and prescribe medicine via independent and supplementary prescribing arrangements
- Provide clinical care and health-promoting interventions
- Coordinate inputs from all other agencies, ensuring all needs are met
- Teach and educate patients and their carers about warning signs of complications or crises
- Provide information so patients and families can make choices about current and future care needs
- Are highly visible to patients, and their families and carers and are seen by them as being in charge of their care
- Are seen by colleagues across all agencies as having the key role for patients with very high intensity needs.

The result of the employment of community matrons was expected to be the prevention of unnecessary admissions to hospital, a reduction in the length of stay in hospital, improved outcomes for patients, the integration of all elements of care, an improvement in patients' ability to function and their quality of life, helping patients and their families plan for the future, increase choice for patients, enable patients to remain in their home and communities and improve end-of-life care.[89] Best practice guidance was issued by the Department of Health in April 2006 to provide a framework for commissioners and providers of education and training for community matrons and case managers.[90] A report on nurses as case managers in primary care and their contribution to chronic disease management for the National Institute for Health Research in 2010 found that while their role was extremely significant it was undermined by continued organisational experimentation.

The specialist community public health nurse

The specialist community public health nurse (SCPHN) has been defined by the specialist community public health nursing committee as follows:

> **Specialist Community Public Health nursing aims to reduce health inequalities by working with individuals, families, and communities promoting health, preventing ill health and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of whole populations.**

Standards were set for SCPHNs by the NMC in 2004 and can be downloaded from the NMC website. Guidance has also been issued for nurses working in public health or as school nurses and occupational health nurses for them to qualify as SCPHNs.[91] In 2012 the NMC published clarification of admission criteria to SCPHN programmes.[92] Entrants to the SCPHN programmes must be a first-level nurse or midwife before being accepted onto a SCPHN programme. The RCN published a fact sheet in February 2013 on specialist nursing in the UK. In 2012 there were 27,133 nurses on the register with a SCPHN qualification. Ten key areas of public health practice form the basis for the SCPHN qualification:

1. Surveillance and assessment of the population's health and well-being
2. Promoting and protecting the population's health
3. Developing quality and risk management within an evaluative culture
4. Collaborative working
5. Reducing inequalities by developing programmes and services
6. Policy development and implementation
7. Working with and for communities
8. Strategic leadership for health
9. Research and development
10. Ethically managing self, people and resources.

In England, specialist community public health nurses are being transferred to the employment of local authorities who are taking over responsibilities for public health. (See chapter 26.)

The school nurse

The traditional role of one school nurse per school with a wide job description has generally been replaced by a nurse with responsibility for several schools, but having an advisory and teaching role rather than seeing children individually and with no direct involvement in first aid for pupils. She may be employed by the NHS (but increasingly now by local authorities), but works within an educational environment, which could cause tension, as the discussion on Case 23.8 shows. The Department of Health stated that in March 2006 there were 2,409 school nurses in England and it was the intention of the joint strategy of the Department for Education and Skills (now the DE) and the Department of Health to increase these numbers. The aim of the strategy was that there should be at least one full-time qualified nurse working with every cluster of primary schools and their related secondary schools by 2010. *Looking for a School Nurse*[93] was published by the government in 2006, aimed at head teachers and setting out the advantages and practical considerations of employing a school nurse.

Extent of duty

Case 23.8 An asthma attack[94] (2010)

A boy suffering from asthma had been left to wait in a hallway while having an attack. The emergency services were not called. The inquest jury found that staff had failed to implement the asthma policy, were not sufficiently trained to deal with asthma and that a healthcare plan was not in place. The jury found that the boy had died of natural causes but that neglect at an individual and systemic level had been a significant contributory factor. The headmistress and four school staff were suspended.

In this tragic situation, many different questions arise. There is no mention of a school nurse but, if one had been appointed, what should have been her role? Is she on call for the whole time in school hours, waiting for such an emergency to arise? Many would say no, but it does depend, of course, on the individual employment contract and job description. The role she plays as far as teaching is concerned also varies from school to school. In some, she might take on the task of teaching such subjects as personal hygiene, health education, sex education, biology, etc. Where she is undertaking this role, it can hardly be expected that she will be fulfilling an emergency first aid role as well. There would appear to be failure by the school and the education authority to provide a basic first aid training for staff, especially when it would have been known that the boy was asthmatic, and to provide a system for dealing with such emergencies.

Details of a school nurse practice development resource pack (updated in 2006), a health visitor and school nurse development programme and primary school/primary health links projects operating with the Health Schools Standard are available from the Department of Health website.[95] This was followed in 2012 by a DH publication *Getting it right for children, young people and families* which provided school nursing with a framework of the services it could provide. To complement this framework, the RCN developed in 2013 a comprehensive tool kit for school nurses.[96] In 2012 the RCN published a UK-wide position statement on school nursing.[97] In 2014 Public Health England produced several documents on school nursing and public health services covering a variety of issues: maximising the school nursing team contribution to the public health of school-aged children; promoting emotional well-being and positive mental health; developing strong relationships and supporting positive sexual health; and supporting the health and well-being of young carers. They are designed to support effective commissioning of school nursing services to provide public health for school-aged children and are obtainable on the government website.[98] School nurses, like health visitors, are now increasingly employed by local authorities which have responsibility for public health. (See chapter 26.)

Use of car

Like any community worker, a school nurse must ensure that she has the appropriate insurance policy to cover all the uses that she is likely to make of a car for work purposes.

Practical Dilemma 23.8 Car insurance

A child, Mary Pugh, cut her head very badly in the gymnasium. The children had been told to trot around like ponies with their heads up high. Mary trotted straight into the teeth of another child. Blood gushed from the wound. Audrey, the school nurse, realised the importance of getting her to the A&E department for stitches. She put the child in her own car and rushed to the local hospital. In her haste, she

came out of a side road too quickly and crashed into a motorcyclist coming along the main road. She got out of the car to see what could be done and, seeing that other people had gathered around, she decided that it was her duty to get Mary to hospital. Subsequently, she was notified that the police were charging her with failing to report an accident and having no adequate insurance cover. Relatives of the motorcyclist were also intending to sue her for causing the accident and failing to provide assistance, since the ambulance had taken 20 minutes to arrive and the cyclist had bled to death.

Any employee who does not usually use their car for work, other than going to and from work, would be well advised to ensure that insurance cover is provided for the exceptional circumstance when a car might be needed. Clinic nurses other than peripatetic nurses, school nurses or outpatient nurses might all find that on very rare occasions they need to use their car for work purposes and then they are not covered. The effect is that, although the insurance company may pay out compensation to the victim, it has the right to claim this money back from the person whose insurance did not cover this use. (If the company refuses to pay out compensation, compensation for physical injuries may be payable by the Motors Insurance Bureau.) If exceptional use of a car is foreseeable, it is wiser for the nurse to ensure that her insurance company is notified of this possibility.

As far as the failure to report the accident is concerned, it is a duty under the Road Traffic Act 1988 as amended to ensure that the police are notified of any accident in which personal injuries are caused. Audrey's failure to ensure that this was done could lead to a successful prosecution. Her failure to stop and help the cyclist is a difficult question. On the one hand there is no legal obligation to volunteer help, but the NMC considers that a professional duty exists at all times (see chapter 3). In this case Audrey caused the harm and is under a legal obligation to mitigate it as far as possible but she also has a duty to Mary and it is a question of assessing who is in most need. From the facts given here, it would appear that the cyclist was in more danger and Audrey should have checked that there was nothing she could do before she went away.

The clinic nurse

Clinic nurses may spend their time in one clinic assisting at mother and baby clinics, be attached to specialist clinics such as family planning clinics or travel from school to school, assisting the school doctors in provision of medical, eye and other examinations for schoolchildren.

Obtaining consent

Practical Dilemma 23.9 Consent to rubella vaccinations

Brenda West provided nursing assistance to the medical team that carried out the school medical examinations. One of their tasks was to offer the Year 8 girls a rubella vaccination. Letters were sent to the parents in advance, advising them of the service and asking for their consent. Unfortunately, Brenda failed to notice that the parents of Rachel Tyne had not signed the consent form and Rachel was given an injection by the school doctor. Shortly afterwards, Rachel came out in an all-over rash. Investigations were made and it appeared that Rachel had recently had a variety of drugs in anticipation of a holiday to Morocco and these had reacted with the rubella vaccination. The parents were threatening to sue since they did not want Rachel to have the vaccination as she had had German measles a few years before. They also felt that the doctor and nurse should have checked with them before they gave the vaccination to ensure that there were no contraindications.

There are two separate issues here: the one is the consent of the parents; the other is the timing of the vaccination. As far as consent is concerned, the basic principles are that parents have the right to consent to treatment for their children. As far as school health is concerned, it could be argued that under the Education Acts the school can provide the care as long as the parents do not object. This may well cover medical examinations, but is unlikely to cover the giving of injections. Some schools rely on a passive consent. A letter is sent saying: 'We intend to examine and give your child X on . . . If you do not consent, please contact . . .'

However, if the vaccination is to proceed, it is essential that actual consent should be obtained, that any potential contraindications are identified and that the parents advise the school of any recent events in the child's medical history that suggest that a vaccination would be inappropriate at that particular time or, indeed, at any time. Because of the importance of this, it is advisable for the parents to give positive consent to the vaccination and reassure the staff about the non-existence of any contraindications. A child who is Gillick-competent (see chapter 13) could give a valid consent to treatment which is in her or his best interests. The government has prepared a consent form for HPV for the parent to be signed which can be downloaded from its website.[99]

As far as responsibility between the nurse and the doctor is concerned, much depends on the local policy in relation to who has the duty of ensuring that the parents' consent has been obtained. In some authorities, this would fall on the doctor. However, this does not necessarily mean that the nurse is free of all liability.

Minors

Practical Dilemma 23.10 Family planning and the under-16-year-old

Maureen was working as a clinic nurse in the family planning clinic. She recognised one of the patients, Denise Wright, as a friend of her eldest daughter, aged 15. She completed the forms and the girl told her she was 17. Maureen knew that this was a lie. She was uncertain whether to tell the doctor and decided against this. The doctor prescribed the pill and asked Denise the name of her family doctor. Denise said she did not have one. She said she did not want any communication with her family and the doctor said that would not be necessary if she was over 16.

Several issues arise here. One is the question of the nurse's personal knowledge and the extent to which she should inform the doctor of this. The other is the question of the law relating to an under-16-year-old in this context (see chapter 13). From the House of Lords' decision in the Gillick case, it can be seen that treatment and advice can be given to a girl under 16 without the parents being involved, provided that she has the requisite capacity to give consent.

As far as the first issue is concerned, it could be argued that even though the nurse has acquired information about the patient from a different source, if this is relevant to the doctor's care and treatment of the patient, then it should be disclosed, i.e. her duty of care to the patient would require her to tell the doctor that the girl was 15. Similarly, if she knew that the girl suffered from epilepsy, even though the girl had not told the doctor this, the nurse should pass on the information. It could be argued that this principle applies only to information that is relevant to the care of the child. Thus, if she by chance knew that the girl had been charged by the police for shoplifting, this need not be passed on.

The Children Act 1989 requires decisions relating to children to take into account the wishes of the child where the child has the capacity.

The practice nurse

The legal situation of the practice nurse can vary, especially as far as employment rights are concerned. Some practice nurses may be employed by a single-handed or group general practitioner; others are employed by clinical commissioning groups (CCGs). Practice nurses employed by CCGs are more likely to be part of a nursing hierarchy and to receive guidance and policies from the employer. Recent years have seen a considerable growth in the educational and management support provided to practice nurses. In many areas, a practice liaison nurse is appointed to provide assistance and professional advice across the CGT area(s). A dedicated website for practice nurses[100] provides a forum for exchanging information. The RCN also has a Practice Nurses' Association[101] providing updates on the significance of the Francis and CQC reports (see chapter 5) and gives information about the Winston Churchill Memorial Trust's Travelling Fellowships.

Scope of professional practice and the practice nurse

Like other nurses, practice nurses are finding that their scope of professional practice is expanding as they are required to undertake a wider range of responsibilities. While practice nurses were not identified in the First Crown Report on nurse prescribing as one of the groups able to prescribe in the community, they were, together with nurses working in walk-in centres, added to the list of nurses who could prescribe in February 2000. The Final Crown Report envisages that many different health professionals will be recognised as dependent or independent prescribers. (This is discussed further in chapter 28. Legal issues relating to the scope of professional practice are considered in chapter 24; see especially pages 658–60.)

Cervical screening

The practice nurse may be required to undertake cervical screening. It is essential that they have appropriate approved training. A practice nurse in Birmingham, who had been taught by her GP to undertake cervical screening, was discovered to be using the spatula by the wrong end and her failure to take the correct samples led to non-diagnosis of several women with cervical cancer.

The standard required in cervical screening came before the courts when East Kent Health Authority was alleged to have been liable for the negligent examination of cervical smears, as explained in Case 23.9.

Case 23.9 *Penney, Palmer and Cannon* v. *E Kent Health Authority* (2000)

Cervical screening[102]

The claimants brought an action on the grounds that their cervical smears were negligently examined and reported as negative between 1989 and 1992. As a consequence, they were deprived of the opportunity of obtaining early treatment that would have prevented the development of endocervical carcinoma. Screening was carried out by qualified biomedical scientists or by qualified cytology screeners. They were not qualified to diagnose; their only function was to report what, using their expertise, they were able to see. If the screener detected an abnormality in the smear or was in doubt whether what he saw was abnormal, he had to pass the smear on to a senior screener known as a checker. The cervical screening programme guidelines required an absolute confidence test. The trial judge decided that this absolute confidence test had not been complied with and found for the claimants.

The judge preferred the views of the claimants' experts as to whether, in the light of what the cytoscreeners saw, it was negligent to fail either to classify the smears as borderline or to refer the smears

to the checker and/or to the pathologist. The Bolam Principle did not apply because the Bolam Test was concerned with acceptable and unacceptable practice, whereas no question of acceptable practice arose in the instant case because the cytoscreeners were wrong in their classification of the smears. Even if the Bolam Principle were relevant, the defendant's experts' views did not stand up to logical analysis because the cytoscreeners did not have the ability to draw a distinction between benign and pre-cancerous cells and so should have classified the smears as borderline.

The Court of Appeal dismissed the appeal and upheld the finding that the health authority was liable. It held that the Bolam Test was appropriate where the exercise of skill and judgement of the screener was being questioned. In this case, however, the Bolam Test did not apply since the screeners were not expected to exercise judgement.

It was announced in 2000 that the government was to introduce a pilot study of a new form of cervical screening, liquid-based cytology (LBC), together with tests for the virus HPV that causes cervical cancer. The National Institute for Health and Care Excellence has suggested that LBC could increase the sensitivity of the slides, reduce the number of badly taken smears and improve the speed and accuracy with which cytoscreeners can read the slides.[103] The Department of Health has established a website for information on cancer screening.[104] See also information on specialised websites.[105]

Staffing concerns

Concerns about nurse and general practitioner numbers are growing. The numbers of district nurses who hold the specialist practitioner qualification (SPQ) has declined by 40 per cent over the last 10 years.[106] Yet the Department of Health in its 2013 Report[107] sees district nurses as key professionals in the delivery of care closer to home. Their significance in the present strategy of shifting patients from hospital to the community for treatment is undeniable. The RCN has provided guidance on their role.[108] The Queen's Nursing Institute has also painted a picture of the skills necessary and the tasks faced by district nurses.[109] At least 50 per cent of nurses will do community placements during their training to encourage them to work in local clinics rather than hospitals.[110] The Department of Health has given instructions to Health Education England that half of all medical students should train to become GPs so that there are 2,000 more family doctors by 2018 while more than 100,000 NHS staff will have more training on treating people with dementia. In June 2013 the Academy of Royal Colleges, the NHS Confederation and the patient group National Voices all agreed that resources must be transferred from hospitals to GP surgeries, health centres and district nurses. This was the only way the NHS could survive and meet the demographic changes ahead.[111] A survey by the National Nursing Research Unit at King's College London found that many district nurses did not have time to answer patients' questions, talk about their condition or offer emotional support.[112]

Developments in technology and structure

Major developments are also taking place in technology which could have significant implications for professional practice. For example, NHS North East Essex has launched a fully fledged tele-health service in partnership with Tunstall Healthcare. Over six months the average number of GP visits made by patients had fallen by 66 per cent, the average number of patient hospital attendances or 999 call-outs was down 44 per cent and the average number of home visits required had dropped by 19 per cent. Increased use of IPads and similar devices are changing the methods of communication and have considerable implications for the record keeping of community staff.

Social enterprise groups

We are also seeing a development, especially in the community, where staff are taking over the running of certain services on a cooperative basis. For example, in Central Surrey Healthcare 700 nurses have

taken over the community services across most of the county. They each open a 1p share in the not-for-profit company which provides £26 million of services each year. The buildings, equipment and pensions remain the responsibility of the NHS; the co-owners are in charge of running the services.[113] Such schemes increased following the implementation of the White Paper published in 2010 and the Health and Social Care Act 2012.

Social Enterprise UK[114] is collaborating with CCGs in Building Health Partnerships programmes between CCGs and local voluntary and community and social enterprise organisations to improve health in local communities. One example given is that of a social prescribing project in City and Hackney to improve the health of isolated over-50s and people with type 2 diabetes.

Conclusions

The Care Act 2014 represents a major development in the law relating to care in community implementing the Law Commission's recommendations[115] of a single statute on adult social care supported by regulations and guidance. At the time of writing, consultation on the regulations which will determine the detailed provision of the Care Act 2014 is still taking place. The outcome of those discussions will determine how successful the Care Act is. Many provisions are still to come into force and it remains to be seen how far the deferred payment scheme protects residential care clients from heavy financial burdens.

Reflection questions

1 You break an ornament while visiting a patient. The ornament is valued at £5,000. You are personally unable to meet the costs of replacing it. What remedies are available to the owner of the ornament? (See also chapter 25.)

2 What special concerns does the community professional have in relation to health and safety and what specific precautions should be taken to protect her? (Refer also to chapter 12.)

3 What difficulties, if any, arise from the fact that the school nurse is now employed by the local authority but works with education authority staff as a health professional? Could the school nurse refuse to undertake tasks allocated by the head teacher? What are the likely implications?

4 What differences exist in law between the clinic nurse who spends all her time in a clinic and the nurse who visits patients in their own homes?

5 Consider the expanded-role activities that are sometimes undertaken by the practice nurse or community nurse and outline the legal requirements. (See chapter 24.)

Further exercises

1 As a community nurse, you visit a patient who appears to you to be incapable of caring for herself. What action would you take? Outline a procedure to cover the situation if the patient shows extreme reluctance to move from her home and there are no relatives to care for her.

2 What procedures would you follow in assessing a patient for community care? What criteria are used to decide if the patient is entitled to long-term NHS care?

3 What are the implications of the Care Act 2014 for your work as a community nurse? In what way do the provisions of the Act affect your professional practice and the quality of care provided to the patient?

4 Access the CQC website and find out its powers in relation to the registration and inspection of residential care homes.

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Chapter 24

Scope of professional practice, clinical nurse specialist and consultant nurse

This chapter discusses

- Scope of professional practice
- Delegation and supervision
- Nurse consultants
- Clinical nurse specialists and specialist nurses
- Concerns about developments in scope of professional practice
- Scope of professional practice in primary care
- Scope of professional practice in theatre nursing
- Scope of professional practice in emergency nursing
- Scope of professional practice and X-rays
- NHS 111 (formerly NHS Direct) and walk-in clinics
- Modern matrons
- Clinical supervision
- Agency nurses
- Healthcare support workers

Introduction

The government's plans for the NHS as shown in the White Paper in 1997,[1] in the document *Making a Difference*[2] and in the NHS Plan[3] relied heavily on a widened scope of practice for the nurse. NHS 111 (formerly NHS Direct) and walk-in clinics are run by nurses and provide an increasingly extensive and popular service. As a consequence of these developments, the role of the nurse has changed and is changing radically and these changes have major legal implications. This chapter considers the background to the scope of professional practice and the NMC advice, the role of the consultant nurse and clinical nurse specialist. One development in the scope of professional practice is the change in nurse prescribing and this is considered in chapter 28.

Scope of professional practice

In June 1992, the UKCC (the predecessor to the NMC) published the *Scope of Professional Practice*. It marked a major development in the thinking underlying professional practice. Previously, the concept of the extended role highlighted the distinction between the basic training that the practitioner received in order to become a registered professional and post-registration training. Under 'the extended role', professional development was seen as incremental, task-oriented and often delegated from other professionals (usually medical). A circular in 1977 (CHC (77)22) gave advice on extended role tasks. This advice has now been superseded by subsequent developments on the scope of professional practice.

In 1986, a working party was set up by the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Committee to review the extended role of the nurse. Its report was circulated under cover of a DHSS letter from the Chief Nursing Officer, dated 26 September 1989, and it paved the way for the publication of the UKCC's *Scope of Professional Practice*.

The UKCC emphasised that professional practice must be sensitive, relevant and responsive to the needs of individual patients and clients and have the capacity to adjust, where and when appropriate, to changing circumstances (paragraph 1). It set out principles that should govern adjustment to the scope of professional practice (paragraph 9). These are laid out in Box 24.1. The *Scope of Professional Practice* should be seen in the light of the new Code of Professional Conduct drawn up by the NMC.[4] Under the heading 'Provide a high standard of practice and care at all times' it states:

Keep your skills and knowledge up to date

- **You must have the knowledge and skills for safe and effective practice when working without direct supervision**
- **You must recognise and work within the limits of your competence**
- **You must keep your knowledge and skills up to date throughout your working life**
- **You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.**

Where an aspect of practice is beyond the practitioner's level of competence or outside one's area of registration, then the registered professional must seek help and supervision from a competent practitioner, until the practitioner and her employer consider that the requisite knowledge and skill have been acquired. The NMC also recognises a duty for the practitioner to facilitate students and others to develop their competence. In requiring practitioners to provide a high standard of practice and care at all times, the NMC states that the practitioner must use the best available evidence:

- **You must deliver care based on the best available evidence or best practice.**
- **You must ensure any advice you give is evidence based if you are suggesting healthcare products or services.**

Box 24.1 Principles for adjusting the scope of professional practice

The registered nurse, midwife or health visitor:

1. must be satisfied that each aspect of practice is directed to meeting the needs and serving the interests of the patient or client
2. must endeavour always to achieve, maintain and develop knowledge, skill and competence to respond to those needs and interests
3. must honestly acknowledge any limits of personal knowledge and skill and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients and clients
4. must ensure that any enlargement or adjustment of the scope of personal professional practice must be achieved without compromising or fragmenting existing aspects of professional practice and care and that requirements of the Council's Code of Professional Conduct are satisfied throughout the whole area of practice
5. must recognise and honour the direct or indirect personal accountability borne for all aspects of professional practice
6. must, in serving the interests of patients and clients and the wider interests of society, avoid any inappropriate delegation to others that compromises those interests.

The post-registration education and practice (PREP), which is the NMC's framework for continuing education, includes a duty on practitioners to have at least five refresher days every three years (now 35 hours of learning activities). Implementation commenced in April 1995. Undoubtedly, there are opportunities for nursing, midwifery and health visiting to develop safely beyond the original boundaries. It enables professional practice to develop naturally into areas that were once seen as delegated medical tasks; it moves development away from new tasks to a more holistic view of professional practice relevant to a nurse, midwife or health visitor (since 2004 known as the specialist community public health nurse, SCPHN). A revised handbook for PREP was published by the NMC in 2008 and revised in 2010. It is available on the NMC website (see chapter 11).

The NHS Plan,[5] published in July 2000, envisaged that within the reformed NHS there would be radical changes in the ways in which staff work. The NHS Modernisation Agency (set up by the government to plan and implement the changes) led a major drive to ensure that protocol-based care took hold throughout the NHS. A statement on the future direction of the NHS Modernisation Agency was published by the DH in 2005 which envisaged the original organisation being replaced by a new central organisation smaller than the Modernisation Agency with a focus on innovation and an emphasis on local implementation. The NHS Quality Board is part of the DH Measuring for Quality Improvement initiative which identifies and develops quality indicators. Two hundred indicators were initially published. The 2010 annual report of the NHS Quality Board is available on the NHS England website. Reference should also be made to the Department of Health's essence of care benchmarks which were first published in 2001[6] and updated in 2010 (see chapter 3).

The new approach to the scope of professional practice shattered old demarcations that have held back staff and slowed down care. NHS employers are required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks, including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs. The inclusion of the suitably experienced nurse with the consultant and GP in identifying those responsible for making decisions on cardiopulmonary resuscitation[7] (see chapter 29) is a natural development of the scope of professional practice of the registered nurse. It is the responsibility of the individual nurse to ensure that she has the requisite competence to make such a decision.

The 10 key roles identified for the nurse by the Chief Nursing Officer and set out in the NHS Plan are shown in Box 24.2.

Box 24.2 Ten key roles for nurses in the NHS Plan

1 To order diagnostic investigations such as pathology tests and X-rays.
2 To make and receive referrals direct, say, to a therapist or pain consultant.
3 To admit and discharge patients for specified conditions and within agreed protocols.
4 To manage patient caseloads, say for diabetes or rheumatology.
5 To run clinics, say for ophthalmology or dermatology.
6 To prescribe medicines and treatments.
7 To carry out a wide range of resuscitation procedures, including defibrillation.
8 To perform minor surgery and outpatient procedures.
9 To triage patients using the latest IT to the most appropriate health professional.
10 To take a lead in the way local health services are both organised and run.

Delegation and supervision

The scope of professional practice of individual health professionals cannot be expanded unless there is either an increase in those registered professionals or activities are delegated to others such as healthcare assistants or support workers. The Bolam Test (see chapter 3) applies to the delegation of activities. It is the personal and professional responsibility of each practitioner who delegates activities to ensure that the person to carry out that activity is trained, competent and has the necessary experience to undertake the activity safely. The delegating practitioner must also ensure that the appropriate level of supervision is provided.

In its Code published in 2008[8] the NMC states:

- Delegate effectively
- You must establish that anyone you delegate to is able to carry out your instructions
- You must confirm that the outcome of any delegated task meets required standards
- You must make sure that everyone you are responsible for is properly supervised and supported.

The NMC issued advice for delegation to non-regulated healthcare staff in 2007[9] which is available on its website. It has also updated its A to Z guidance[10] (now replaced by guidance leaflets) which defines delegation as:

> **Delegation – the transfer to a competent individual, the authority to perform a specific task in a specified situation that can be carried out in the absence of that nurse or midwife and without direct supervision.**

The guidance considers the accountability and responsibility of the delegator, the documentation required and the principles which apply to delegation. It sets out 10 principles for nurses and midwives to follow when delegating to non-regulated healthcare staff. These principles are as follows:

1 The delegation of nursing or midwifery care must always take place in the best interests of the patient or client and the decision to delegate must always be based on an assessment of the individual patient or client's needs.
2 Where a registrant has authority to delegate tasks to another, they will retain responsibility and accountability for that delegation.
3 A registrant may only delegate an aspect of care to a person whom they deem competent to perform the task and they should assure themselves that the person to whom they have delegated fully understands the nature of the delegated task and what is required of them.

4 Where another, such as an employer, has the authority to delegate an aspect of care, the employer becomes accountable for that delegation. The registrant will, however, continue to carry responsibility to intervene if she feels that the proposed delegation is inappropriate or unsafe.
5 The decision whether or not to delegate an aspect of care and to transfer and/or to rescind delegation is the sole responsibility of the registrant and is based on their professional judgement.
6 The registrant has the right to refuse to delegate if they believe that it would be unsafe to do so or is unable to provide or ensure adequate supervision.
7 It is essential that those delegating care, and those employees undertaking delegated duties, do so within a robust local employment policy framework to protect the public and support safe practice.
8 The decision to delegate is either made by the registrant or the employer and it is the decision maker who is accountable for it.
9 Healthcare can sometimes be unpredictable. It is important that the person to whom aspects of care are being delegated understands their limitations and when not to proceed should the circumstances within which the task has been delegated change.
10 No one should feel pressurised into either delegating or accepting a delegated task. In such circumstances, advice should be sought, in the first instance, from the registrant's professional line manager and then, if necessary, the NMC.

The NMC has also provided guidance on the delegation of tasks by midwives.[11] It states that only a practising midwife (i.e. a registered midwife who has met all the updating requirements for her midwifery practice and has notified her intention to practise to the LSA) is able to provide care and advice during the antenatal, intra-partum or postnatal period:

> **It is for the midwife to decide whether the delegation of tasks is appropriate in the care of a woman or her baby.**
>
> **If the midwife considers that any part of the care programme can be safely delegated to another member of the caring team, she remains accountable for the appropriateness of the delegation. If a task is delegated, the midwife must ensure that the person who does the work is able to do it and must provide adequate supervision and support. Such delegation must not compromise existing care and the midwife must be satisfied that the care meets the needs of the woman.**

Such advice does of course apply to all the different specialties registered by the NMC. The RCN has provided guidance on delegation to the scrub nurse[12] and in 2011 published a document setting out the principles of accountability and delegation for nurses, students, healthcare assistants and assistant practitioners.[13] The role of the healthcare support worker is discussed below.

Nurse consultants

Clinical nurse specialists and consultant nurses are seen as having a major role to play in providing an improved service for patients. The NHS Plan envisaged that there would be 1,000 nurse consultants and therapist consultants would also be appointed. The key features of the consultant nurse as envisaged in the Department of Health's *Making a Difference*,[14] are shown in Box 24.3.

Box 24.3 Key features of the consultant nurse

1 Expert practice.
2 Professional leadership and consultancy.
3 Education and development.
4 Practice and service development linked to research and evaluation.

It was envisaged that at least 50 per cent of the time of nurse consultants will be spent on clinical work with career opportunities. NHS trusts were required to agree the posts with regional offices of the DH. Nurse consultant posts are advertised on the website for NHS careers.[15] The RCN has published a report on becoming and being a nurse consultant.[16] This resulted from two years' research into the role of the nurse consultant which aimed at enabling nurse consultants and aspiring nurse consultants to become effective through a programme of support.

Clinical nurse specialists and specialist nurses

In addition, clinical nurse specialists have taken on a wide range of expanded duties, often working within protocols agreed with medical staff. They may also have managerial responsibilities. Other specialist nurses may or may not come within the category of clinical nurse specialists, but are increasingly taking on expanded-role functions. It would be impossible in a book of this type to explore the wide range of specialties covered by nurses, often functioning within a multidisciplinary team, but making many decisions on their own. They include continence care, stoma care, pain management, diabetic and A&E nurse practitioners.

A checklist published by the RCN that applies to all expanded-role tasks covers the following questions for extending roles:

Is this new skill/role consistent with nursing practice?
Is it consistent with my current job description?
Does it fit current priorities – nursing and organisational?
What changes will it entail?
Will I need to stop some parts of my current care?
Do I need accreditation?
How will I get it?
Do I need additional skills?
How will I get them?
Do I need a training period before I take on the new responsibility?
Do I have a mentor for this change?
How will I evaluate my performance in the new role?
Have I got clinical supervision?[17]

Clinical nurse specialists and consultant nurses and clinical guidelines

It has been emphasised that when a clinical nurse specialist or consultant nurse takes on an expanded role they must provide the same standard of care which would have been provided by the health professional who would originally have performed that activity. Thus an A&E clinical specialist nurse undertaking activities that would in the past have been performed by doctors would be expected to provide the reasonable standard of care of a doctor. Jo Wilson[18] has suggested that guidelines can be very useful in role expansion and assist the expanded-role practitioner in delivering a higher standard of care that reflects: additional training and regular updates; additional competency and expertise; skills required for the activity. She lists the considerations that should be taken into account in drafting guidelines:

- description and limitations to the activity being performed
- degree of supervision required
- audit, evaluation and outcome data
- making the status of the treating nurse known to patient
- obtaining the patient's consent
- regular education/training updates.

(Further consideration on the legal significance of guidelines, procedures and protocols can be found in chapter 3.) The RCN has provided guidance on clinical nurse specialists in the context of rheumatology[19] in stoma care[20] and dementia care.[21]

Concerns about developments in scope of professional practice

Practitioners have concerns, however, as a result of the move away from certified tasks and the rapid development in the scope of professional practice, which include the following:

1 How do I know if I am competent?
2 How does my employer know if I am competent?
3 What happens if I undertake an activity that is outside my field of competence?
4 Where do I stand if a doctor/senior manager/other professional ignores my refusal to undertake an activity because I have not sufficient competence or experience to undertake that activity?
5 How can I ensure that I receive the appropriate training for my expanded role?

Some situations will be considered that highlight these dilemmas.

Practical Dilemma 24.1 Scope of professional practice (1)

Mavis, a staff nurse, was asked by the registrar to do the intravenous infusions. The registrar rushed away before she had the chance to explain to him that she had not developed the skills, competence and knowledge to undertake that activity safely. However, she decided that she would carry out his instructions as best she could. Unfortunately, when she was adding a drug to Jimmy Price's intravenous infusion, she failed to set the speed of his drip correctly and as a result Jimmy became very ill. Where do Mavis and the registrar stand in relation to the responsibility for the harm to Jimmy?

As far as Mavis was concerned, she was at fault in failing to mention her lack of competence for that activity to the registrar. No nurse should work outside her range of competence and skill unless a dire emergency arises when the risks in failing to act are greater than the risks in acting. There is no suggestion that this was an emergency. The nurse ignored a fundamental principle of the Code of Professional Conduct quoted above. The failure of Mavis to notify the doctor that she was not competent in this area and the resulting mistake that caused harm to the patient could result in a civil action being brought against her employer because of its vicarious liability for the negligent actions of an employee acting in the course of employment (see pages 77–82). Mavis herself may be subject to fitness to practise proceedings before the NMC Conduct and Competence Committee. Were Jimmy to die, she might also face criminal proceedings. Her employer, of course, would commence its own disciplinary inquiry and proceedings.

What of the registrar? Is he also at fault? If the addition of drugs to intravenous transfusions were seen as a task delegated by a doctor to a nurse practitioner, he would be liable as delegator in failing to ensure that he was delegating to a competent person. However, under the scope of professional practice, such activities are not seen as 'delegated tasks' and the duty is incumbent on the individual nurse practitioner to ensure that, if she herself was not competent, another practitioner, whether medical or nursing, who was competent, performed the activity. The standard of care that the patient is entitled to expect does not depend on which professional is undertaking a particular activity. The reasonable standard of care will be required of any professional carrying out an extended role: if that activity were formerly carried out by a doctor, then a nurse undertaking that activity will be expected to provide the reasonable standard that a doctor would have provided. The Bolam Test is used to define the reasonable

standard (see chapter 3). The managerial responsibilities in ensuring appropriate supervision and allocation of activities are discussed in chapter 4.

Can a nurse refuse to undertake training in new areas of competency?

It was a principle under the concept of the 'extended role' that nurses could refuse to undertake a new task or activity. However, this approach is no longer appropriate in relation to the scope of professional practice. The Code of Professional Conduct requires nurses to 'keep your knowledge and skills up to date throughout your working life'.

It would be entirely inappropriate for a practitioner to refuse to develop her professional practice beyond the level she reached when she became registered. In addition, it is directly contrary to the principles of PREP. She would be contractually entitled to receive from her employer the necessary training to ensure that she was competent in the new range of activities. It is a contractual requirement of the employer to ensure that staff are competent to perform the work they are asked to perform.

There are other contractual considerations. In an interview for a job, for example, a nurse might be told that a contractual requirement for that particular post is that the nurse is competent in a specified area. If the nurse agrees to this condition, then she is contractually bound to develop, with support from the employer, the appropriate skills, knowledge and competence. If she refuses the condition, she will probably not get the post.

Scope of professional practice in primary care

Practical Dilemma 24.2 Liability and the scope of professional practice (2)

Practice Nurse Jenny Brown was asked by the GP, her employer, to make a primary visit to a child whose mother had reported him too ill to come to surgery. Jenny Brown visited the child, took his temperature and blood pressure and examined him. She told the mother that she thought he was suffering from the flu that was going round at present, to keep him warm with lots of drinks and, if he worsened or failed to improve within a few days, to let the surgery know. She reported the results of the visit to the GP, who approved of her action. Unfortunately, that same night an emergency call was made by the mother to the out-of-hours service and the boy was rushed to hospital, where he was diagnosed as suffering from meningitis. He eventually died. The mother is now demanding that action be taken against both the nurse and the doctor. What is the responsibility of the nurse and the doctor?

If the nurse had acted outside her competence, been negligent and caused harm as a consequence, then she will be liable. The doctor or clinical commissioning group will be vicariously liable for the actions of a negligent nurse employed by the doctor or clinical commissioning group. In this case, there would be an investigation to establish the tests undertaken by the nurse and the advice that she gave to the mother and whether her actions satisfied the standard of the reasonable medical practitioner. The competence of a nurse in making a primary visit has become of increasing importance with the expansion of nurse prescribing. In any case, even when the doctor is not the employer of the nurse, where there is delegation of a task that is normally performed by a doctor, the doctor will remain liable in civil law for that task unless he has delegated it to a competent, trained person and provides the requisite supervision for the task to be done safely. Here one might question whether it was a suitable case for the practice nurse to undertake. Had she the necessary training and skills to detect whether the patient was suffering from mumps or another condition? Once she had visited the patient, should she

not have arranged for the GP to attend or ensured that a closer eye was kept on him? Did she make all the appropriate tests and checks when she visited the boy? If these questions are answered in such a way that the nurse is shown to be at fault, then the GP could well be liable for any harm that has consequentially befallen the boy (there may, in fact, be no harm suffered, since the short delay in diagnosis may have had no effect) and the nurse would also be liable for undertaking a task that she was not competent to perform. In either event, the nurse would be held professionally accountable before the NMC for her actions. Even had there been no negligence on the part of the GP, he, as her employer, would be vicariously liable for the practice nurse's negligence. The White Paper of 2010[22] envisaged that commissioning responsibilities would be devolved to GPs. Subsequently, the Health and Social Care Act 2012 has created Clinical Commissioning Groups which may lead to further expansion in the scope of the primary care nurse (see chapters 5 and 23).

Scope of professional practice in theatre nursing

Practical Dilemma 24.3 Scope of professional practice and theatres

Myra Jones had worked in theatre for over 20 years and was an extremely experienced nurse. She had asked for training in acting as a first assistant, but the surgeons had stated that this was not a role that should be performed by nurses. One day, she was asked by the registrar to assist in an appendectomy because there was a shortage of junior doctors. She knew that she could do the work competently, but was hesitant. What is the legal situation?

Should she refuse on the grounds that she has not been trained to fulfil this role? What if this request comes at night when there is only a registrar on his own and it is an emergency case? The basic principle is that, whatever duties she is called on to perform, she should undertake no work that she is not competent to undertake.

In an emergency situation, when the harm to the patient of her acting is outweighed by the harm to the patient of her not acting, the balance might be in favour of her acting as assistant (but these occasions are likely to be rare). To refuse to perform certain tasks is not pleasant for the nurse, but it is her duty both in civil law and also as part of the Code of Professional Conduct of her profession. Only in this way can the safety of the patient be ensured. If such situations arise where the nurse is expected to undertake tasks for which she is not trained, this must ultimately be referred to nurse management. If this proves ineffective, then the nurse may need to take advantage of the whistleblower's protection (discussed in chapter 4).

In Practical Dilemma 24.3 the Royal College of Surgeons (RCS) has the responsibility of recognising the extent to which nurses can play a significant role in theatre. In 2005 the RCS published *Modern Surgical Workforce* (available on its website[23]) which considered the move from the role of the individual consultant to multidisciplinary team working. It recognised the increasing role for non-medically qualified practitioners (NMQP) which would lead to a wider role for the theatre nurse. Julie Quick[24] has analysed the role of the surgical care practitioner (SCP) within the surgical team showing that the surgeons interviewed considered the addition of the SCP to the surgical team brought benefits to the patient, the members of the surgical team, the practitioner and the employing organisation. She challenges my view that the standard of care of the SCP must be that of the medical role which she is replacing. Would it be effective for an SCP to argue following harm to a patient, 'but I am only a SCP, a registered doctor would not have caused harm'? A court case is necessary to determine the issue.

Scope of professional practice in emergency nursing

A joint report by the RCN and the DH[25] attempted to dispel the myths about what nurses and other health professionals may or are entitled to do in emergency care. The booklet aimed to show directors of nursing how they could empower staff to take responsibility for change and to show managers to use it to support staff in developing their roles. It is available from the DH website.[26] Fact sheets cover the myths about the legal and professional framework, clinical governance, the emergency services collaboration, coronary heart disease and primary care collaboratives. (See chapter 21 for further discussion on the emergency care practitioner.)

Scope of professional practice and X-rays

The ordering of X-rays may constitute an expanded role for the nurse, but she should be aware of the rules relating to this. The Ionising Radiation (Medical Exposure) Regulations 2000[27] were enacted, together with the Ionising Radiations Regulations 1999,[28] to comply with European Directive 97/43/Euratom.[29] This Directive lays down:

- basic measures for the health protection of individuals against dangers of ionising radiation in relation to medical exposure
- duties on those responsible for administering ionising radiation
- need to protect persons undergoing medical exposure whether as part of their own medical diagnosis or treatment or of occupational health surveillance, health screening, voluntary participation in research or medicolegal procedures.

The regulations do not specify that any specified health professional must be a referrer (i.e. the person ordering the X-ray), but require that the referrer must be entitled in accordance with the employer's procedures to refer individuals for medical exposure to a practitioner. Regulation 6 prohibits any medical exposure from being carried out that has not been justified and authorised and sets out matters to be taken into account for justification.

The referrer has a duty to supply the practitioner with sufficient medical data relevant to the medical exposure requested by the referrer to enable the practitioner to decide whether there is sufficient net benefit as required by Regulation 6(1)(a). Applying these requirements to nurses: this means that nurses may be referrers, i.e. order X-rays, but they must have the training and competence which enables them to provide the medical data to enable the radiographer to decide whether the patient should be exposed to the X-rays.[30] Guidance has been provided by the Department of Health on the regulations and is available on the internet.[31] The fact sheet provided within the publication *Freedom to Practise: dispelling the myths*[32] points out that nurses requesting radiological examinations can be referrers under the Ionising Regulations, provided that they have the competence, conferred by training and experience, to provide the medical data required to enable the practitioner (usually a radiologist) to decide whether there is net benefit to the patient from the exposure. The nurse would require the consent of the employer who would specify the type or range of conditions for which the nurse can be the referrer. The RCN has provided guidance for non-medically qualified persons on clinical imaging requests which also sets out the law relating to ionising radiation regulations.[33] The scope of professional practice of the nurse is extended by their ability to refer patients for X-rays and, by their wider remit in the X-ray department.

NHS 111 (formerly NHS Direct) and walk-in clinics

NHS 111 (formerly NHS Direct) and walk-in clinics (see chapter 5) depend heavily on nursing staff, who are the main group employed in these areas. Nurses have to be sure that they work within the scope of their professional competence.

Practical Dilemma 24.4 Scope of professional practice (3)

A nurse employed by NHS 111 received a phone call from a woman of 28 who said she was suffering from severe indigestion and asked what was recommended. The nurse failed to clarify whether the woman was pregnant and suggested that she should take some indigestion pills. Subsequently, the woman was admitted in an emergency to hospital with hypertension. The family are now wishing to sue the NHS.

In this situation, there would probably be a protocol the nurse should have followed and ascertaining the possibility of pregnancy would have been an essential question to ask. There would appear to be *prima facie* evidence of negligence. Clearly, the safest advice to be given by any nurse answering calls on the NHS 111 Service is for the patient to seek an appointment with his or her general practitioner. However, this might reduce the value of the service.

From 2013 NHS Direct was being replaced by locally commissioned services using the NHS 111 number. The 111 service is provided by a range of providers such as Ambulance Service Trusts or GP's out of hours service. There are separate NHS Direct Services for Wales and Scotland; for NHS 24 in Scotland phone 08454 24 24 24 and for Wales 0845 4647.

Similar problems beset the nurse providing the services in walk-in clinics, since the majority are nurse-led. It is essential that nurse practitioners have the appropriate training to run such clinics competently and to be aware of the limits of their knowledge and have the confidence to be firm on what they do not know. Minor injuries can probably be dealt with on a one-off basis, such as suturing or bandaging a sprain. However, there may be a need to refer to X-ray, to arrange for further diagnostic tests or to seek specialist advice, and the nurse needs to be confident when this is required and when she needs to refer the patient on for medical advice. In February 2000 practice nurses and nurses who work in walk-in centres were given statutory powers to prescribe from a limited list, as do community nurses and health visitors.[34] Subsequently, the new developments in nurse prescribing enable any nurse who has had the appropriate training to prescribe medications within her competence (see chapter 28). These powers increase the dangers of a nurse working outside her competence. (For further discussion on NHS 111 and walk-in centres, see chapter 5.)

Modern matrons

The role of matron was reintroduced into the NHS as part of the NHS Plan. It was intended that matrons should provide strong leadership on wards and be highly visible and accessible to patients; that they should set an example in driving up standards of clinical care and empowering nurses to take on a greater range of clinical tasks to help improve patient care. A report was published in April 2003 on progress in these appointments and the Chief Nursing Officer of the Department of Health set out the plans to extend the role of modern matrons in A&E departments to improve patient experience of NHS emergency care. Each matron in charge of an A&E department was to have a £10,000 budget to help bring these improvements about. A progress report was provided in February 2004 that gave examples of how the monies had been spent.[35] The function of modern matrons in A&E departments includes: clinical leadership; improving patient experience; improving the clinical and patient environment; and managing the ward/departmental environment budget. The intention to appoint 3,000 community matrons was announced in June 2004. In September 2007 the DH announced that it was placing responsibility for the cleanliness of wards and departments upon nurses who would have the right of appealing to the chief management if their recommendations were not accepted. This further emphasises the importance of the role of the matron. By 2008 over 5,000 matrons had been appointed

but, interestingly, whether or not they had made a difference was questioned in an article in the *Nursing Times*.[36] Increasingly matrons have been appointed from the ranks of health professions other than nurses. They are paid, like consultant nurses on band 8a–c.

The basic principles which apply to the scope of professional practice are shown in Box 24.4.

Box 24.4 Basic principles that apply to the scope of professional practice

1. Always work within the scope of your professional practice.
2. Identify any training or supervised practice needs and take steps to ensure that these are met.
3. Be aware that the law does not accept a principle of team liability; each individual practitioner is personally and professionally accountable for their own actions.
4. Do not obey orders, except in an extreme emergency, unless you are satisfied that they constitute reasonable professional practice.
5. Be prepared to refuse to undertake any activity unless it is within your competence.
6. Do not accept an undertaking that someone else will accept responsibility for what you do. (I'll take responsibility!)
7. Ensure that any development in your professional practice takes place in the context of multidisciplinary discussions, with full management support and an awareness of the need to educate the patient and others to the new situation.

Clinical supervision

An important part of the support mechanism and professional development of the nurse is clinical supervision. Described by the UKCC in its position paper as 'reflective practice',[37] it provides an opportunity for nurses to discuss in confidence the issues that they have encountered in practice and how they can develop and learn from these experiences. Bond and Holland have provided guidance on the skills required.[38] Alec Grant raised issues about why clinical supervision is in practice falling short of the theory.[39] The NMC A–Z advice sheet on clinical supervision[40] (now replaced by guidance sheets) states that clinical supervision allows registrants to receive professional supervision in the workplace by a skilled supervisor. It enables registrants to:

Identify solutions to problems
Increase understanding of professional issues
Improve standards of patient care
Further develop their skills and knowledge
Enhance their understanding of their own practice.

The NMC suggests that clinical supervision should be available to registrants throughout their careers. It considers that it is best developed at a local level in accordance with local needs and therefore does not advocate any particular model of clinical supervision, nor does it provide detailed guidance about its nature and scope. It puts forward the following set of principles which should underpin any system of clinical supervision:

- Clinical supervision supports practice, enabling registrants to maintain and improve standards of care.
- Clinical supervision is a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor.
- Registrants and managers should develop the process of clinical supervision according to local circumstances. Ground rules should be agreed so that the supervisor and the registrant approach clinical supervision openly, confidently and are aware of what is involved.

- Every registrant should have access to clinical supervision and each supervisor should supervise a realistic number of practitioners.
- Preparation for supervisors should be flexible and sensitive to local circumstances. The principles and relevance of clinical supervision should be included in pre-registration and post-registration education programmes.
- Evaluation of clinical supervision is needed to assess how it influences care and practice standards. Evaluation systems should be determined locally.

Agency nurses

In recent years the shortage in the number of nurses has led to the growth in the use of agencies for the provision of nurse staffing. Many nurses, too, find working for an agency suits their practical needs of combining family and work by giving them greater flexibility and control over their time. Nursing agencies were regulated under the Nurses Agencies Act 1957, but following the implementation of the Care Standards Act 2000, the National Care Standards Commission (NCSC) took over responsibility for their regulation.[41] (In Wales, this is carried out by a department or agency set up by the National Assembly for Wales.) Subsequently, following the Health and Social Care (Community Health and Standards) Act 2003, the NCSC was abolished and its functions taken over by the Commission for Health Audit and Inspection (i.e. the Healthcare Commission) and the Commission for Social Care Inspection (CSCI). From April 2009 the Care Quality Commission (CQC) has taken over the functions of the Healthcare Commission and CSCI. Nurse agencies now have to register with the CQC and complete an annual quality assurance assessment. Further information is on the CQC website.[42]

Nurses working for an agency should be clear over the legal implications of their status when they are allocated to an NHS trust. Do they become employees of the trust or are they employees of the agency or are they classified as self-employed practitioners? Their employment status has considerable repercussions for both their legal liability and also for their entitlements to statutory provisions for the employee (see chapter 10). The RCN has provided guidance on agency nurse induction for employers, nursing agencies and nursing staff.[43] The European Union issued a Directive[44] giving new rights for temporary workers, including workers hired through agencies which came into force in the UK in 2010 (see chapter 10).

Healthcare support workers

Essential to the development of enhanced professional practice of the registered nurse is a trained competent body of nursing auxiliaries/healthcare support workers who are able to undertake those activities delegated to them. Although there have been discussions over the registration of such support workers, with the NMC and the Health Professions Council (HPC) both being contenders for the role of registration authority, no action has as yet been taken. Indeed there is evidence that such workers are not even being trained in some of the activities they are expected to undertake. The *Sunday Times* published an alarmist article on the fact that support workers were undertaking technical nursing tasks with limited, if any, training.[45] Peter Carter, the RCN General Secretary, recommended that healthcare assistants should receive a substantial minimum training period as well as being subjected to a code of conduct. In July 2010 the NMC published the findings of research it had commissioned into the regulation of healthcare support workers. It is available on the NMC website.

There has been considerable pressure for the registration and training of support workers. The Mid-Staffordshire Inquiry[46] (see chapter 5) made several recommendations on this topic.

> Recommendation 209: healthcare support workers should be registered and no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a doctor or nurse (or who are dependent on such care by reason of disability or

infirmity) in a hospital or care home setting. The system should apply to healthcare support workers whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)
Recommendation 210: there should be a national code of conduct for healthcare support workers.
Recommendation 211: there should be a common set of national standards for the education and training of healthcare support workers.
Recommendation 212: the NMC should be responsible for the preparation of the code of conduct, education and training standards and requirements for registration of healthcare support workers.

The Report led to demands for basic skills training and testing of healthcare assistants. The Health Secretary has ruled out full registration but a review conducted by Camilla Cavendish, the *Sunday Times* columnist, concluded that all support workers should be required to have a certificate of fundamental care without which they would not be allowed to care for patients.[47]

The Care Minister announced in October 2013 that all healthcare assistants and social care support workers would, before starting work, have to be certified in a skills and values test. The Care Certificate will provide clear evidence to employers, patients and service users that the person in front of them has been trained to a specific set of standards. Section 95 of the Care Act 2014 adds a new subsection to section 20 to the Health and Social Care Act 2008 to enable the Secretary of State to specify persons to set the standards which persons undergoing training in regulated activities must attain. Under section 98 of the Care Act 2014 Health Education England (see chapter 18) must ensure that a sufficient number of persons with the skills and training to work as healthcare workers is available throughout England. To many these reforms do not go far enough, with the RCN recommending mandatory regulations for all healthcare support workers.[48] However, until the regulations are published it is impossible to say how effective this provision will be in setting and improving standards for healthcare assistants.

Karen Barker[49] considers that perhaps registration would allow HCAs to feel more valued and access the training to help them do the job they want to do to a high standard.

A report in 2014 by Baroness Kingsmill criticised the fact that the 1.8 million of care workers for the elderly were under qualified, under trained and paid below the minimum wage which led to frail, elderly not receiving the help they required.[50] She recommended a licence to practice for care managers and a register for all care workers with zero hours contracts being banned and minimum wage laws rigorously enforced.

In May 2014 the NMC and Health Education England commissioned a review into nurse and healthcare assistant education and training in England to be led by Lord Willis of Knaresborough.

In the light of the concern about the lack of regulation of healthcare support workers it is interesting that proposals are being put forward for a new grade of medical assistant: science graduates with an intensive two-year training. Known as 'physician associates' they will not be registered with the GMC or any other regulator, except possibly have entry onto to voluntary register. The concept has proved popular in the USA where they have existed for over 50 years and now number over 80,000.[51] Critics say the scheme is a means of getting doctors on the cheap and could be dangerous for patients. However, the President of the UK Association for Physician Associates[52] stated that patients are in safer hands with them than with junior doctors.[53]

Conclusions

The scope of professional practice of the nurse, midwife and specialist community public health nurse has continued to develop and it is clear that the initial pre-registration training is the foundation upon which an expanded professional role can take place. Registered practitioners must work within their competence and ensure that they have the training and supervision to develop their practice in new

areas. The most extensive area of expansion has been in the field of prescribing and these developments are considered in chapter 28. However, other traditional areas of clinical practice such as surgery are opening up to nurses. The repercussions of such developments are significant not just for the individual registered practitioner, but also for the culture and interrelationships of professionals within health and social care. The 'Freedom to Practise: dispelling the myths' template has paved the way for further professional development but there is still much further to go. There are very few Acts of Parliament which require certain activities to be carried out by a member of a specified registered health profession, which means that the law enables an expansion of the professional role of the registered nurse and midwife across almost the whole field of health and social care.

Reflection questions

1 You have been working as a clinical nurse specialist in the diabetic clinic and have now been asked if you would wish to seek a post of consultant nurse in the same department. What differences would you anticipate there would be between your present post and the post of consultant nurse? What legal implications would there be if you were to obtain the new post?

2 You are aware that your expanded scope of professional practice includes several activities that were originally performed by doctors. In what ways could you assure patients that you are competent to perform these activities?

3 You have been asked to undertake training to be able to act as a clinical supervisor. What are the legal implications of this role?

4 What documentation should be kept in respect of clinical supervision?

Further exercises

1 Study a copy of your NHS trust's policy on the scope of professional practice duties and the principles contained therein. In what ways do you consider that your professional practice could develop? What are the barriers to such development and how could these barriers be overcome?

2 To what extent does the White Paper on the NHS published in 2010[54] have implications for the scope of professional practice of the nurse?

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Part III
General areas





Chapter 25

Legal aspects of property

This chapter discusses

- Principles of liability
- Administrative failures
- Exclusion of liability
- Property of the mentally incompetent
- Mental Capacity Act 2005
- Day-to-day care of money
- Power of attorney
- Court of Protection
- Protecting patients from relatives
- Returning the patient's property
- Staff property
- Gifts

Introduction

The nurse may have many concerns about property. She may wonder if she is liable if the patient's property is lost. This becomes of particular concern in those situations where the patient is incompetent to take care of his own possessions. What are the legal requirements? The nurse may also be concerned for her own property. Does the NHS trust as an employer have any duty to make arrangements to care for the nurse's property? What happens if the nurse's car is damaged in the hospital car park? Does it make any difference to the liability of the employer if a patient damages the car?

Principles of liability

Practical Dilemma 25.1 Seen on X-ray

Janice was rushing to get to a party when she felt faint and collapsed in the street. She was unconscious and was taken in an ambulance to hospital. On admission she was X-rayed and then admitted to the emergency ward. She recovered consciousness and asked to have her necklace returned. The ward staff told her that she was not wearing a necklace and showed her a plastic patient's property bag into which had been placed everything that she had with her on admission. She checked and there was no necklace in the bag. She asked for the loss of the necklace to be investigated. Subsequently it was found that the X-ray showed that she was wearing a necklace. Janice is now claiming that the hospital is responsible for its loss which she estimates to be over £10,000.

In Practical Dilemma 25.1, the first issue that arises is: can it be said that the NHS trust is liable for the missing property and is anyone personally liable? In general, a person does not become liable for another person's property unless he or she can be shown to have assumed some responsibility for it. The person who undertakes to look after the property of another person is known as a *bailee*. The person who owns the property is known as the *bailor*. Thus, if a patient were to give a gold watch to the ward sister, the sister on behalf of the NHS trust acts as bailee of that property entrusted to it by the patient, the bailor. It is the duty of the bailee to carry out the instructions of the bailor and to surrender the property of the bailor when requested to do so or as previously agreed. In most circumstances, the relationship of bailor/bailee is a voluntary one and one person cannot force another into being the bailee of one's property. When the person agrees to act as bailee (and there may be no reward for doing so), a transfer of possession takes place so that the bailee then becomes liable. In contrast with the usual principles of negligence, once the existence of the bailment is established, it is not for the bailor to establish negligence by the bailee, but for the bailee to show that he exercised all reasonable care for the goods and was not negligent. This is a reversal of the usual burdens of proof.

In the context of hospital care, another duty arises under the law of negligence. If an unconscious patient is brought into the A&E department, the NHS trust and the professionals have a duty to care for the patient and this would include caring for his property if he is unable to look after it. This is known as involuntary bailment. Looking at Janice's situation, could it be said that the NHS trust became an involuntary bailee of her property and had a duty of care in relation to it? The answer is that in the street when she was unconscious and was unable to look after her property herself, first the ambulance staff had a duty of care and then when she was transferred to the A&E staff the latter then assumed the duty of care of both herself and her property. Were it not for the evidence of the X-ray there would be doubt as to whether someone in the street or the ambulance staff had removed and kept the necklace. However, the X-ray shows clearly that Janice was still wearing the necklace when she came to hospital and it was 'lost' after that. There would have to be an inquiry to find out at what point Janice was not wearing the necklace and who had the opportunity of taking the necklace after the X-ray. The fact that Janice had not personally entrusted the necklace to the care of the hospital could not be used as a defence in the involuntary bailment situation. The burden would be on the hospital to establish that it took good care of Janice and her property.

The trust would probably be advised to offer an ex gratia payment to Janice (i.e. an offer in which liability is not admitted but a sum of money is offered to dispose of the case quickly (see chapter 3)). There is likely to be difficulty in establishing the value of the missing necklace, unless Janice has a receipt and can prove that it was the receipted item which can be seen in the X-ray.

Administrative failures

When property, which has not been entrusted to the care of hospital staff, is lost, there is unlikely to be litigation, since it would be difficult to establish the responsibility of the hospital. The loss is more likely to be the subject of a complaint about the administrative procedures. For example, there may have been a failure by staff to point out to the patient and to the relatives the procedures for dealing with property. Complaints of this kind, though they may not lead to a court action, may result in the NHS trust making an ex gratia payment to the patient or relatives. This is not an admission of liability, but an attempt to appease the relatives and make up for administrative shortcomings. Under the current complaints scheme, any complaint of missing property would be investigated at a local level and an attempt made to resolve it. If the complainant is not satisfied with the outcome, then he/she can apply to the Health Service Commissioner for an independent review (see chapter 27).

Practical Dilemma 25.2 A lost engagement ring

Mavis was admitted for an appendectomy and was expecting to stay in hospital only for a few days. She took very little cash in with her, but did take her engagement ring. When she was using the wash basin in the toilets, she took off her ring, placing it on the side and then forgot to put it back on. She had been back in the ward only a short time when she realised what she had done and rushed back to fetch it, but unfortunately it was gone. She knows that someone must have stolen it. Can she recover compensation from the trust?

There is no legal right for Mavis to obtain compensation from the trust. She did not entrust her property to the trust employees, and at the time that it was lost she was responsible for it. However, she may be able to show that there were administrative failings. For example, it might not have been pointed out to her that she brings her property into the hospital at her own risk. While, therefore, there may be no legal basis for a claim, she may be able to use the complaints procedure to raise concerns and, depending on the results, the trust may make an ex gratia payment to her. Contrariwise, if the trust explained the situation about patient's property and a notice pointing out that the trust did not accept liability was shown to her, she would probably be unable to obtain any compensation.

Exclusion of liability

What is the legal significance of the notice absolving the NHS trust or PCT of all responsibility for the patient's property? Under the Unfair Contract Terms Act 1977 (see Statute Box 6.2 on page 147), such an exemption or exclusion notice is effective in relation to the loss or damage of property, provided that it is reasonable to exclude liability for the negligence that has led to such loss or damage. (Liability for negligence that leads to personal injury or death cannot be excluded.) How is reasonableness defined? The requirement of reasonableness is defined in Statute Box 25.1.

Statute 25.1 Definition of reasonableness in section 11 of the Unfair Contract Terms Act 1977

[I]t should be fair and reasonable to allow reliance upon it, having regard to all the circumstances obtaining when the liability arose or [but for the Notice] would have arisen (section 11(3)).

It is for the party claiming that a contract term or notice satisfies the requirement of reasonableness to show that it does (section 11(5)).

If in Practical Dilemma 25.1, a notice had been displayed on the wall, and if it could be argued that the NHS trust's employees had been negligent in relation to her property, then the NHS trust might claim to rely on the notice to avoid liability. It would then have to show that it was reasonable for them to rely on it. This would be difficult since Janice, being unconscious and incapable of reading the notice, would not have been aware of the exclusion of liability. In contrast, in Practical Dilemma 25.2 Mavis would have been able to read such an exemption notice, and exclusion of liability by the trust would be more likely to succeed.

Patients should be advised not to bring valuable property into hospital. If they do, then it can be recommended to them that the property should be taken into safekeeping by the nursing staff. If they are unwilling to part with the property, then they can be asked to sign a form whereby they accept responsibility for the care of the property which has the added advantage of impressing upon the patient the dangers of having valuable property in hospital, as in Box 25.1.

Box 25.1 Patients' property: form of notice disclaiming liability

I acknowledge that the opportunity has been given to me to hand over my personal property to be placed in safekeeping, that I have been advised to do so and that I have declined the offer of safekeeping of my personal property.

Signature of patient
Witnessed by
(Member of staff)
Designation
Date
To be filed in patient's case notes folder

Property of the mentally incompetent

What about the property of those who are unconscious or who have learning disabilities or who are mentally ill or the elderly infirm?

Temporary incapacity

Practical Dilemma 25.3 Lost teeth

Arthur Brown was rushed into hospital one night with a cardiac arrest. He survived following a six-hour operation. When he recovered from the operation, he was told that it was touch and go as to whether he would pull through. A few days later, he discovered that his set of teeth was missing. He told the staff nurse who said that a search would be started, but they were not found. What remedies does he have?

In this situation, it is clear that Arthur was incapable of taking care of his personal property on admission and it is likely that his teeth were removed preoperatively. (There would have to be a check

to see if they were removed pre-admission or by the ambulance crew.) If following investigations it appears that the hospital staff did remove them and failed to take reasonable care, the trust would be seen as the bailee of the property and responsible for their loss. It would be advisable for the trust to admit liability and make Arthur a speedy offer of an ex gratia payment. Some staff may feel that, in view of the fact that staff saved Arthur's life, it is unreasonable of Arthur to complain. However, if there were a justified complaint, the fact that a patient's life has been saved would not be a successful defence.

Permanent incapacity

In other situations of long-term mental incapacity, there may be tensions between attempting to develop the autonomy of a person and the care of personal property as the following situation indicates.

Practical Dilemma 25.4 Pocket money

Jimmy Jones, an adult of 24 with learning disabilities, lived in a community home with others of a similar condition. He regularly earned himself significant amounts of money from doing odd jobs around the home and thus accumulated over £100. The staff in the home attempted to encourage Jimmy to put this in the bank. However, he could not be persuaded and there were rumours that he slept with it under his pillow at night. One morning, he screamed with distress and it appeared that all his money had been stolen from under his bed. A search revealed nothing and there was no hint as to where it had gone. Is the organisation which ran the home liable for the loss?

In Practical Dilemma 25.4 there was no transfer of possession from Jimmy to the care home owners or managers, so that the latter is not *prima facie* liable. However, much depends on Jimmy's mental competence and whether sufficient effort was made to persuade him to allow it to be taken for safe-keeping. A system of tokens can sometimes be devised to protect patients' property, although care must be taken not to limit their purchasing power and to ensure that the funds are available for them when they want them. In addition, in this case, it could be argued that the care home had a duty of care in relation to the security of the home.

Mental Capacity Act 2005

The Mental Capacity Act 2005 established a new Court of Protection whose jurisdiction covers both personal welfare and property and affairs for those over 16 years. The Court has the power to make orders in respect of those under 16 years if there is reasonable belief that their incapacity will continue beyond 16 years. The Court can make declarations and/or it can appoint a deputy to make decisions on behalf of those lacking mental capacity. In addition, a person, over 18 years, when mentally competent can draw up a lasting power of attorney (LPA) which gives the power to make decisions to another person over 18 years on both personal welfare and property and affairs. The LPA must be registered with the Office of Public Guardian. The LPA over personal welfare can only take effect when the donor loses the requisite mental capacity. Where small amounts of money are involved the present system whereby appointees can collect DSS moneys on behalf of those incapacitated continues.

Day-to-day care of money

Practical Dilemma 25.5 Shopping

At the heart of the philosophy of community care of those with learning disabilities or severe mental health problems is the principle of autonomy. Clients are encouraged to shop and take part in community activities and realise as much of their potential as possible. In these circumstances, moneys might be entrusted to staff to guide clients in making small purchases. On one such shopping expedition, Gary White, the team leader at a community home for those with learning disabilities, took three residents to the shops. Two were able to manage their own purchases, but the third, Leonard, needed some guidance and Gary aided him in purchasing several small items – toiletries, sweets, etc. On their return, Leonard complained to another resident that Gary had spent all his money. This came to the attention of the home manager who asked Gary for an immediate explanation. Gary showed how the money had been spent, but was unable to produce any receipts or supporting evidence. Neither was he able to remember exactly where the money had gone.

In a situation like this, the member of staff is like a trustee for the resident's property and should be able to account for it in detail with supporting receipts. Of course, the receipts do not in themselves show that the money was spent on the patient but, together with evidence from other witnesses, it should be possible to record exactly how the money was spent and that it was spent in the interests of the resident. In a case like this, the home manager would discipline Gary for his failure to follow the correct procedure.

In the community, many residents may have considerable sums to spend and the staff are therefore vulnerable to an accusation that they have spent the money on themselves. Under the Health and Social Care Act 2008 the Care Quality Commission (CQC) is responsible for the regulatory system for care homes (see chapter 23) which require that there should be accurate records kept of residents' property. It is essential that staff be trained in good practices of bookkeeping and that there should be, as far as possible, witnesses to give evidence as to how the money has been spent. The ultimate aim is, of course, that the resident should be the watchdog for his own funds, but many residents/clients may never get beyond the stage of entrusting all such matters to others. As the registration authority and the inspector of care homes, the Care Quality Commission is responsible for ensuring that regulations relating to patients'/clients' property are observed.

It was reported in December 2013 that the Royal Mencap Society had paid out more that £60,000 to five severely disabled clients at one home after carers spent their money on hundreds of unauthorised purchases.[1] These included the purchase of a karaoke machine for a resident who could not speak. The sister of one resident set up a company Finacare to safeguard the finances of at-risk adults and her brother was threatened with the loss of his place in the home. Mencap subsequently retracted the threat. Criminal investigations are being made. Mencap stated that it was confident that it had appropriate financial procedures in place across its 128 registered care homes to prevent financial abuse. The CQC had carried out eight inspections in the home since 2010 and none of them apart from the most recent one raised financial abuse. The CQC said that it had the power to check financial processes but could not carry out restrospective investigations on financial abuse.[2]

Local authority and duties in relation to financial abuse and care of property

Under section 42 of the Care Act 2014 the local authority has a duty to make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case where (among other situations) an adult is experiencing, or is at risk of, abuse or neglect.

'Abuse' includes financial abuse; and for that purpose 'financial abuse' includes:

(a) having money or other property stolen,
(b) being defrauded,
(c) being put under pressure in relation to money or other property, and
(d) having money or other property misused.

Under section 47 of the Care Act 2014 the local authority has a duty to protect the property of adults being cared for away from home. The section is shown in Statute Box 25.2

Statute 25.2 Care of property under section 47 Care Act 2014

(1) This section applies where
  (a) an adult is having needs for care and support met under section 18 or 19 in a way that involves the provision of accommodation, or is admitted to hospital (or both), and
  (b) it appears to a local authority that there is a danger of loss or damage to movable property of the adult's in the authority's area because –
    (i) the adult is unable (whether permanently or temporarily) to protect or deal with the property, and
    (ii) no suitable arrangements have been or are being made.
(2) the local authority must take reasonable steps to prevent or mitigate the loss or damage.
(3) For the purpose of performing that duty, the local authority –
  (a) may at all reasonable times and on reasonable notice enter any premises which the adult was living in immediately before being provided with accommodation or admitted to hospital, and
  (b) may deal with any of the adult's movable property in any way which is reasonably necessary for preventing or mitigating loss or damage.
(4) A local authority may not exercise the power under subsection (3)(a) unless –
  (a) it has obtained the consent of the adult concerned or, where the adult lacks capacity to give consent, the consent of a person authorised under the Mental Capacity Act 2005 to give it on the adult's behalf, or
  (b) where the adult lacks capacity to give consent and there is no person so authorised, the local authority is satisfied that exercising the power would be in the adult's best interests.
(5) Where a local authority is proposing to exercise the power under subsection (3)(a), the officer it authorises to do so must, if required, produce valid documentation setting out the authorisation to do so.
(6) A person who, without reasonable excuse, obstructs the exercise of the power under subsection (3)(a) –
  (a) commits an offence, and
  (b) is liable on summary conviction to a fine not exceeding level 4 on the standard scale.
(7) A local authority may recover from an adult whatever reasonable expenses the authority incurs under this section in the adult's case.

Power of attorney

Patients who have the necessary mental capacity can grant a power of attorney. Under the Powers of Attorney Act 1971 this power was revoked (i.e. withdrawn) if the person granting it became mentally incapable. However, since this is often the very occasion when it would be useful to exercise the power on behalf of the patient, an Enduring Power of Attorney Act 1985 was passed, which came into effect in 1986. The enduring power of attorney came into existence only if the person wished the power to continue after the time at which he became incapable; he had to sign to this effect and indicate that he was aware of the significance of the enduring element. From 1 October 2007 it is no longer possible to

create an enduring power of attorney. Instead, as the result of the Mental Capacity Act 2005, a lasting power of attorney can be set up. Different forms are completed and registered for an LPA covering personal welfare and one covering property and affairs. Existing enduring powers of attorney continue to be valid, and if the donor still retains the requisite mental capacity could be replaced by an LPA. Box 25.2 sets out some of the requirements for and the characteristics of an LPA.

Box 25.2 Lasting powers of attorney

1. Lasting powers of attorney can be set up in respect of personal welfare and property and affairs. The LPA in respect of personal welfare only comes into force when the donor lacks the requisite mental capacity. The LPA in respect of property and affairs can come into effect even though the donor still has the requisite mental capacity.
2. The LPA must be in the exact form prescribed in the Regulations.[3]
3. The LPA may give:
   - a general power – which authorises the attorney to carry out any transactions or make personal welfare decisions on behalf of the donor, or
   - a specific power – which authorises the attorney to deal only with those aspects of the donor's affairs that are specified in the power or make specific personal welfare decisions.
4. The donor can revoke or cancel the lasting power at any time while she/he remains mentally capable, but the power cannot be cancelled or revoked once it has been registered, unless the Office of Public Guardian confirms the revocation.
5. When the donor becomes mentally incapable, the attorney must notify the Office of Public Guardian.
6. Once registered, the attorney has the power to act on behalf of the donor – either general or specific.

Court of Protection

In October 2007 a new Court of Protection was established under the Mental Capacity Act 2005[4]. The Court has considerable jurisdiction in relation to both personal welfare and property and affairs of those who lack the requisite mental capacity. It can also determine whether capacity is lacking. Ordinary hearings take place in private but an application can be made for the hearing to be held in public on specified conditions.[5] The Court of Protection is consulting on allowing the public to sit in on hearings and is seeking greater openness while at the same time protecting the anonymity of those needing its protection.

Where there is no enduring or lasting power of attorney in existence and the person is incapable of managing his affairs, an application can be made to the Court of Protection for the appointment of a deputy to manage the affairs. There is a short procedure that can be used where the assets are small. A relative, or perhaps an NHS organisation or social services organisation, could apply for a deputy to be appointed to manage the patient's affairs and to allow money to be spent on the patient. The powers of the Court of Protection are considerable. The applicant will have to pay in to the court a sum of money as a *recognisance*. Notice of the application is given to the patient, who has the opportunity of opposing it. Medical evidence will also be required to show that the patient lacks the requisite mental capacity (as defined in the Mental Capacity Act sections 2 and 3 (see chapter 7)) to be capable of handling his affairs. This medical evidence can be challenged by the patient. The Court of Protection has the power of making a will in the name of the incompetent person and can arrange for sums to be paid to other persons who would have been dependent on the patient or would have looked to him for help, even though these obligations would not have been legally enforceable. Obviously, there is a power to pay all debts. The powers given to the Court of Protection under Part 7 of the Mental Health Act 1983 have been replaced by those given under the Mental Capacity Act 2005. In Scotland the Adults with

Incapacity (Scotland) Act 2000 has been in force since 2001. Further information can be obtained from the Office of Public Guardian website.[6]

Protecting patients from relatives

Practical Dilemma 25.6 Grasping relatives

Mary Bennet was visited regularly by her daughter, Jean, and each week the ward sister noticed that Jean brought the pension book in for her mother to sign. However, it was noticeable that Mary never seemed to have any money for purchases from the ward trolley and if the ward had not supplied her with squash, tissues and soap, she would not have had any of those items. Janice, the ward sister, mentioned it to Jean, who flushed a little and said that she did not have anything to do with her mother's money and by the time she had personally paid for the bus fare to the hospital, she did not have any funds for such purchases and, anyway, the hospital provided that, did they not?

Many nurses would recognise this type of situation and the dilemma that arises for them is this: to what extent is the nurse a protector of the patient, even when she has to protect the patient from his own relatives? In one sense, this type of situation will not continue for very long since certain benefits are reduced and ultimately end after several weeks. However, the same issue can arise in other circumstances, for example, the signing of wills (considered in chapter 29). In the above situation, there is little that the ward sister can do. In any event, she cannot be sure that the money is not being used to meet Mary's bills at home and the sum is, of course, far too small to consider taking out a Court of Protection order. However, the fact that the relatives are aware of her concern might be of some small influence.[7] The Department for Work and Pensions (DWP)[8] can appoint someone (an appointee) to claim and spend benefits on a person's behalf if that person lacks the requisite mental capacity[9]. The DWP has a responsibility to visit the claimant and see if an appointee is needed and to supervise the situation. Any concerns about misappropriation could be reported to the DWP.

(The law relating to the care of a patient's property on the death of a patient and the making of wills is considered in chapter 29.)

Returning the patient's property

Practical Dilemma 25.7 Weekend property problems

It was the accepted practice at Roger Park General Hospital for the money on any patients who were admitted in an emergency to be retained by the general office for safekeeping during their stay. On discharge, they were then able to obtain a cheque representing that amount of money from the general office. Most patients, except those with no bank accounts, accepted the system. Problems, however, arose at weekends when no general office staff were on duty or when discharge was sudden and the cheques could not be made available in time. On such occasions, patients complained that the actual cash that was taken from them was not returned and, since not all banks were open on Saturday, they could not change the cheques and some had no cash with which to return home. What is the legal position?

The legal position depends to a certain extent on the circumstances of the money being taken by the NHS trust. If the patient is fully conscious when the money is handed over, he should be told that he will be given a cheque for this amount on discharge. If he refuses to agree to this, then it is open to him to ask relatives to look after his money or to take the risk of keeping that sum on his person. If, however, the money has been taken from the unconscious patient after an emergency admission, then there is no chance of the terms of the bailment being agreed with him. In such circumstances, the hospital holds the money as part of its duty of care to look after the patient. It could be argued that this duty requires the hospital to return to the patient exactly the same coins and notes that were taken from him. Alternatively, it could be said that the hospital carries out its duty of care by giving the patient the equivalent of what was taken in the form of a cheque. Unfortunately, there is no decided case to clarify the position in law. As far as administrative practice is concerned, possibly the best solution is to discuss with the patient as soon as he is conscious and capable of handling his affairs what the patient would prefer and, if the patient is unhappy at receiving a cheque for the entire amount, to consider the possibility of providing part in cash for immediate needs. Where the discharge is contemplated for a weekend, then either the cheque should be prepared in advance or there should be an emergency scheme to provide the patient with a cash advance. Where the patient has no bank account, the hospital should be able to make special arrangements either for the cheque to be cleared at a local branch or for the cash to be made available.

Staff property

Practical Dilemma 25.8 Lost handbag

Mavis Jarvis, a staff nurse, was going straight from work to a travel company to pay for her holiday to Greece. She was holidaying with a friend and had £500 in cash to pay for both of them. The money was contained in a wallet inside her handbag. At the hospital, all nursing staff were provided with a locker in a staffroom in their ward or department. The lockers were fitted with a padlock and key. Mavis locked her locker and carried the key around for the whole shift. Several people knew that she was going to the travel agent after work. At the end of the shift, when she went to her locker, she found that it had been broken into: the small padlock had been forced open and the money was missing from the wallet. The police were summoned, but despite intensive questioning and a search the money was never recovered or the thief discovered. Mavis feels that the NHS trust should pay for the missing money since, she argued, the padlock was inadequate and a far tougher system should have been provided for taking care of staff property. Is she right in law?

Unfortunately for Mavis, it is highly unlikely that she would win in a court action against the NHS trust. The NHS trust is not the bailee of Mavis's cash; she has not transferred it for its safekeeping. She has, so to speak, brought the property into the hospital at her own risk. If, of course, she had gone to the general office and said, 'Please take care of this for me since I have to go to the travel agent straight after work', and it had done so, the situation would have been very different. In that case, the NHS trust would have become a bailee of her money and would be accountable to her for its return. What about the argument that the locker should have been stronger? The locker should be as strong as is compatible with the value of property that is reasonable to be kept in there. There must be few who would think that attempting to keep £500 is reasonable. Anyone who brings valuable goods to work and keeps them there cannot expect the NHS trust to be held responsible for their loss, unless, of course, it is a requirement of the job that such items are brought to work, or unless the employer has assumed responsibility for the property. The employer can, through the contract of employment, take on a wider responsibility for the property of employees, although this would be unusual. The courts are unlikely to imply a term that the employer has a duty to take care of the property of the employee. There would have to be an explicit undertaking to that effect.

Practical Dilemma 25.9 Staff car park

Jean Jones, a staff nurse in the outpatients department, parked her car in the hospital car park, paying the daily fee of £3.00. When she came back, she found that her car had been broken into and the radio/DVD player taken. A pathology laboratory technician whose office overlooked the car park came up to her as she was looking at the damage and said that he had seen the whole incident. He had seen two youths break into the car who were then chased by the car park attendant. When car park charges were introduced, staff had been assured that there would be better protection for their cars. Could Jean Jones hold the security firm or the NHS trust responsible for the damage?

There are two possible causes of action: one against the security firm and the other against the trust. If it were the responsibility of the security firm to protect the vehicles in the car park on a 24-hour basis, then they have failed to fulfil that responsibility. There may be a contractual right against them by the NHS trust, but it depends on the terms of the contract. Although the trust has a right of action in contract, Jean Jones does not have a right of action, unless she can make use of the Contracts (Rights of Third Parties) Act 1999, which enables a person not a party to the contract to sue for benefits under it. In addition, it may be argued that the security firm owed a duty of care in the law of negligence to each employee or user of the car park. This might be difficult to establish. Any liability of the trust depends on Jean's being able to establish that it owed Jean a duty of care in respect of her car and had not excluded any liability by an exemption notice. This would depend on the actual facts. The likelihood is that Jean will be unable to obtain compensation from either the security firm or her employers and will be dependent on any insurance cover she has for theft. (See Statute Box 25.1 on page 673) on reasonableness of excluding liability).

Gifts

It is extremely important that NMC guidance and local policies relating to gifts from patients/clients are closely followed to prevent any accusations of theft or bribery. The NMC in its Code of Practice[10] under the heading 'Maintain clear professional boundaries', states:

> **You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment.**

As a consequence of their ability to prescribe, nurses may be offered inducements by medicine companies. Therefore in its Practice Standard 21 on gifts and benefits in its Guidance on nurse prescribing[11] the NMC states:

> **21.1 You must make your choice of medicinal product for the patient/client, based on clinical suitability and cost effectiveness**
> **21.2 You must maintain a 'register of interests' within your own personal portfolio, which may be produced on request if required for audit purposes**
> **21.3 You should adhere to local corporate policy when maintaining a 'register of interests'.**

The NMC points out that:

> **Personal gifts are prohibited and it is an offence to solicit or accept a gift or inducement. Companies may offer hospitality for a professional/scientific meeting, but such hospitality must be reasonable in level, and subordinate to, the main purpose of the meeting.**

If a grateful patient wishes to express thanks in some tangible way it is preferable to refer the patient to the manager to ensure that the patient is appropriately represented and that any element of undue influence can be prevented. This may be significant where the patient makes a gift to the hospital in a will (see chapter 29). Even where smaller gifts such as boxes of chocolates are made, the line manager should be notified about the gift. In July 2014 a nurse who used donations to buy drinks for patients and pay for staff parties was cleared of misconduct by the NMC after she admitted accepting money from four patients' families and failing to record them. Her employers demoted her and gave her a warning. She was acquitted at Edinburgh Sheriff Court, where it was held that although she broke hospital accounting rules, she was not dishonest.[12]

In determining whether a gift has been made and no theft has taken place, the court would consider the mental capacity of the owner of the property. For example, the House of Lords held in the case of *R* v. *Hinks*[13] that the main carer of a man with limited intelligence who gave her about £60,000 in small amounts over a six-month period had in fact stolen the money. She was convicted of theft, the jury considering her to have dishonestly appropriated the money, applying the test of the standards of reasonable and honest people. The House of Lords upheld the conviction.

Conclusions

The Mental Capacity Act 2005, in establishing a new Court of Protection, an Office of Public Guardian and the concept of the lasting power of attorney is having a major impact on the property and affairs of those lacking the requisite mental capacity to make decisions. A Code of Practice[14] has been prepared to assist those responsible for the property of others, and help and information on the Mental Capacity Act is available from the Ministry of Justice.[15] Local policies should be in place relating to the protection of patient property, exclusion of liability and receipt of gifts.

Reflection questions

1 Consider the liability of the NHS trust, if any, for the loss of a patient's pyjamas. It appears that they were removed when the patient was given a bath and probably placed with the sheets in the laundry bag. The laundry has denied any knowledge of them.

2 Examine the procedure followed in relation to property when patients are admitted to hospital.

3 You are working at a psychiatric hospital and one of the patients drags a nail along the side of your new car. Is the NHS trust responsible? Would it make any difference if there were a notice by the car park exempting the NHS trust from loss or damage to staff cars parked there?

4 The Court of Protection has been appointed to manage the property of one of the patients on your ward. What powers does it have and who will administer the property?

Further exercises

1 How many disclaimer notices or exclusion notices do you see around the hospital? Consider the extent to which reliance on each notice would be reasonable to exclude liability for damage or loss of property caused by the negligence of the NHS trust or its staff.

2 The relative of a patient in your medical wards asks you if you would witness a power of attorney so that the relative can manage the patient's affairs on his behalf. You know that the patient is mentally disordered but is reputed to be quite wealthy. What advice would you give to the relative?

References

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[2] Alexi Mostrous, Staff at care home 'too scared to tell of financial deceit', *The Times*, 24 December 2013

[3] The Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian Regulations 2007, SI 2007/1253

[4] Ministry of Justice www.gov.uk

[5] *Independent News and Media Ltd and Others* v. *A*, The Times Law Report, 17 November 2009; [2009] EWHC 2858

[6] www.publicguardian.gov.uk

[7] B. Dimond, *Legal Aspects of Mental Capacity*, Blackwell Scientific Publishing, Oxford, 2007

[8] www.dwp.gov.uk

[9] www.gov.uk/become-appointee-for-someone-claiming-benefits

[10] Nursing and Midwifery Council, Code of Professional Conduct: standards for performance, conduct and ethics, NMC, London, 2008

[11] Nursing and Midwifery Council, Standards for prescribing, NMC, London, 2006

[12] News item, *The Times*, 14 July 2014

[13] *R* v. *Hinks* [2001] 2 AC 241

[14] Code of Practice, Mental Capacity Act 2005, Department for Constitutional Affairs, February 2007, paragraph 7.21

[15] Ministry of Justice www.gov.uk



Chapter 26

Legal aspects of public health

This chapter discusses

- Public health legislation
- Notifiable diseases
- Cross-infection control
- Health and Social Care Act 2008
- Health Protection Agency (now Public Health England)
- Public Health England
- Tuberculosis (TB)
- Hepatitis
- HIV-infected persons and AIDS patients
- Vaccination
- Blood donors
- Confidentiality

Introduction

Significant changes have taken place in the management of public health. The establishment of Public Health England and transfer of responsibility from health service organisations to local authority is still taking place with health visitors now being employed by local authorities. The challenge of hospital acquired infections, though still present, is slowly coming under control and the legal issues relating to AIDs and HIV no longer hold such a prominent position in public health management. The worldwide

threat from diseases such as Ebola and the concern about antibiotic-resistant diseases means that public health law will have a prominent place in health professional practice.

Public health legislation

Our public health legislation has developed piecemeal from the Public Health (Control of Diseases) Act 1984 and subsequent legislation. Notification provisions revised in 2010 require information to be given about specified infectious diseases and considerable powers are given to Justices of the Peace to protect public health. In 2005 the Law Commission[1] recommended that significant changes should be made to the 1984 Act to strengthen the response to infectious diseases and contamination by chemicals and radiation. These recommendations have been enacted in the Health and Social Care Act 2008 together with three sets of regulations (2010/657, 2010/658 and 2010/659). Information on diseases which must be notified is available on the Health Protection Agency (HPA) website;[2] the HPA is now absorbed into Public Health England. The Health Protection (Notification) Regulations 2010 (SI 2010/659) can be accessed on the legislation website[3] and are shown together with the other two sets of regulations in Statute Boxes 26.1, 26.2 and 26.3.

Statute 26.1 Local authority powers (SI 2010/657)

The requirement to keep a child away from school
The requirement to provide details of children attending school
Disinfection or decontamination of things:
- on the request of the owner
- on the request of person with custody or control
- on premises on request of tenant

Requests for cooperation for health protection purposes
Restriction of contact with dead bodies
Restriction of access to dead bodies
Relocation of dead bodies

Statute 26.2 Part 2A orders (ie. Application to Justice of the Peace) (SI 2010/658)

Duty of local authorities to give notice of Part 2A applications
Evidence required for a Part 2A application
Period for which Part 2A order in relation to persons may be in force
Affected persons in relation to Part 2A orders in relation to persons and dead bodies or human remains
Discretionary power for local authorities to charge in connection with Part 2A order in relation to things and premises
Duty on local authorities to provide information in relation to Part 2A order in relation to persons
Duty on local authorities to have regard to welfare following a Part 2A order in relation to persons
Duty on local authorities to report Part 2A applications to the Health Protection Agency
Duty on local authorities to report variations or revocations of Part 2A orders to the Health Protection Agency (now Public Health England)

Statute 26.3 Notification provisions (SI 2010/659)

Duty to notify suspected disease, infection or contamination in patients
Duty to notify suspected disease, infection or contamination in dead persons
Duty of notify causative agents found in human samples
Duty to provide information to the Health Protection Agency (now Public Health England)
Duty on the relevant local authority to disclose notification to others.

Schedule 1 lists the notifiable diseases and Schedule 2 the causative agents.

The Health Protection Agency was abolished by the Health and Social Care Act 2012 and its functions have been transferred to the Secretary of State and Public Health England – an executive agency of the Department of Health – which came into being in April 2013 (see page 692).

The role of Healthwatch England and the local healthwatch is considered in chapter 27.

Powers of the Justice of the Peace

The Justice of the Peace (JP) has considerable powers in relation to the protection of public health. The powers were set out in Public Health (Control of Disease) Act 1984 which has been substantially amended by the Health and Social Care Act 2008 by the insertion of a new Part 2A to the 1984 Act. The powers of the JP to order health measures in relation to persons are set out in section 45G; to order health measures in relation to things in section 45H; to order health measures in relation to premises in section 45I; and to make these orders in relation to groups of people, things or premises in section 45J.

Under section 18 of the 2012 Health and Social Care Act, regulations may require a local authority to exercise any of the public health functions of the Secretary of State (so far as relating to the health of the public in the authority's area) by taking such steps as may be prescribed.

Notifiable diseases

Diseases that are notifiable are shown in Statute Box 26.4.

Statute 26.4 Notifiable diseases

Schedule 1 of the 2010 Regulations:

acute encephalitis, acute meningitis, acute poliomyelitis, acute infectious hepatitis, anthrax, botulism, brucellosis, cholera, diphtheria, enteric fever (typhoid or paratyphoid fever), food poisoning, haemolytic uraemic syndrome (HUS), infectious bloody diarrhoea, invasive group A streptococcal disease and scarlet fever, legionnaire's disease, leprosy, malaria, measles, meningococcal septicaemia, mumps, plague, rabies, rubella, SARS, smallpox, tetanus, tuberculosis, typhus, viral haemorrhagic fever (VHF), whooping cough, yellow fever.

Schedule 2 Causative Agents:

Bacillus anthracis, *Bacillus cereus* (only if associated with food poisoning), *Bordetella pertussis*, *Borrelia* spp., *Brucella* spp., *Burkholderia mallei*, *Burkholderia pseudomallei*, *Campylobacter* spp., Chikungunya virus, *Chlamydophila psittaci*, *Clostridium botulinum*, *Clostridium perfringens* (only if associated with food poisoning), *Clostridium tetani*, *Corynebacterium diphtheriae*, *Corynebacterium ulcerans*, *Coxiella burnetii*, Crimean–Congo haemorrhagic fever virus, *Cryptosporidium* spp., dengue virus, Ebola virus, *Entamoeba histolytica*, *Francisella tularensis*, *Giardia lamblia*, Guanarito virus *Haemophilus influenzae* (invasive), hantavirus hepatitis A, B, C, delta and E viruses, influenza virus, Junin virus, Kyasanur Forest disease virus, Lassa virus, *Legionella* spp., *Leptospira interrogans*, *Listeria monocytogenes*, Machupo virus, Marburg virus, measles virus, mumps virus, *Mycobacterium tuberculosis* complex, *Neisseria meningitidis*, Omsk haemorrhagic fever virus, *Plasmodium falciparum*, *p. vivax*, *p. ovale*, *p. malariae*, *p. knowlesi*, polio virus (wild or vaccine types), rabies virus (classical rabies and rabies-related lyssaviruses), *Rickettsia* spp., Rift Valley fever virus, rubella virus, Sabia virus, *Salmonella* spp., SARS coronavirus, *Shigella* spp., *Streptococcus pneumoniae* (invasive), *Streptococcus pyogenes* (invasive), varicella zoster virus, variola virus, verocytotoxigenic *Escherichia coli* (including *E. coli* O157), *Vibrio cholerae*, West Nile virus, yellow fever virus, *Yersinia pestis*.

Schedule 1 covers those notifiable diseases that come under the notification procedure set out in Regulation 2 (see Statute Box 26.5). Schedule 2 covers those diseases which must be reported by diagnostic laboratories to the Health Protection Authority under Regulation 4 of the Health Protection (Notification) Regulations 2010.[4]

Procedure for notification

Under section 11 of the 1984 Act, a registered medical practitioner has a duty to notify the proper office of the local authority if he becomes aware, or suspects, that a patient whom he is attending within the district of a local authority is suffering from a notifiable disease or from food poisoning. The duty does not apply if he believes, and has reasonable grounds for believing, that some other registered medical practitioner has complied with the duty. See Statute Box 26.5.

Statute 26.5 Notification procedure (Regulations 2010/659, Regulation 2)

2(1) A registered medical practitioner (R) must notify the proper officer of the relevant local authority where R has reasonable grounds for suspecting that a patient (P) whom R is attending –

(a) has a notifiable disease;

(b) has an infection which, in the view of R, presents or could present significant harm to human health; or

(c) is contaminated in a manner which, in the view of R, presents or could present significant harm to human health.

What information must be notified?

Statute Box 26.6 shows the information that must be notified.[5]

Statute 26.6 Notification Regulations 2010

Information that must be notified

Regulation 2(2) The notification must include the following information insofar as it is known to R –

- (a) P's name, date of birth and sex;
- (b) P's home address including postcode;
- (c) P's current residence (if not home address);
- (d) P's telephone number;
- (e) P's NHS number;
- (f) P's occupation (if R considers it relevant);
- (g) the name, address and postcode of P's place of work or education (if R considers it relevant);
- (h) P's relevant overseas travel history;
- (i) P's ethnicity;
- (j) contact details for a parent of P (where P is a child);
- (k) the disease or infection which P has or is suspected of having or the nature of P's contamination or suspected contamination;
- (l) the date of onset of P's symptoms;
- (m) the date of R's diagnosis; and
- (n) R's name, address and telephone number.

(3) The notification must be provided in writing within 3 days beginning with the day on which R forms a suspicion under paragraph (1).

(4) Without prejudice to paragraph (3), if R considers that the case is urgent, notification must be provided orally as soon as reasonably practicable.

(5) In determining whether the case is urgent, R must have regard to –

- (a) the nature of the suspected disease, infection or contamination;
- (b) the ease of spread of that disease, infection or contamination;
- (c) the ways in which the spread of the disease, infection or contamination can be prevented or controlled;
- (d) P's circumstances (including age, sex and occupation).

(NB: Public Health (Control of Disease) Act 1984 section 11(4) imposes a criminal sanction on a person who fails to comply with an obligation imposed on him under the provisions set out above.)

Regulation 3 extends the obligation set out in Statute Box 26.6 to cover notification of a suspected disease, infection or contamination in a dead body.

Cross-infection control

The last two decades have seen major concerns about the level of hospital-acquired infection (HAI). A report by the National Audit Office (NAO)[6] in 2000 raised concerns about the level of HAI suggesting that HAI could be the main or a contributory cause in 20,000 or 4 per cent of deaths a year in the UK and that there are at least about 100,000 cases of HAI with an estimated cost to the NHS of £1 billion. The NAO made recommendations on the strategic management of HAI.

The government responded to this report by announcing a multi-pronged initiative to tackle HAI. Among the initiatives planned were an antimicrobial strategy, including a clampdown on inappropriate antibiotic use and better infection control measures.[7] The Audit Commission and Commission for Health Improvement (now the Care Quality Commission) were to assume the responsibility of independent inspection of wards and had the right to seek information on HAI and to publish it.[8] Numerous initiatives have followed since then, with the emphasis on different types of infections changing. The Secretary of State for Health admitted in 2001 that methicillin-resistant Staphylococcus aureus (MRSA) was endemic in England's hospitals.[9] The role of 'Matron' was reintroduced with responsibilities

for hygiene and standards of cleanliness. The NMC provided advice to registrants on infection control.[10] The RCN has also provided guidance on good practice in infection prevention and control.[11]

Clostridium difficile (C. difficile) was described by the HPA in 2007 as the most important cause of hospital-acquired diarrhoea. Further information, including the findings and recommendations from a review of epidemiology by the Directors of Infection Prevention and Control in England,[12] can be found on the HPA website[13] and the DH website.[14] In 2007 one of the first acts of the then new Secretary of State, Alan Johnson, was to give £50 million to tackle MRSA and C. difficile by doubling the size of the DH's infection improvement team who advise NHS trusts on developing plans to cut infections. In July 2007 the Healthcare Commission published a national study into healthcare-associated infection. To reduce the risk of infections the report recommended that trusts should develop a culture of safety, have a good system of corporate and clinical governance, review performance, manage risk and communicate with patients and the public. A report by the Healthcare Commission in October 2007 into Maidstone and Tunbridge Wells Trust revealed that up to 90 patients had died between 2004 and 2006 after being infected with C. difficile. The Minister of Health responded by announcing plans for a new super-regulator to be established in April 2009, i.e. the Care Quality Commission, combining the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection, with powers to close NHS and private hospitals and residential care homes. The new powers under the Corporate Manslaughter and Corporate Homicide Act may be used against NHS trusts which fail to control HAI. It was reported on 17 January 2007 that Lesley Ash, an actress, received a £5 million settlement after she caught MRSA at the Chelsea and Westminster Hospital. It caused her devastating disabilities and meant that she would never again be able to play an active roles as an actress.

The Chief Medical Officer in December 2013 issued an international blueprint to fight antibiotic resistance which included a proposal to use vaccinations against common bacteria and hospital super-bugs.[15] In July 2014 the Prime Minister urged global action to find new antibiotics and he appointed an economist to lead the challenge to encourage pharmaceutical companies to undertake more research.

Further information on the levels of infection and the most common infections can be found on website of the Health Protection Agency[16] (which is now part of Public Health England) and the Cochrane Library website.[17]

Practical Dilemma 26.1 Cross-infection nurse

Joan was appointed as the hospital infection control nurse. Immediately on starting her new post, she undertook an audit of existing practices on infection control. She found that basic standards, including handwashing, were extremely lax, particularly among junior doctors. However, her attempts to raise standards appeared to be thwarted. What is the legal situation?

When Joan was appointed, she should have been notified of the organisational support that would be given to her post. This would include such details as to whom she reported, who was her immediate line manager, the resources available to her and the strategy of the organisation in setting down and complying with the standards issued by the government. There should be in place a committee for infection control. She would need to prepare a report on her findings, giving her conclusions in a clear, unemotional report with constructive recommendations on the action that could be taken. If there is no follow-up action from her report, then she may have justification in following the procedures set up under the Public Interest Disclosure Act 1998 (see chapter 4) to ensure that action is taken.

In 2014 the ebola outbreak in west Africa was declared an international emergency as over 1,000 people had died from the disease. Ethical and legal issues were raised in the discussion over whether to give untested drugs to sufferers. The World Health Organization (WHO) panel ruled that the severity of the outbreak meant that it was ethically acceptable to give the drugs to patients. Informed consent by the patient was essential.[18] Fortunately early indications suggested that the untested drug was effective.

Health and Social Care Act 2008

Provision was made in the Health and Social Care Act 2008 to strengthen measures to protect the public health from infection and contamination. Under section 20 the Secretary of State is given power to make regulations in respect of regulated activities which include:

> **the prevention and control of health care associated infections and may include such provision as the Secretary of State considers appropriate for the purpose of safeguarding individuals (whether receiving health or social care or otherwise) from the risk, or any increased risk, of being exposed to health care associated infections or of being made susceptible, or more susceptible, to them (s. 20(5)).**

Under section 21(1) the Secretary of State may issue a code of practice about compliance with any requirements of regulations under section 20 which relate to the prevention or control of healthcare-associated infections.

Under section 21(3) the Secretary of State must keep the code under review and may from time to time –

(a) revise the whole or any part of the code, and
(b) issue a revised code.

Prior to the issue of the code the Secretary of State is obliged to consult with such persons as he considers appropriate. The code of practice is to be taken into account by the Care Quality Commission in making decisions under the Act and it is admissible in evidence in civil and criminal proceedings, but a failure to observe any provision of a code of practice under section 21 does not of itself make a person liable to any criminal or civil proceedings (s. 25(3)).

The Health and Social Care Act 2008 section 129 also inserted a new Part 2A into the Public Health (Control of Disease) Act 1984 which gives greater powers to make regulations controlling contamination and the spread of disease. For example, a new section 45C to the Public Health (Control of Diseases) Act 1984 covers domestic health protection regulations and is shown in Statute Box 26.7.

Statute 26.7 Domestic health protection regulations – Section 45C of 1984 Act (Inserted by Health and Social Care Act 2008)

(1) The appropriate Minister may by regulations make provision for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales (whether from risks originating there or elsewhere).
(2) The power in subsection (1) may be exercised –
  (a) in relation to infection or contamination generally or in relation to particular forms of infection or contamination, and
  (b) so as to make provision of a general nature, to make contingent provision or to make specific provision in response to a particular set of circumstances.
(3) Regulations under subsection (1) may in particular include provision –
  (a) imposing duties on registered medical practitioners or other persons to record and notify cases or suspected cases of infection or contamination,
  (b) conferring on local authorities or other persons functions in relation to the monitoring of public health risks, and
  (c) imposing or enabling the imposition of restrictions or requirements on or in relation to persons, things or premises in the event of, or in response to, a threat to public health.
(4) The restrictions or requirements mentioned in subsection (3)(c) include in particular –
  (a) a requirement that a child is to be kept away from school,
  (b) a prohibition or restriction relating to the holding of an event or gathering,
  (c) a restriction or requirement relating to the handling, transport, burial or cremation of dead bodies or the handling, transport or disposal of human remains, and
  (d) a special restriction or requirement.

The power to make the regulations shown in Statute Box 26.7 is subject to restrictions set out in section 45D which requires that the restriction or requirement is proportionate to what is sought to be achieved by imposing it. Special restrictions or requirements cannot be imposed unless (a) the regulations are made in response to a serious and imminent threat to public health, or (b) imposition of the restriction or requirement is expressed to be contingent on there being such a threat at the time when it is imposed.

1 Under section 45G a Justice of the Peace may make an order under subsection 2 if satisfied that –
   (a) P is or may be infected or contaminated,
   (b) the infection or contamination is one which presents or could present significant harm to human health,
   (c) there is a risk that P might infect or contaminate others, and
   (d) it is necessary to make the order in order to remove or reduce that risk.
2 The order may impose on or in relation to P one or more of the following restrictions or requirements –
   (a) that P submit to medical examination;
   (b) that P be removed to a hospital or other suitable establishment;
   (c) that P be detained in a hospital or other suitable establishment;
   (d) that P be kept in isolation or quarantine;
   (e) that P be disinfected or decontaminated;
   (f) that P wear protective clothing;
   (g) that P provide information or answer questions about P's health or other circumstances;
   (h) that P's health be monitored and the results reported;
   (i) that P attend training or advice sessions on how to reduce the risk of infecting or contaminating others;
   (j) that P be subject to restrictions on where P goes or with whom P has contact;
   (k) that P abstain from working or trading.
3 A Justice of the Peace may make an order under subsection (4) in relation to a person ('P') if the justice is satisfied that –
   (a) P is or may be infected or contaminated,
   (b) the infection or contamination is one which presents or could present significant harm to human health,
   (c) there is a risk that a related party might infect or contaminate others, and
   (d) it is necessary to make the order in order to remove or reduce that risk.
4 The order may impose on or in relation to P a requirement that P provide information or answer questions about P's health or other circumstances (including, in particular, information or questions about the identity of a related party).

The World Health Organization warned in May 2013 that a virus similar to Sars, called coronavirus, has killed more than half of the people it has infected and is a threat to the entire world.[19]

European Union and patient safety

In 2009 the Council of the European Union made recommendations on patient safety[20] which included recommendations relating to education and training of healthcare workers and national strategies, and long-term priorities for the control and prevention of healthcare-associated infections.

Health Protection Agency (now Public Health England)

In April 2003 the HPA was created to provide a coordinated approach to health protection and reduce the impact of infectious diseases, poisons, chemicals, biological and radiation hazards. It was set up in the light of the Chief Medical Officer of Health's report *Getting Ahead of the Curve*,[21] which recognised

the need to bring together in one organisation the skills and expertise in a number of organisations to work in a more coordinated way, to reduce the burden and consequences of health protection threats or disease with the aim of providing a more comprehensive and effective response to threats to the public's health. The HPA brought together the following organisations into the one body:

- Public Health Laboratory Service (including the Communicable Disease Surveillance Centre and Central Public Health Laboratory)
- Centre for Applied Microbiology and Research
- National Focus for Chemical Incidents
- Regional service provider units that support the management of chemical incidents
- National Poisons Information Service
- NHS public health staff responsible for infectious disease control, emergency planning and other protection support
- National Radiological Protection Board (NRPB) (incorporated into the Health Protection Agency in April 2005).

The HPA was established as a special health authority under section 11 of the National Health Service Act 1977 but under the Health Protection Agency Act 2004 it became a non-departmental public body.

However, with a budget of £175 million a year, it had to be accountable and this was initially to the Department of Health and parliamentary monitoring.

The HPA was one of the quangos that was identified for closure, with its functions being reallocated to save costs. The review of arm's-length bodies recommended the abolition of the HPA and the National Treatment Agency (see chapter 28) as statutory organisations and the transfer of their functions to the Secretary of State as part of the new Public Health Service in 2012.[22]

Public Health England

As envisaged in the Public Health White Paper *Healthy Lives, Healthy People – our strategy for public health in England* (November 2010), the Health Protection Agency was abolished by the Health and Social Care Act 2012. Its functions were transferred to the Secretary of State and Public Health England – an executive agency of the Department of Health – and came into being in April 2013. At local level, local authorities now have responsibility for improving the health of their local populations and must employ a director of public health, and publish annual reports. LAs coordinate the work done by the NHS, social care, housing, environmental health, leisure and transport services. Further information on Public Health England can be found on its website.[23]

Care Quality Commission

In April 2013 Public Health England signed a memorandum of understanding with the Care Quality Commission. The Care Quality Commission (CQC) (formerly the Healthcare Commission) also has powers under the Health and Social Care (Community Health and Standards) Act 2003 section 53A (as added by the Health Act 2006 section 16) to issue improvement notices in respect of hygiene failings.

Tuberculosis (TB)

TB was once thought to have been eradicated. However, there is evidence that poor housing conditions, poverty and malnourishment are leading to an increase in TB levels, often particularly associated with the refugee population. A National Knowledge Service has been set up to provide information directly relevant to the treatment, prevention and management of TB. It is accessible on the HPA website. The

HPA, in cooperation with the DH is aiming to eliminate TB within England in accordance with the action plan published by the Chief Medical Officer of Health in 2004.[24] In May 2005 more than 700 patients who had been treated at the Lister Hospital Stevenage were sent letters urging them to be alert to TB symptoms after an unnamed health worker had been diagnosed with the disease.[25]

Figures from the HPA in November 2010 showed that figures for TB have doubled over the past decade and have reached a 30-year high. Further information on its strategy and local and national surveillance can be obtained from the HPA website.[26] In March 2010 the HPA website stated that:

> **Around 9000 cases of TB are currently reported each year in the United Kingdom. Most cases occur in major cities, particularly in London. The Health Protection Agency aims to contribute to the elimination of TB in England through support to the National Health Service and the Department of Health in the key areas identified for controlling TB in the National Action Plan, Stopping Tuberculosis in England, published by the Chief Medical Officer in October 2004. Through its TB Programme, the HPA co-ordinates its TB control activities, which are carried out by different parts of the organisation: the Centre for Infections, Local and Regional Services, the Regional Microbiology Network and the Centre for Emergency Preparedness and Response. The activities include local and national surveillance, laboratory diagnostic and reference services, disease control in the population, international partnership and leading edge research.**

Hepatitis

The BMA called for all children in Britain to be immunised against hepatitis B since transmission rates were rising and it was 50 to 100 times more infectious than the AIDS virus.[27] In 2004 the Department of Health issued revised guidance on prevention and testing in children and HIV which also covers advice about hepatitis B and C.[28] The British HIV Association has published guidelines for the management of HIV infection in pregnant women.[29] Sharon Wilson describes the challenges for midwives in facing HIV-positive pregnant woman.[30]

Practical advice for midwives in suggesting tests for sexually transmitted infections in pregnancy is given by Julie Williams.[31] In January 2004 NICE approved new treatment for those suffering from hepatitis C. It suggested that the drug pegylated interferon should be prescribed on the NHS along with another drug, ribavirin.[32]

HIV-infected persons and AIDS patients

Significant progress has been made in the past 30 years in the treatment and prevention of AIDS and attitudes to those who are HIV-infected. A diagnosis of HIV-positive now means long-term antiretroviral drugs, but no automatic full-blown AIDS. In November 2013 it was reported that research was to commence on a potential cure for HIV[33] and in January 2014 the European Commission gave approval to a once a day pill to control HIV developed by GlaxoSmithKline.[34] Gone is the hysteria which once surrounded the condition, so that any healthcare worker who worked with exposure-prone procedures would lose his job if he or she was HIV-infected. The Department of Health lifted the ban on health workers with HIV performing surgery and dentistry and self-testing kits for HIV were to be made legal from April 2014 and are available on the internet.[35]

Government policy on testing

In December 1998 the government launched a campaign to encourage all pregnant women to have an HIV test. The press release stated that only 30 per cent of women who are HIV-positive are aware that they are infected. If a pregnant woman is known to be HIV-positive, then the risk of passing on HIV to the fetus can be reduced by arranging for delivery to be by Caesarean section. Avoiding breastfeeding

also removes the risk of passing on the virus through the milk. However, the law has not been changed and a test for HIV still requires the consent of the woman. The government set a national target to achieve an 80 per cent reduction by December 2002 in the number of children who acquire HIV from their mothers.[36] In their HIV/AIDS Services 2000/2001 allocation and strategy, NHS organisations were instructed that part of the HIV-prevention budget was to be used to support antenatal services in recommending an HIV test to all pregnant women. A research project to estimate the cost-effectiveness of a universal, voluntary HIV screening programme suggested that it is effective and should be implemented in the London area, with other areas being considered for screening.[37] For further information on guidelines for the management of HIV infections in pregnant women see the article by Lyall[38] and guidance from the Department of Health.[39] The Expert Advisory Group on AIDS published guidelines which were updated in 2002 and are available on its website.[40] It points out that all women in England are now offered and recommended an HIV test as part of their antenatal care and it sets out the pre-test discussions which should take place. Named testing should only take place with the consent of the person.

A GP who carried out secret HIV tests on five patients he suspected were indulging in risky sex was given a serious reprimand by the GMC. One of the patients had found out about the test when he applied for a life insurance policy and he notified the GMC. The disciplinary committee of the GMC noted that the GP believed that he was acting in the patients' best interests, but concluded that 'such a benevolent, paternalistic attitude has no place in modern medicine'.[41]

In Case 26.1, an HIV-positive mother refused to allow her baby to be tested for HIV.

Case 26.1 *Re C (HIV test)* (1999)

Refusal of HIV test[42]

The local authority applied for a specific issue order that a baby born to an HIV-positive mother be tested for HIV. The mother was sceptical of the conventional treatment for HIV and AIDS, had refused medication during the pregnancy and intended to continue breastfeeding until the child was about 2 years old. The judge found that there was a 20–25 per cent chance that the baby was infected with HIV; the risk had been increased with the breastfeeding. The judge held that the views of the parents were important factors in the decision and any court invited to overrule parental wishes had to move extremely cautiously. He concluded that in the present circumstances the arguments for overruling the wishes of the parents and for testing the baby were overwhelming. The baby had rights of her own, recognised in national and international law; the baby's welfare was paramount and in the baby's interests the test should take place. The parents appealed, but did not attend court on the date their application was due to be heard, having disappeared from their home, taking the child with them. The Court of Appeal refused permission to appeal: the question whether the child should or should not be tested was a matter relating to the welfare of the child, not the rights of the parents, and it was clearly not in the child's best interests for either the parents or the health professionals to remain ignorant of her state of health.

The Royal College of Paediatrics and Child Health published an update report on reducing mother-to-child transmission of HIV infection in the UK in 2006.[43] It recommended the development of networks for sharing expertise and facilities, the improvement of case management, the evolution in the management of HIV disease (through the use of antiretroviral treatment, Caesarean section and avoidance of breastfeeding) and the long-term follow-up of infants exposed to antiretroviral drugs. Annex E of the Expert Advisory Group Report considers the special circumstances of pregnancy and the use of HIV post-exposure prophylaxis (PEP).[44] Guidelines on good practice for pupils living with

HIV were published by the National Children's Bureau and the Children and Young People HIV Network[45] which give advice to schools on supporting children infected or affected by HIV. The guidance was updated in 2010 and is available on its website.[46]

The Aids Control Act 1987 was repealed by the Health and Social Care Act 2012. It required district health authorities to report matters set out in a schedule and other such relevant information as the Secretary of State may direct. The schedule included information on the number of people known to have AIDS and the timing of the diagnosis; the particulars of facilities and services provided by each authority; the numbers of people employed by the authority in providing such facilities and future provision over the next 12 months. A subsequent statutory instrument extended the information required to include HIV-positive persons.[47]

The HIV Testing Kits and Services Regulations[48] – which made it an offence to advertise HIV testing kits, services or components, or to sell or supply such kits without an accompanying warning note, and to provide HIV testing services which were not provided or directed by a registered medical practitioner – were repealed in 2014.[49]

Criminal law and HIV/AIDS

In the first successful prosecution for sexually transmitting HIV in England, a man was convicted of inflicting 'biological' grievous bodily harm on two women and sentenced to 4½ years' imprisonment.[50] The Court of Appeal set out the basic provisions which apply to this criminal offence in the case of Konzani.[51] A man who had known for three years that he was HIV-positive was sentenced to 9 years' imprisonment for having unprotected sex with a woman to whom he did not disclose his HIV status.[52] In September 2010 a man was jailed for 1 year for infecting a woman with HIV.[53]

Human Rights and HIV/AIDS

In a case brought against the Swedish government, an HIV patient argued that there had been a breach of his human rights under Article 5(1) of the European Convention on Human Rights when he had been compulsorily isolated for periods amounting to one and a half years over a seven-year period. The European Court of Human Rights held that the authorities had failed to strike a fair balance between the need to ensure that HIV did not spread and the applicant's right to liberty.[54] In contrast, the House of Lords held that there was no breach of Article 3 rights when a Ugandan woman was refused asylum even though she was suffering from full-blown AIDS and needed the retroviral drugs available in the UK to stay alive. Article 3 could not be interpreted as requiring contracting states to admit and treat AIDS sufferers from all over the world for the rest of their lives. They came to their unanimous decision despite their considerable sympathy for the woman.[55]

Under the Equality Act 2010 paragraph 6 of Schedule 1 defines certain medical conditions as a disability: cancer, HIV infection and multiple sclerosis. HIV infection is defined as an infection by a virus capable of causing the Acquired Immune Deficiency Syndrome. Therefore anyone diagnosed with HIV would be entitled to the same protection against discrimination in employment, getting goods and services, education, trade union membership and accommodation as other protected categories. (See chapter 10.)

Confidentiality and identifying patients who may be at risk

In one case,[56] the claimant was working as a healthcare worker when he was diagnosed as HIV-positive. He informed the health authority and ceased working immediately. The health authority wanted to conduct a 'look back' exercise that involved contacting various patients of the claimant's who were thought to be potentially at risk of infection. The claimant did not believe that his patients were at sufficient risk to justify that exercise and sought a declaration that the look back exercise was unlawful on the grounds that it breached clinical confidentiality. He also sought an order restraining the authority

from making use of the patient records and from doing anything that might directly or indirectly reveal his identity. An order was in force stating that the parties were only to be identified by initials. A newspaper wished to publish the story and the claimant sought an order to prevent its revealing his identity. The injunction was issued but was subsequently varied on the application of the newspaper so that it could name the health authority, the claimant's specialty and the date of his diagnosis as HIV-positive. The Court of Appeal held that it was appropriate for the health authority and claimant to be identified by initials, for the claimant's specialty to be identified, and ordered the claimant to make available to the health authority such patient records as were reasonably required on the understanding that they would not be disclosed without either the permission of the claimant or the court.

The Department of Health initiated a consultation on confidentiality and sexually transmitted diseases in 2006 in the light of a High Court case where claimants sought a declaration relating to the common law on disclosure, the Human Rights Act and the legislation relating to disclosure and sexually transmitted diseases.

HIV-infected healthcare workers

The Department of Health has updated its guidance on HIV-infected healthcare workers[57] and it is now incorporated in the report of the Expert Advisory Group on AIDS[58] and its advice on HIV post-exposure prophylaxis should be followed. It makes it clear that, because of the very low risk of infection, there is no longer a requirement to notify all patients, but whether notification is necessary should be assessed on a case-by-case basis using risk assessment.

In 2011 a report by the Tripartite working group on the management of HIV-infected healthcare workers recommended they could perform exposure-prone procedures (EPP) provided they satisfied certain conditions and were under the supervision of a consultant in occupational health.[59]

Announcing the ending of restrictions, the Chief Medical Officer of Health Dame Sally Davis stated that it was more likely that someone would be struck down by lightning than infected by an HIV-infected healthcare worker. In addition the restriction on the purchase of HIV home testing kits was lifted, enabling people to find out their HIV status.[60]

Vaccination

Compensation for vaccine damage can be obtained in two ways. First, there is a statutory scheme of compensation under the Vaccine Damage Payments Act 1979. Under this scheme, £120,000[61] is payable to a person who can establish that they have been severely disabled as a result of a vaccination against the specified diseases of diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps, rubella, tuberculosis, smallpox (up to August 1971), *Haemophilus influenza* type b infection (HIB), meningococcal group C and pneumococcal infection and any other disease specified by the Secretary of State. Human papillomavirus was added in 2008.[62] Subsequent regulations[63] have reduced the severity of the disability, which must be proved to 60 per cent. Whether the disability has been caused by the vaccination shall be established on a balance of probabilities. The claim must be made before whichever is the later of the date on which the disabled person attains the age of 21 years (or, where he has died, would have attained that age) and the end of a period of six years, beginning on the date of the vaccination against the disease to which the claim relates. The person need not be under 18 at the time of vaccination, neither need there be an outbreak of the disease.[64]

This statutory scheme does not prevent a claim being made in the civil courts for negligence in relation to damage caused by vaccine. Clearly, if such a case could succeed, far more than £120,000 would be payable for severely disabled persons. However, civil action faces a further difficulty, as well as having to establish a causal link between the vaccine and the disability. The claimant must also show that the disability occurred as a result of negligence by the defendant; for example, the professionals failed to take account of the person's present health condition or previous history and the vaccine was

contraindicated for that person. A claim could also be brought against the drug company if there were some defect in the vaccine and this claim could now come under the Consumer Protection Act (considered in chapter 12), under which it is not necessary to show negligence by a manufacturer, but simply that there was a defect in the product. This would be extremely difficult if the victim was the only one from a particular batch who suffered harm. The civil cases so far have not overcome the problems of proving causation (see Case 26.2) apart from a case in Ireland.

In November 2013 a mother whose son died of CJD refused £120,000 in compensation and warned that the illness remains a ticking time bomb in Britain.[65]

It was reported in August 2010 that the mother of a Cheshire teenager who was left severely brain-damaged by the MMR vaccine won a compensation award from the government. Robert Fletcher, 18, from Warrington, suffered a fit 10 days after he had the vaccination when he was 13 months old. His mother Jackie received a £90,000 pay-out from a medical assessment panel. The family successfully appealed after their application for compensation was originally turned down in 1997. The tribunal specifically stated that the finding that his brain damage was caused by the MMR jab is not relevant to the claims of a link between the jab and autism.[66] It was reported in November 2013 that more than 1,000 families who wished to claim compensation following MMR vaccines are now due to sue their lawyers. A class action on behalf of the families was dropped in 2003 during the Andrew Wakefield controversy (see page 698), but some of the families are now suing their lawyers on the grounds that their action should have been based on a faulty batch of vaccines used between 1988 and 1992 and not the Wakefield dispute.[67] They alleged that the time limit of bringing the action within 10 years from the date of supply of the vaccine from the manufacturers was breached.[68]

It is estimated that 60 people will share in a £60 million payout because they suffered brain damage caused by swine flu vaccine. The compensation will be paid by GlaxoSmithKline (GSK) who will reclaim the cost from the government.[69] (GSK obtained an indemnity from the government against any claim for side effects.)

The *Sunday Times* used a Freedom of Information request to establish that 40 children are suspected of having died as a result of receiving routine vaccinations over a period of seven years.[70]

Case 26.2 *Loveday v. Renton and Another* (1988)

Vaccine damage[71]

Susan Loveday was vaccinated for whooping cough in 1970 and 1971, following which she suffered permanent brain damage. She claimed compensation from the Wellcome Foundation, which made the vaccine, and from the doctor who administered it.

The judge held that on a balance of probabilities the claimant had failed to show that pertussis vaccine could cause permanent brain damage in young children. The case therefore failed on this point of causation. The judge also said that even if he had found in favour of the claimant on this preliminary point, the claimant would still face insuperable difficulties in establishing negligence on the part of the doctor or nurse who administered the vaccine. Such a claim would have to be based on the ground that the vaccination had been given in spite of the presence of certain contraindications.

In a case in Ireland brought against the Wellcome Foundation,[72] £2.75 million was awarded in respect of brain damage following a vaccination. It was established that a particular batch of vaccine was below standard and should not have been released on to the market.

In another case an appeal by a GP against a finding of negligent advice in respect of a polio vaccine succeeded. The Court of Appeal held that the trial judge had wrongly found the GP to be in breach of his duty of care when he advised parents that there was no reason to postpone a polio vaccination because the child had an abscess on his buttocks. Subsequently the child contracted polio. The Court

of Appeal held it was not reasonably foreseeable that the GP could have foreseen the results of his failure to explain his advice to the parents. His reasoning was based on possible pain to the child, not the possibility of polio being contracted.[73]

Further information on compensation for vaccine damage is available from the government website.[74] Payments can be claimed and forms can be downloaded from a dedicated vaccine payments website.[75] The Department of Health publishes the *Green Book* giving information on vaccines and preventable infectious diseases which is updated on a regular basis and available on the government website.

In March 2014 it was announced that a vaccine for meningitis B would be made available. This reverses an earlier decision of the Joint Committee on Vaccination and Immunisation which said it would not be cost-effective to make it part of the routine child immunisation programme.[76] However, in June 2014 there were complaints that discussions with the company had yet to begin.[77]

The Mesothelioma Act 2014

This legislation allows for a package of support, funded by insurance firms, to pay in excess of 800 eligible people in 2014 and 300 every year after that until 2024. Payments are increased to around £123,000 plus £7,000 towards legal fees. The scheme applies to those diagnosed with mesothelioma since 25 July 2012. Further information is available on the government website[78] and from the Asbestos Victims Support Group Forum.[79]

The MMR dispute

Concern about MMR was raised in 1995[80] by Dr Wakefield of the Royal Free Hospital, London, who published claims of a link between the measles vaccination and the inflammatory bowel condition known as Crohn's disease. He subsequently published a second study that showed that some children who had developed the bowel condition also developed autism. The study was too small to demonstrate a causal connection with MMR, but it was suggested by Dr Wakefield that, pending further research, MMR should be temporarily abandoned and single doses of the different vaccines should be given. Subsequently, there was considerable disquiet over whether it was safe for health professionals to recommend MMR and many parents opted for the single dose that is not available on the NHS. The government attempted to induce confidence in MMR. For example, on 13 December 2001 a Department of Health press release[81] announced the publication of a report commissioned by the Department of Health and carried out by the Medical Research Council that there was no evidence to link autism with the measles, mumps and rubella vaccine. The apparent increase in prevalence of autism spectrum disorders (ASDs) was likely to have resulted from better diagnosis and clearer definition as well as increased awareness. In January 2004 the Department of Health published an MMR information pack for parents setting out the reasons why MMR is recommended, and providing seven information sheets.[82] Further information on supplies and the administration of MMR was issued in May 2005[83] and an assessment of the press coverage of the MMR vaccine was published by the Department of Health two days earlier.[84]

The issue came to the attention of the courts when a dispute arose between two sets of parents over whether the children should be given the MMR vaccine; in each case the mother was against the triple vaccine and the father wanted it given. The High Court ruled that it was in the best interest of the children to have the MMR. The Court of Appeal dismissed the appeal on the grounds that the judge had decided the applications by reference to the paramount consideration of the welfare of the two children, in accordance with section 1 of the Children Act 1989.[85] A practice direction was issued in July 2003 on MMR/MR vaccine litigation, which required such actions to commence in the Royal Courts of Justice and those that have commenced in the county court or district registry must be transferred. The actions had been allocated to the multi-track and came under the Civil Procedure Rules.[86] The independence of Dr Wakefield's research was subsequently criticised and the safety of MMR reaffirmed. Following three years of investigations, the GMC found Dr Wakefield guilty of serious professional misconduct and he was struck off the Register.[87] In 2007 an increase in measles was held

to be directly linked with the failure in uptake of the MMR vaccine as a result of the controversy, and figures published in January 2010 show that there were 1,348 cases of measles in 2008 compared with 56 in 1998.[88] A similar outbreak took place in Swansea, south Wales in 2013. Fears that a time bomb of babies being born deaf and blind as a result of teenagers not receiving the MMR jab have been expressed by Professor Colin Blakemore.[89]

The MMR controversy is explored in a book by Tammy Boyce.[90] In September 2014 the Texan state appeals court ruled that Mr Wakefield could not sue for defamation against the *BMJ* and its editor, and Brian Deer, a freelance writer for the *Sunday Times*, in Texas because the state did not have jurisdiction to hear the case.

In 2013 Mrs Justice Theis ruled that two girls of 15 and 11 could be given the MMR vaccine despite the opposition from them both and their mother. Their divorced father brought the case having originally been opposed to MMR but having changed his mind after the link between the vaccination and autism was discredited.[91]

Blood donors

The present practice is for blood donors to be asked to agree that their blood can be tested for AIDS and a leaflet is given to them to sign as to whether they are in any of the high-risk groups and which asks them not to give blood if they are. The donors should not, of course, run any risk of contracting AIDS as a result of giving blood. In October 2009 a review suggested that the ban on homosexual blood donors could be lifted in 2010.[92] The NHS Blood and Transplant Agency had called for an increase of 50 per cent in blood donors and it was felt that the ban was no longer necessary.[93]

Haemophiliacs and recipients of blood

The compensation available to those who received contaminated blood together with the Archer Report (the Skipton and Caxton Funds) is discussed in chapter 16.

Confidentiality

Practical Dilemma 26.2 A justified disclosure?

Dr Jones, a general practitioner, was treating Ben James for an undiagnosed condition. He thought initially that it could be glandular fever. However, the blood tests revealed that he was suffering from AIDS. Dr Jones was uncertain as to who he could inform about this result. Ben was anxious that no one be told and that the information should be kept from his wife until much later on. Dr Jones wondered if the practice nurse and others working in the health centre who were likely to come into contact with Ben should be notified.

One of the exceptions to the duty of confidentiality was where disclosure was justified on grounds of the public interest (see chapter 8). This is one of the most difficult exceptions, since there is no clear judicial or statutory definition over what are the limits and extent of the term 'public interest' in this context. In the story of Ben in Practical Dilemma 26.2, if Dr Jones also treats Ben's wife, it could be argued that he is not fulfilling his duty of care to her if he fails to inform her that she is at risk of contracting AIDS and, even if she is not his patient, he should inform her GP (unless, of course, he can persuade Ben to tell her). This breach in the duty of confidentiality owed to Ben is therefore justifiable

on the grounds of the public interest. The same argument could be applied to informing any person in the health centre who is likely to be at risk from infection from Ben. Thus there may be justification in informing the practice nurse, but not the receptionist, since the latter is not likely to acquire the disease from Ben. The fact that the law is uncertain makes for considerable difficulties and ultimately it is up to individual practitioners to decide whether, in the specific circumstances of an individual case, there should be disclosure. The balance between an action for breach of confidentiality and an action for breach of a duty to care for the safety of a fellow employee is a very fine one.

In contrast to the case of *X* v. *Y* (see Case 26.3), the Court of Appeal allowed an order of disclosure of the person who had informed the press about an Ashworth patient. Subsequently a later Court of Appeal decided that the journalist did not have to identify his source.[94] (The case is further discussed in chapter 8, page 190.)

Case 26.3 *X* v. *Y* (1988)

Order of disclosure and non-disclosure under contempt of court[95]

The High Court held that public interest did not justify a newspaper publishing or using information disclosed by a health authority employee in breach of contract who admitted to a journalist that two identified doctors were being treated for AIDS at an identified hospital. The newspaper was fined £10,000 for contempt of a court order. However, the health authority was not able to obtain disclosure of the name of the informant employee, even though he or she was clearly in breach of the duty of employment, because this was not one of the occasions on which the press were obliged to disclose the source of their information under the contempt of court legislation.

Conclusions

In recent years the focus in infectious diseases has moved away from that of AIDS/HIV infection to that of MRSA/*Clostridium difficile*. However, the continuing increase in the numbers infected with HIV leaves no room for complacency. There are suggestions that AIDS could be under control worldwide imminently.[96] There are signs that a reduction of hospital-acquired infections is at last being achieved as a result of the work of the Health Protection Agency and the Care Quality Commission. The figures for *C difficile* and other superbugs show a declining rate with infections down 70 per cent over recent years. However, research suggests that there may be underreporting with one in two doctors believing that hospitals underreport superbug cases in order to avoid paying heavy fines.[97]

It is clear that improvements in the safety of hospitals and the reduction of deaths through hospital-acquired infections rests with individual standards of personal hygiene. It remains to be seen whether the provision made in the Health and Social Care Act 2008 for amending the Public Health (Control of Disease) Act 1984 to provide a more effective and proportionate response to infectious disease is effective in controlling outbreaks. There is uncertainty too over the effect of a new public health service which has seen the abolition of the Health Protection Agency and the National Treatment Agency. Local authorities have now taken over responsibilities for public health and it is as yet too soon to evaluate the effects of this.

A dispute has arisen over the value of the NHS Health Check programme with the Nordic Cochrane Centre in Copenhagen arguing that they could find no beneficial effects and that they were likely to lead to unnecessary diagnoses and treatments.[98] The tests were defended by Public Health England on the grounds that the precautionary principle justified efforts to spot risk factors for disease.[99] Public Health will continue to be a controversial area.

Reflection questions

1 What is meant by 'reasonably practical precautions to safeguard the safety of other employees'? To what extent do you consider your present practice meets this requirement in relation to the dangers of infection from infections? (See also chapter 12.)

2 Many regard the hepatitis B virus as an even greater danger to health service staff than AIDS. What are the main differences in the law (if any) relating to AIDS and to hepatitis?

3 Look again at the laws relating to the notification of infectious diseases. To what extent do you consider they could impinge on your professional practice?

4 What is meant by the duty of confidentiality in relation to those suffering from infections? Are any exceptions to the duty justified? To what extent do you consider that the duty is carried out and what suggestions would you make for improvements for all staff to observe this duty? (See also chapter 8.)

Further exercises

1 Obtain a copy of the Secretary of State's Code of Practice relating to infection control and discuss the extent to which this is fully implemented in your organisation.

2 Study the figures of your organisation on the cross-infection of patients following admission. What improvements could be made in cross-infection control?

3 What role do you consider that the individual nurse should play in ensuring that hospitals and other health premises are clean and hygienic?

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Chapter 27

Handling complaints

This chapter discusses

- Methods of complaining
- Handling complaints
- Hospital Complaints Procedure Act 1985 and the Wilson Report
- Complaints procedure 2004
- Complaints procedure 2004 and 2006
- Complaints procedure 2009
- The Health Service and Parliamentary Ombudsman (HSC)
- The House of Commons Select Committee
- Healthwatch England
- Local Healthwatch (formerly LINKS)
- Independent Complaints Advocacy Service (ICAS)
- Patient Advice and Liaison Services (PALS)
- Other quality assurance methods
- Complaints relating to detained patients
- Secretary of State inquiries
- The NHS Constitution
- Review of NHS complaints system

Introduction

It is highly likely that at some time in her career a nurse will be involved in a complaint, either in relation to her own conduct or in handling a complaint about someone else's. There is no doubt that there is an increase in the number of complaints made about the NHS. To some, this is a very bad sign and is indicative of a growing discontent with the health services.

However, others see this as a positive and valuable sign – an opportunity to improve the service and at the same time a sign that patients are more prepared to raise their voices over their concerns. Certainly, the current emphasis on customer and consumer relations is encouraging patients, through consumer satisfaction surveys, to make their views known so that the service can be improved. Feedback from the patient is essential if the quality of care is to be improved. There are now statutory duties for the NHS Commissioning Board (NHS England) and the clinical commissioning groups to involve patients in decision-making processes and to ensure that they have the requisite information. Unfortunately, as the reports of the Health Service Commissioner show only too frequently, whether or not a complaint is initially justified, the way in which the complaint is handled can itself become a cause for complaint. Patients' charters, the Human Rights Act 1998, National Service Frameworks and reports from the Care Quality Commission, other bodies and the NHS Constitution (see the website for this book and pages 126–7 and 720) may also encourage patients to criticise the services they have received in comparison with the standards they were led to expect and their rights as laid down in the European Convention on Human Rights (see chapter 1 and the website for this book). This section will review the procedures for handling complaints and discuss the legal powers of those statutory bodies that can represent or investigate the grievances of the patient.

Methods of complaining

Figure 27.1 shows the variety of ways of making a complaint about the NHS. Private hospitals have their own system for handling complaints and these tend to be on an individual hospital basis.

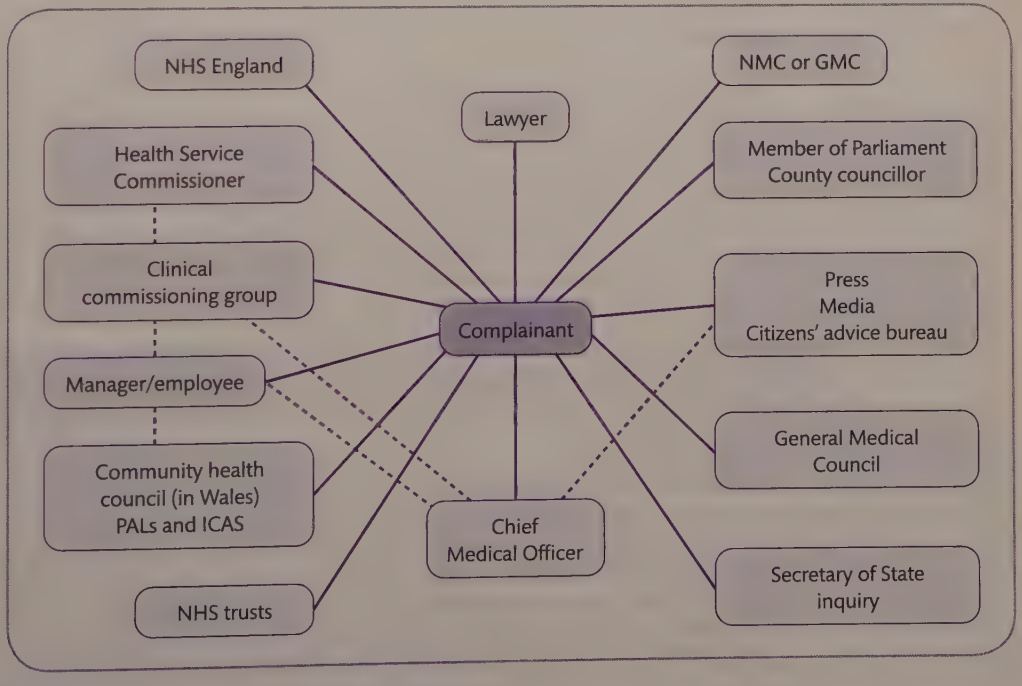


Figure 27.1 Various ways of making a complaint

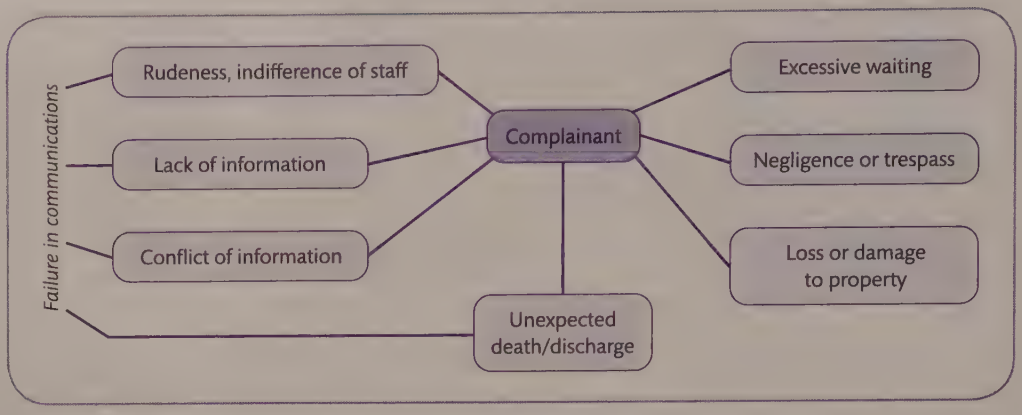


Figure 27.2 Why do people complain?

Many different motives exist behind a complaint. Some of the reasons why patients complain are shown in Figure 27.2 and the outcomes that they are seeking are shown in Box 27.1. However, it should be appreciated that, for many people, to make a formal complaint requires considerable courage and there are many reasons why justifiable grievances are not brought to the attention of management (see Box 27.2). It is very difficult for patients who are suffering from chronic conditions where they are dependent on the continued support of a particular department to make a formal complaint.

Box 27.1 What do complainants seek?

Apology
Explanation
Improvement
Prevention of similar occurrences
Compensation
Punishment:
- discipline
- dismissal
- striking off

Criminal proceedings.

In the Review conducted by Ann Clwyd MP and Professor Tricia Hart (see page 720) the following actions were sought by complainants: information and accessibility; freedom from fear; sensitivity; responsiveness; prompt and clear process; seamless service; support (through the process of complaining) effectiveness and independence.

Box 27.2 Why do people *not* complain?

1 No reason to complain.
2 No perceived reason to complain.
3 There is a perceived reason *but*:
- Positive reasons:
  - **(i)** sympathy with staff
  - **(ii)** immediate apology/explanation offered
  - **(iii)** promise of rectification/improvement
  - **(iv)** immediate interview with consultant/senior manager.

- Negative reasons:
  - (i) apathy/indifference
  - (ii) ignorance of how to complain
  - (iii) acceptance that errors/inefficiency are inevitable
  - (iv) useless to complain – no point
  - (v) fear of retribution.

A typical letter of complaint will be considered to illustrate how it should be handled and the role of the nurse.

Handling complaints

Practical Dilemma 27.1 Dear Sir

Dear Sir

I was furious at the way my daughter was treated when we went to the diabetic clinic the other day. We waited two hours to be seen and then we saw a foreign doctor who could barely speak English and who changed her drugs. Since then she has had a diabetic coma and the GP has said that the dose should never have been changed. I think that that doctor should be prevented from practising again.

Yours sincerely
Valerie Machin

This type of complaint is typical since, like many, it covers several different complaints, some of which relate to clinical matters and others to non-clinical matters, and often a lack of communication underlies the problem. This complaint is not directly concerned with nursing matters, but the nurses in the clinic may well be asked to provide a statement as to what took place in the clinic and whether the parents complained at the time and what was done.

The complaint raises the following issues:

- waiting time in an outpatient department clinic
- communication between doctor and patient
- clinical practice of the doctor
- patient's current clinical condition.

The normal procedure would be for a letter of this kind to be referred to the hospital complaints manager acting on behalf of the chief executive. Many complainants are not always aware of the procedure and the letter could be sent to anyone. Staff should be aware of a procedure that ensures the letter is received by the complaints manager, who can follow it up to ensure that the correct procedure is followed and an acknowledgement, and later a report, are sent to the complainant by the chief executive.

The designated complaints manager would be responsible for ensuring that every point raised by the complainant is investigated and reported on satisfactorily. The chief executive officer would be expected to sign letters to a complainant personally:

1 The first task would be to refer the last two points listed above urgently to the consultant in charge of the patient to assess: it may be necessary for the consultant to discuss her present condition urgently with the GP to ensure that she is now on the appropriate medication.
2 Once her present clinical condition is satisfactory, the complaints relating to clinical matters would be investigated according to the appropriate procedure, which is considered below.
3 An investigation into the waiting times would be initiated by asking the director of nursing services for a report and also asking for a report from the medical records officer or any administrative officer in charge of that department. There should be a system in place for recording the times of the patients' arrival and departure and a system for pinpointing unreasonable delays. Some clinics do not operate an appointments system and block booking can often create unacceptable waiting times. Nursing staff will be required to provide information as to the usual way in which the diabetic clinic functioned, whether this could be improved and whether there were any extenuating circumstances on that occasion.
4 The consultant and director of nursing services would also be asked to report on the level of communication of the doctor in question, and whether his English was of an acceptable level. (Knowledge of English is a requirement for a licence to practice medicine in England.[1]) It may be that that aspect of the complaint could be due to some form of racial prejudice, but it should never be assumed that the complaint is without foundation. A full inquiry must always be held.

The usual practice would be for the Director of Nursing Services or his/her assistant to arrange for any individual nurse who was present at the time of the clinic visit to make a statement on what occurred. It is essential that the nurse receives guidance in preparing such a report and also checks with all the available documentation on the ward or department. (Guidance is given in chapter 9 on preparing statements.) The nurse should never submit the statement unless she is 100 per cent satisfied with the contents and that she has, where possible, checked its accuracy. The report that is sent to the complainant will be based on what the nurse has said and if there are any inaccuracies in this which are not spotted by other hospital personnel, then the nurse could, if the complainant took the complaint further, be questioned in an investigation by the Parliamentary and Health Service Ombudsman and criticism could be made of her.

When the complaints manager has received all the relevant reports, including at this stage the report by the consultant on the clinical complaints, a response will be sent to the complainant. This might be just a letter or it might be an invitation to attend a meeting or both. It is vital that every single point raised by the complainant is answered fully and honestly. This might at this stage mean apologising for some shortcoming that has been revealed in the service.

In serious cases, the NHS trust might decide to set up an inquiry into the complaint. Such inquiries will come under the recommendations set out by the DH in 2001, *Building a Safer NHS for Patients*, and the statutory complaints regulations (see page 719).

Hospital Complaints Procedure Act 1985 and the Wilson Report

Under the Hospital Complaints Act 1985 each health authority was required to establish a complaints procedure. Guidance also required authorities to establish a procedure in relation to community health services. Following a review chaired by Professor Alan Wilson into the handling of hospital complaints, a consultation document was published.[2] The Department of Health accepted the principal recommendations of the Wilson Report and published guidance and directions for its implementation by NHS trusts and health service authorities.[3]

The Wilson Report found the system for dealing with complaints relating to health services to be confusing, bureaucratic, slow and inefficient. The Report reviewed the current situation and set objectives for any effective complaints system. The principles it saw for any effective complaints system are set out in Box 27.3.

The Report recommended that these principles should be incorporated into an NHS complaints system. On 1 April 1996 a new complaints procedure came into effect that implemented the majority of recommendations contained in the Wilson Report.

Box 27.3 Key elements in a complaints procedure

1 Responsiveness
2 Quality enhancement
3 Cost-effectiveness
4 Accessibility
5 Impartiality
6 Simplicity
7 Speed
8 Confidentiality
9 Accountability.

Complaints procedure 2004

Research into the complaints system

The Department of Health commissioned an investigation into the effectiveness of the complaints procedure established following the Wilson Report. In its publication, *NHS Complaints Reform: making things right*,[4] the Department of Health noted that criticisms of the existing complaints procedure were that:

- It is unclear how, and difficult, to pursue complaints and concerns
- There is often delay in responding when concerns arise
- Too often there is a negative attitude to concerns expressed
- Complaints seem not to get a fair hearing
- Patients do not get the support they need when they want to complain
- The independent review stage does not have the credibility it needs
- The process does not provide the redress the patients want
- There does not seem to be any systematic processes for using feedback from complaints to drive improvements in services.

The aims of the reforms to the complaints procedure were to establish clear national standards and accountabilities, devolution to clinicians and managers backed up by independent scrutiny, flexibility and ensuring that patients can choose how they wish to pursue their concerns and have the support they need to help them do so.

The Department of Health recommended that there be:

- Increasing support and information for people who make complaints through local patient advice and liaison services and independent complaints and advice services.
- Patient feedback and customer care and training for NHS staff, including board members, to improve the way people are dealt with to help resolve complaints quickly.
- Subject to legislation, responsibility for independent complaints review placed with the Commission for Healthcare Audit and Inspection (CHAI) (The Healthcare Commission). (This was abolished in April 2009 and replaced by the Care Quality Commission which does not act as a second stage in the complaints system. Instead, dissatisfied complainants can apply to the Parliamentary and Health Service Ombudsman.)

Complaints procedure 2004 and 2006

The Health and Social Care (Community Health and Standards) Act 2003 Part 2 Chapter 9 gave power to the Secretary of State to make regulations on the handling of complaints about healthcare (s. 113), social services (s. 114), and section 115 set out topics that could be covered by regulations. Under the Department of Health's complaints procedure in 2004 there were still three stages: local resolution, independent review, Health Service Commissioner (Ombudsman), but there were significant changes to each stage and the support provided to patients. On 30 July 2004 regulations[5] on the new complaints system came into force with the Healthcare Commission acting as the independent second stage.

NHS and social services complaints: a single comprehensive procedure

Regulations relating to social services complaints[6] came into force on 1 September 2006. They impose time limits on making complaints, new timescales for handling stages of the process and provide greater independence at the final review panel stage. They can be downloaded from the Office of Public Sector Information.[7] The NHS complaints regulations were amended[8] following the White Paper commitment to develop a single comprehensive complaints procedure across health and social care by 2009. The amendments are intended to make the system more responsive and give better links with the arrangements for responding to social care complaints.

Criticisms by the Healthcare Commission

In October 2007 the Healthcare Commission published its first audit on how NHS trusts handled complaints, which is available on the website of its successor, the CQC.[9] It found considerable variation in how complaints were handled across the country. Its report highlighted the issues shown in Box 27.4.

Box 27.4 Issues raised by Healthcare Commission on complaints handling (2007)

- More needs to be done to make the complaints system open and accessible, especially for those with learning disabilities and from ethnic communities
- People who complain should be confident that their care will not suffer
- Trusts should use complaints data to inform decision making
- While there is no one-size-fits-all approach to investigating complaints, a common approach would improve risk management of complaints and manage the expectations of complainants
- There are no nationally available standard tools and resources such as case studies, checklists and training aids for staff.

Complaints procedure 2009

Since 2009 there has been a simplified two-stage complaints procedure in the NHS. The first stage is local resolution and the second is an application to the Ombudsman (Parliamentary and Health Service Commissioner). The procedure is described by the NHS website as follows:

> **Since April 2009, the NHS has run a simple complaints process, which has two stages. Ask your hospital or trust for a copy of its complaints procedure, which will explain how to proceed. Your first step will normally be to raise the matter (in writing or by speaking to them) with the practitioner, e.g. the nurse or doctor concerned, or with their organisation, which will have a complaints manager. This is called local resolution, and most cases are resolved at this stage.**

If you're still unhappy, you can refer the matter to the Parliamentary and Health Service Ombudsman, who is independent of the NHS and government.

The DH then gives reference details for the Ombudsman, PALS (see page 717) and ICAS (see page 717).

The 2009 regulations[10] which came into force in April 2009 place a duty on each responsible body (local authority, NHS body, primary care provider and independent provider) to make arrangements for handling and consideration of complaints so as to ensure that:

(a) complaints are dealt with efficiently;
(b) complaints are properly investigated;
(c) complainants are treated with respect and courtesy;
(d) complainants receive, so far as is reasonably practical –
  (i) assistance to enable them to understand the procedure in relation to complaints; or
  (ii) advice on where they may obtain such assistance;
(e) complainants receive a timely and appropriate response;
(f) complainants are told the outcome of the investigation of their complaint; and
(g) action is taken if necessary in the light of the outcome of a complaint.

The responsible body must identify a person (the chief executive) to be responsible for compliance with the regulations and a complaints manager responsible for managing the complaints procedures and hearing the complaints.

Excluded from the complaints procedure are the following:

(a) a complaint by a responsible body;
(b) a complaint by an employee of a local authority or NHS body about any matter relating to that employment;
(c) a complaint which –
  (i) is made orally; and
  (ii) is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made;
(d) a complaint the subject matter of which is the same as that of a complaint that has previously been made and resolved in accordance with sub-paragraph (c);
(e) a complaint the subject matter of which has previously been investigated under –
  (i) these Regulations;
  (ii) the 2004 Regulations, in relation to a complaint made under those Regulations before 1 April 2009;
  (iii) the 2006 Regulations, in relation to a complaint made under those Regulations before 1 April 2009; or
  (iv) a relevant complaints procedure in relation to a complaint made under such a procedure before 1 April 2009;
(f) a complaint the subject matter of which is being or has been investigated by –
  (i) a Local Commissioner under the Local Government Act 1974(a); or
  (ii) a Health Service Commissioner under the 1993 Act;
(g) a complaint arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000(b); and
(h) a complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services, etc.) or section 24 (compensation for loss of office, etc.) of the Superannuation Act 1972(c), or to the administration of those schemes.

The complainant must be notified if his/her complaint comes under the above exclusions. A complaint must not be made later than 12 months after the date that the matter which is the subject of the complaint occurred or from when the complainant had knowledge of the matter. This time can be extended if the responsible body is satisfied that (a) the complainant had good reasons for not making

the complaint within that time limit; and that (b) notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

Paragraph 13 of the regulations lays down the procedures which the responsible body must comply with and is shown in Box 27.5.

Box 27.5 Procedure for handling complaints from April 2009 Regulation 13

1 A complaint may be made orally, in writing or electronically.
2 Where a complaint is made orally, the responsible body to which the complaint is made must –
  (a) make a written record of the complaint; and
  (b) provide a copy of the written record to the complainant.
3 Except where Regulation 6(5) (where the complaint is referred to another responsible body) or 7(1) (primary care trust complaint) applies in relation to a complaint, the responsible body must acknowledge the complaint not later than 3 working days after the day on which it receives the complaint.
4 Where paragraph (5) of Regulation 6 applies, and a responsible body ('the recipient body') receives a complaint sent to it by another responsible body in accordance with that paragraph, the complaint must be acknowledged by the recipient body not later than 3 working days after the day on which it receives the complaint.
5 Where Regulation 7(1) applies to a complaint –
  (a) the primary care trust which receives the complaint must acknowledge the complaint not later than 3 working days after the day on which it receives it; and
  (b) where a responsible body receives notification given to it under Regulation 7(5)(a), it must acknowledge the complaint not later than 3 working days after the day on which it receives the notification.
6 The acknowledgement may be made orally or in writing.
7 At the time it acknowledges the complaint, the responsible body must offer to discuss with the complainant, at a time to be agreed with the complainant –
  (a) the manner in which the complaint is to be handled; and
  (b) the period ('the response period') within which –
    (i) the investigation of the complaint is likely to be completed; and
    (ii) the response required by Regulation 14(2) is likely to be sent to the complainant.
8 If the complainant does not accept the offer of a discussion under paragraph (7), the responsible body must –
  (a) determine the response period specified in paragraph (7)(b); and
  (b) notify the complainant in writing of that period.

The requirements for the investigation and response are shown in Box 27.6.

Box 27.6 Requirements for investigation and response, Regulation 14

1 A responsible body to which a complaint is made must –
  (a) investigate the complaint in a manner appropriate to resolve it speedily and efficiently; and
  (b) during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation.
2 As soon as reasonably practicable after completing the investigation, the responsible body must send the complainant in writing a response, signed by the responsible person, which includes –

(a) a report which includes the following matters –
  (i) an explanation of how the complaint has been considered; and
  (ii) the conclusions reached in relation to the complaint, including any matters for which the complaint specifies, or the responsible body considers, that remedial action is needed; and
(b) confirmation as to whether the responsible body is satisfied that any action needed in consequence of the complaint has been taken or is proposed to be taken;
(c) where the complaint relates wholly or in part to the functions of a local authority, details of the complainant's right to take their complaint to a Local Commissioner under the Local Government Act 1974(a); and
(d) except where the complaint relates only to the functions of a local authority, details of the complainant's right to take their complaint to the Health Service Commissioner under the 1993 Act.

3 In paragraph (4), 'relevant period' means the period of 6 months commencing on the day on which the complaint was received, or such longer period as may be agreed before the expiry of that period by the complainant and the responsible body.

4 If the responsible body does not send the complainant a response in accordance with Paragraph (2) within the relevant period, the responsible body must –
(a) notify the complainant in writing accordingly and explain the reason why; and
(b) send the complainant in writing a response in accordance with paragraph (2) as soon as reasonably practicable after the relevant period.

Form of communications (Regulation 15)

Any communication which is required by these Regulations to be made to a complainant may be sent to the complainant electronically where the complainant –

(a) has consented in writing or electronically; and
(b) has not withdrawn such consent in writing or electronically.

Any requirement in these regulations for a document to be signed by a person is satisfied, in the case of a document which is sent electronically in accordance with these regulations, by the individual who is authorised to sign the document typing their name or producing their name using a computer or other electronic means.

Publicity (Regulation 16)

Each responsible body must make information available to the public as to –

(a) its arrangements for dealing with complaints; and
(b) how further information about those arrangements may be obtained.

Monitoring (Regulation 17)

For the purpose of monitoring the arrangements under these Regulations each responsible body must maintain a record of the following matters –

(a) each complaint received;
(b) the subject matter and outcome of each complaint; and
(c) where the responsible body informed the complainant of –
  (i) the response period specified in Regulation 13(7)(b); or
  (ii) any amendment to that period,
  whether a report of the outcome of the investigation was sent to the complainant within that period or any amended period.

Annual reports (Regulation 18)

1 Each responsible body must prepare an annual report for each year which must –
   (a) specify the number of complaints which the responsible body received;
   (b) specify the number of complaints which the responsible body decided were well-founded;
   (c) specify the number of complaints which the responsible body has been informed have been referred to –
      (i) the Health Service Commissioner to consider under the 1993 Act; or
      (ii) the Local Commissioner to consider under the Local Government Act 1974; and
   (d) summarise –
      (i) the subject matter of complaints that the responsible body received;
      (ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
      (iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.
2 In paragraph (1), 'year' means a period of 12 months ending with 31 March.
3 Each responsible body must ensure that its annual report is available to any person on request.
4 This paragraph applies to a responsible body which is –
   (a) an NHS body other than a primary care trust; or
   (b) a primary care provider or an independent provider,
   and which in any year provides, or agrees to provide, services under arrangements with a primary care trust.
5 Where paragraph (4) applies to a responsible body, the responsible body must send a copy of its annual report to the primary care trust which arranged for the provision of the services by the responsible body.
6 Each primary care trust must send a copy of its annual report to the strategic health authority whose area includes any part of the area of the primary care trust.
7 The copy of the annual report required to be sent in accordance with paragraph (5) or (6) must be sent as soon as reasonably practicable after the end of the year to which the report relates.

Statutory feedback from patients

From April 2013 all acute NHS trusts are required to ask both inpatients and emergency department patients one standard question known as the Friends and Family Test introduced by NHS England. Further information about the test including the feedback from patients for individual hospitals can be found on the NHS Choices website.[11] The question is 'How likely are you to recommend our ward/emergency department to friends and family if they needed similar care or treatment?' Subsequently, fuller feedback is being sought from every patient visiting a GP, hospital or dentist. Guidance for more comprehensive feedback was issued by NHS England in July 2014 to be implemented by April 2015.

The Health Service and Parliamentary Ombudsman (HSC)

Since 2009 the only independent review for unresolved complaints is recourse to the Ombudsman.[12] Its jurisdiction derives from the Health Service Commissioners Act 1993 (as amended). (Northern Ireland has its own Health Service Ombudsman and the Scottish Public Services Ombudsman has had jurisdiction over complaints about the NHS in Scotland since 2002 and the Public Services Ombudsman for Wales has had jurisdiction over complaints about the NHS in Wales since 2005.)

If a complainant is not satisfied with the response of the authority to a complaint, he can apply to the Ombudsman for further investigation: the Parliamentary and Health Service Ombudsman in respect of complaints about the NHS and the Local Authority Commissioner Ombudsman in respect of complaints about local authority services. As a result of legislation in 1996 the Health Service

Commissioner's (HSC) jurisdiction was extended to cover matters relating to family practitioner services, independent providers of NHS services and matters of clinical judgement. Disciplinary matters were not included in its jurisdiction (see Box 27.7 below). The HSC has a duty to prepare a report that is submitted to Parliament, under section 14(4) of the Health Service Commissioners Act 1993. These reports are available on the HSC website and can be a very useful source of information. For example, its second report for 2008–2009 was concerned with the provision of services for people with learning disabilities which it had investigated following complaints by the families of six people with learning disabilities whose complaints were taken up by Mencap.[13] The Select Committee of the House of Commons has the power to investigate further any complaint reported by the HSC, if necessary summoning witnesses to London for questioning (see below). The HSC is completely independent of the NHS and the government and has the jurisdiction to investigate complaints against any part of the NHS, as shown in Box 27.7. It was held in a case heard in 2006 that the HSC had exceeded her statutory powers by going outside the remit of the complaint. The complaint concerned the discontinuation by a trust of a specialist vitamin unit which a father had found benefited his son who had epilepsy and learning and communication difficulties. The Court found that the HSC had not confined herself to the investigation of the complaint but had expanded the ambit of the investigation beyond the scope of the original complaint and had therefore exceeded her statutory powers.[14] Further information can be found on its website.[15]

Box 27.7 Jurisdiction of the Health Service Ombudsman

The Health Service Ombudsman's jurisdiction covers:

1. A failure in service
2. A failure to purchase or provide a service one is entitled to receive or
3. Maladministration (administrative affairs)
4. Matters of clinical judgement.

The following are excluded from his investigation:

1. Actions where there is already an existing remedy in law (but there is a discretion to hear such matters if the Ombudsman is satisfied that it is not reasonable to expect the complainant to resort to this)
2. Personnel matters or contractual matters to do with the NHS
3. Out-of-time complaints – although there is discretion to extend this
4. Complaints that have not yet been referred to the organisation for dealing through the complaints procedure.

The House of Commons Select Committee

A final possibility in the complaints process (and this can be very effective) is for an inquiry to be set up by the Select Committee of the House of Commons, to whom the Health Service Ombudsman reports. This Committee has the power to investigate a matter further by summoning witnesses to appear before it and if, in the report of the Ombudsman, it is clear that an authority has ignored its recommendations, the Committee can ask the authority to explain itself – an experience that few witnesses who have appeared before it will ever forget. There is no secrecy. All these cases are fully reported and the proceedings of the Select Committee are themselves published and may also be televised. There is no doubt that the fact that eventually an authority might have to explain how it dealt with any complaint is an important factor in ensuring that the complaint is properly, speedily and effectively dealt with.

Healthwatch England

The Commission for Patient and Public Involvement in Health (CPPIH), envisaged in the NHS Plan,[16] was established under section 20 of the NHS Reform and Health Care Professions Act 2002 in January 2003. Its functions set out in section 20(2) of the 2002 Act, included advising the Secretary of State about arrangements for public involvement in and consultation about matters relating to the health service in England and the provision of independent advocacy services. It was abolished in 2008 when the Local Government and Public Involvement in Health Act 2007 was enacted (see page 717) and LINKS replacing the patient forums were established.

Healthwatch England was established as a Statutory Committee of the Care Quality Commission under section 181 of the 2012 Act amending the Health and Social Care Act 2008 by adding sections 45A, B and C to that Act.

The purpose of Healthwatch England is to:

> **provide the Commission or other persons with advice, information or other assistance in accordance with provision made by or under this or any other Act.**

Specific functions are set out as follows:

- It must provide local Healthwatch organisations with general advice and assistance in relation to their activities under section 221 of the Local Government and Public Involvement in Health Act 2007.
- It can give written notice to a local authority of its concern about a failure to carry out its functions.
- It must provide (a) the Secretary of State; (b) the National Health Service Commissioning Board; (c) Monitor; and (d) English local authorities with information and advice on –
  - **(a)** the views of people who use health or social care services and of other members of the public on their needs for and experiences of health and social care services, and
  - **(b)** the views of local Healthwatch organisations and of other persons on the standard of provision of health and social care services and on whether or how the standard could or should be improved.

A person provided with such advice must inform the Healthwatch England committee in writing of its response or proposed response to the advice.

The Healthwatch England committee may provide the Commission with information and advice on the matters mentioned above and the Commission must inform the committee in writing of its response or proposed response to the advice.

In performing functions under this section, the Healthwatch England committee must have regard to such aspects of government policy as the Secretary of State may direct.

The Healthwatch England committee is obliged to publish an annual report to the Care Quality Commission as soon as possible after the end of each financial year, covering topics specified. It must lay the report before Parliament and give a copy to the Secretary of State and the local Healthwatch organisations. It can also publish other reports at such times and on such matters relating to health or social care, as it thinks appropriate. Its annual report for 2012–13 is available on its website.[17]

Local Healthwatch (formerly LINKS)

Various organisations established to ensure local involvement and input into the organisation and standards of local services have been established. Patient Forums were set up under the NHS Reform and Health Care Professions Act 2002. There were over 400 patient and public involvement forums, one for each NHS trust in England, supported by the Commission for Patient and Public Involvement in Health (CPPIH).

The House of Commons Select Health Committee published a report on patient and public involvement in the NHS in April 2007.[18] As a consequence of its recommendations significant changes were proposed to the arrangements for the involvement of the public in healthcare and incorporated in the Local Government and Public Involvement in Health Act 2007. Local involvement networks (LINKS) replaced patients' forums and the Commission for Patient and Public Involvement in Health was abolished. The changes came into force in 2008.

LINKS have now been replaced by local Healthwatch organisations.

Sections 182 to 189 of the Health and Social Care Act 2012 makes provision for the local Healthwatch organisations building on the statutory provision for LINKS and section 221 of the Local Government and Public Involvement in Health Act 2007. Local Healthwatch organisations can be found on the Healthwatch website.[19]

Local Healthwatch organisations are independent, able to employ their own staff and involve volunteers with the aim of giving citizens and communities a stronger voice to influence and challenge how health and social care services are provided within the locality. It has a role in promoting public health, health improvements and in tackling health inequalities. Each local Healthwatch group will have a seat on the Health and Wellbeing Board. It will enable people to share views and concerns about local health and social care services and can alert Healthwatch England to concerns about specific care providers. Funded by LAs they are held to account for their ability to operate effectively and be value for money. Regulations relating to their right of entry to premises for public health purposes were enacted in 2013.[20]

Independent Complaints Advocacy Service (ICAS)

Under section 12 of the Health and Social Care Act 2001, the Secretary of State has a responsibility to provide independent advocacy services to assist patients in making complaints against the NHS. ICAS[21] was available nationally from September 2003. A consultation paper, 'Involving Patients and the Public in Healthcare',[22] was issued by the Department of Health in September 2001 for consultation on proposals for greater public representation to replace the community health councils (CHCs).

ICAS focuses on helping individuals to pursue complaints about NHS services. It aims to ensure that complainants have access to the support they need to articulate their concerns and navigate the complaints system, maximising the chances of their complaint being resolved more quickly and effectively. ICAS worked alongside the trust-based patients' forums (subsequently abolished) and patient advocacy and liaison services. Information about ICAS and the current range of pilot services is available on the Department of Health website,[23] from the Healthwatch website[24] and on the Support Empower Advocate Promote website.[25] It was announced in January 2006 that following a rigorous exercise, the DH awarded contracts to three organisations to deliver a new and improved ICAS from 1 April 2006. ICAS has provided advice on its website on patients' complaints and on accessing medical records. Section 185 of the Health and Social Care Act 2012 added section 223A to the Local Government and Public Involvement in Health Act 2007 requiring each local authority to make provision of independent advocacy services (defined as services providing assistance (by way of representation or otherwise) to persons making a complaint. Section 223A (2) a–g lists the complaints in its jurisdiction.

Patient Advice and Liaison Services (PALS)

A significant proposal in the NHS Plan[26] was the Patient Advice and Liaison Services (PALS). The Plan envisaged that by 2002 PALS would be established in every major hospital, with an annual national budget of around £10 million. Their core functions are:

- To provide on-the-spot help and speedy resolution of problems
- To act as a gateway to independent advice and advocacy services

- To provide accurate information about the trust's services and other related services
- As a key source of feedback to the trust, to act as a catalyst for change and improvement
- To support staff in the development of a responsive, listening culture.

Special provision is made in respect of patient and advocacy services for the purposes of the Mental Health Act 1983 and section 134, which concerns the withholding of correspondence. Under regulations of 2003, correspondence with a PALS is exempt from the provisions of section 134.[27]

All NHS trusts were required to establish a PALS service by April 2002. A national evaluation of PALS was conducted from January 2005 to January 2007 and a report on the key messages published in October 2006 by the Department of Health is available on its website. Patients can contact their local PALS by phoning the local hospital, clinic, GP surgery or health centre, phoning NHS 111 or searching the office directory on the PALS online web service which has a direct link to the DH website. The local PALS can be found through the NHS website.[28]

Complaints and litigation

Under the complaints procedure which was based on the Wilson Report, if the complainant indicated that he or she wished to pursue a legal remedy, the complaints procedure would be halted. The proposals for a new compensation scheme for clinical negligence claims, 'Making Amends' (discussed in chapter 6), recommended that complaints handling and early investigation of a potential legal action be combined. This recommendation was not included in the NHS redress scheme and the NHS complaints regulations exclude from its procedure a complaint where the complainant has stated in writing that he intends to take legal proceedings. In contrast, in Wales regulations were implemented to enable complainants to obtain compensation in an NHS redress scheme.

The nurse and complaints

It is in the interests of all health professionals to ensure that any complaints by patients or relatives relating to the provision of health services are resolved as speedily as possible informally, without requiring the complainant to make use of the formal procedure. Nurses should have the confidence to realise that complaints can be a useful way of monitoring and improving the services to patients, that it takes courage to make a complaint, especially where the patient suffers from a chronic condition, and that improvements can be made if clients are prepared to discuss with the health professionals ways in which the services could be enhanced.

Other quality assurance methods

Individuals who have complaints against the services provided in the NHS do not have any contractual right to bring an action before the court for breach of contract. If harm has been suffered as a result of a failure or omission, they may have a successful claim in the law of negligence (see chapter 3) or, if a service has not been provided, they may be able to bring a case of breach of statutory duty for failure to provide that service (see chapter 5). Otherwise, they must rely on the complaints procedure. They could apply for judicial review to the High Court if the principles of natural justice have not been followed, but they would be expected to exhaust appeals procedures within the NHS complaints system first. There are, however, many other mechanisms to ensure the maintenance of high standards of healthcare that cannot be directly utilised by the patient. The White Paper on the NHS in 1997 put forward a strategy for improving quality assurance and its mechanisms which was implemented in the Health Act 1999. These mechanisms included a National Institute for Health and Care Excellence (NICE), a Healthcare Commission (now the CQC) and a framework for national standards. The establishment of clinical governance whereby chief executives of trusts are held accountable for the clinical

performance of their organisations provides more evidence to the patient about the standards of care locally. These innovations are discussed in chapter 5.

Complaints relating to detained patients

Under the 1983 Mental Health Act, there was a statutory duty placed on the Mental Health Act Commission to investigate complaints by detained patients. The jurisdiction could be extended to cover informal patients. Under section 52 of the Health and Social Care Act 2008 the functions of the Secretary of State and of the Mental Health Act Commission (MHAC) under the Mental Health Act were transferred to the Care Quality Commission (CQC) in England and the Welsh Ministers in Wales. The CQC can also investigate complaints of a detained patient on both clinical and non-clinical matters. A high proportion of the complaints that the MHAC has investigated were concerned with clinical matters such as medication, medical and nursing care. There is no power to subpoena witnesses or to take evidence on oath and the CQC is itself one of the bodies whose administrative function can be investigated by the Parliamentary and Health Service Ombudsman. From the biennial reports of the MHAC, it was clear that the number and variety of the complaints that it had investigated were considerable. The CQC, like its MHAC predecessor, has complete discretion over how the complaints are to be investigated – methods range from a word to a ward sister to a full-scale investigation by commissioners. It is also apparent that, while its terms of reference are so far only to cover the detained patient, many of its recommendations are wider and affect the care of the informal patient. For example, the MHAC procedure on the consent to treatment of the mentally disordered outside the provisions of Part 4 of the 1983 Act had major implications for the care of the informal patient. In addition, the Code of Practice on the Mental Health Act provides advice about procedures and precautions to take if informal patients are detained in locked wards. The CQC has been given the responsibility of monitoring the operation of the Deprivation of Liberty Safeguards (see chapter 17) under the Mental Capacity Act 2005. Through this function, CQC seeks to ensure that the safeguards are working properly, highlight where they are not and, where necessary, require remedial action to be taken. CQC visits hospitals and care homes and, where necessary, interviews any patients who are deprived of their liberty and ask to see the relevant records. CQC reports once a year to the Secretary of State, summarising its activities and findings in relation to these safeguards.[29] Further information can be obtained on the CQC website[30] (see also chapters 5 and 20).

Secretary of State inquiries

Statutory powers are given in the NHS legislation for the Secretary of State to set up an inquiry into any case 'where he deems it advisable to do so in connection with any matter arising under this Act'.[31] The powers of such an inquiry are extensive and include the power to summon witnesses and order the production of documents and the taking of evidence on oath. Any person who refuses to give evidence or attend or destroys documents is guilty of a criminal offence.

A public inquiry of this nature is kept for the most serious of complaints with very serious implications. One example is the inquiry into Stafford Hospital which was chaired by Robert Francis QC (see chapter 5).[32]

The Secretary of State can also make an intervention order in relation to an NHS body other than NHS foundation trusts where he considers that the NHS body is not performing one or more of its functions adequately or at all or that there are significant failings in the way the body is being run, and he is satisfied that it is appropriate for him to intervene.[33] The effect of an intervention order is that he can remove all or any members from the board of the NHS body and appoint replacements or suspend any members.[34] Under the Health and Social Care Act 2012, Monitor has powers to withdraw the licence of any provider which is failing to perform (see chapter 5).

The NHS Constitution

The Health Act 2009 put the NHS Constitution and the accompanying Handbook on to a statutory basis. It can be seen on the website of this book. It identifies the rights of the patient and staff and sets out pledges which the NHS will endeavour to fulfil. The NHS Constitution sets out seven key principles to guide the NHS in all it does. These were amended in 2013 (see chapter 5, Box 5.2).

The seven key principles in the NHS Constitution are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. The values are: respect and dignity; commitment to quality of care; compassion; improving lives; working together for patients; and everyone counts.

The NHS Constitution sets out the rights of the patient in respect of any complaint and redress and says (as amended in 2013):

Complaint and redress:

You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to be kept informed of the progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body.

You have the right to compensation where you have been harmed by negligent treatment.

It does not specify any additional remedies provided by the NHS Constitution itself, and, any complainant will have to rely upon the existing complaints procedures.

Review of NHS complaints system

In the wake of the Francis Report on Mid Staffordshire the Prime Minister and Health Secretary commissioned Ann Clwyd MP and Professor Tricia Hart, the Chief Executive of South Tees Hospitals NHS Foundation Trust, to carry out a review of the NHS complaints system. The negative personal experience of Ann Clwyd following the mistreatment and death of her husband was reinforced by 2,500 letters about hospital neglect and poor care. The Report was published on 28 October 2013.[35]

The recommendations revolved around the following areas and those responsible for implementation were identified:

- improving the quality of care;
- improvements in the way complaints are handled;
- greater perceived and actual independence in the complaints process and whistleblowing.

Several drivers for change were identified:

- consumer power;
- a champion for complaints reform (the CQC with its Chief Inspector of Hospitals); and
- concrete commitments or pledges to act by major NHS players.

Those organisations who had pledged to take action included: the NMC; the RCN; NHS Trust Development Authority (NHSTDA); Health Education England (HEE); Local Government Association (LGA); NHS Confederation; NHS Employers; General Medical Council; Monitor; Care Quality

Commission; NHS England and the Parliamentary and Health Service Ombudsman. The Report set out the action which each organisation was pledged to take.

The Report also highlighted good work in the NHS such as the critical friend at the Central Manchester University Hospitals NHS Foundation Trust and the customer focus at Birmingham Heartlands Hospital.

The President of the Royal College of Physicians, Sir Richard Thompson, who had made suggestions to the working party which led to the Review, wrote to the editor of *The Times*[36] on 2 November 2013 making more fundamental proposals including:

- the discussion of complaints within annual appraisals of staff with appraisers bringing these concerns to the attention of the management;
- a doctor from the medical staff elected to the Trust Board responsible for overseeing concerns;
- patients to be asked by ward/clinic staff when leaving if they have any concerns which would be collated by the ward/clinic nursing sister and the responsible named consultant and ward sister would handle the complaint face to face with the complainant or in writing, and if necessary they should be responsible for following the complaint through the Trust management system with the consultant signing off the reply not the chief executive.

He also suggested that professional groups should discuss concerns and make suggestions to management, that more attention should be given to the views and experience of junior doctors, and that the professional bodies should provide confidential support for whistleblowers who fail to get satisfaction.

The NMC has also issued guidance on raising concerns about a nurse or midwife (available on its website[37]) which sets out:

- the standards to expect from a nurse or midwife;
- the action which can be taken if care is unsatisfactory;
- where advice can be obtained; and
- the action the NMC can take.

Website Care Connect

The website nhs.uk has set up a care connect facility which enables patients (initially those in London and the North East of England) to go online and report when things are going well or not. Initial responses revealed mistakes in the administration of drugs, not enough staff working at weekends, and failures in maternity care.[38] Interested persons are able to use the website to share experiences, ask a question or report a problem. Phone numbers are also given.

In contrast, Michael Dixon, Chairman of the NHS Alliance, said that the problems of the NHS 'are as much about attitude as they are about funding' as patients had become too demanding and ready to criticise.[39]

Conclusions

Establishing an effective and efficient system of handling patients' complaints is proving an intractable problem for the NHS. The procedure set up following the Wilson Report proved too cumbersome and ineffective. Yet its replacement in 2004 has not been any more successful. The second stage of independent review has now been removed, with the Parliamentary and Health Services Commissioner or Ombudsman being the only independent review stage. The defects reported by the Health Commission and shown in Box 27.4 have still not been remedied. Nor has local representation within the NHS run smoothly. In 2008, patients' forums were replaced by local involvement networks (LINKS), and the Commission for Patient and Public Involvement in Health was also abolished. Local Healthwatch

organisations have taken over from LINKS. Yet the successful implementation of an NHS Constitution depends to a considerable extent on the effectiveness and efficiency of a complaints procedure which can speedily rectify failures to implement the rights and responsibilities recognised in the Charter. The White Paper on the NHS published by the Coalition government declares that patients will be put at the heart of the NHS and will have access to information, can make choices about their care and have increased control over their own records. It also states that:

> **We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.**

However, the only means of enforcing such rights will be through an effective complaints procedure and the NHS has over the past 30 years been singularly unsuccessful in establishing one. The new devolved system of complaints hearings established in 2009 was assessed by the Health Service Ombudsman in the report of its first year.[40] The two most common grounds for complaints were: failings in care and treatment, and the attitude of staff. A poor explanation or an incomplete response were the most common reasons given for people's dissatisfaction with the NHS complaint handling. The Ombudsman held that poor quality or inconsistent information about complaints and their outcomes makes it more difficult for the NHS to learn lessons.

The Francis Report (see chapter 5) shows the weaknesses of our current system for handling complaints and the need for a radical overview has been promoted by Ann Clwyd. Hopefully there will be improvements. In July 2014 the Health and Social Care Information Centre initiated a consultation on NHS written complaints which may lead to changes to the data collection.

Nurses have a professional responsibility to respond appropriately to both informal and formal complaints, and should ensure that their documentation reflects the required standard of professional practice.

Reflection questions

1. What do you consider to be the most appropriate system for recording informal complaints?
2. Complaints are one means of obtaining feedback from patients about their stay. Consider other means of a more positive nature to obtain information relating to patient satisfaction and consider the possibility of implementing them.
3. You are a staff nurse on a medical ward. A patient complains to you that he thinks that he is suffering from the side effects of medication. How would you deal with this complaint? (See also chapter 28.)

Further exercises

1. Obtain a copy of the complaints procedure of your NHS trust or employer and familiarise yourself with it.
2. Ask the complaints manager in your organisation if you may see the complaints book and, if you can, see how an individual complaint has been followed up. (Remember the duty of confidentiality.)
3. Access the reports of the Health Service Commissioner on its investigations of NHS complaints and consider the extent to which any of its recommendations could apply in your organisation.

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[35] Clwyd Ann and Hart Tricia, A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture, DH, October 2013; www.gov.uk
[36] Letter to the Editor, *The Times*, 2 November 2013
[37] www.nmc-uk.org
[38] Jon Ungoed-Thomas, Patient attack care on NHS 'TripAdvisor', *Sunday Times*, 1 December 2013
[39] Chris Smyth, Patient demand and complain too much, says top GP, *The Times*, 3 January 2014
[40] Health Service Ombudsman's review of complaint handling by the NHS in England 2009–10, Stationery Office, London, 2010



Chapter 28

Legal aspects of medicines

This chapter discusses

- General principles
- Controlled drugs
- Problems in the administration of medicine
- Management of errors or incidents in the administration of medicines
- Self-administration by patients
- Covert administration of medicines
- Medicines and the operating department practitioner (ODP)
- Nurse as prescriber
- Group protocols or patient group directions
- Nurse prescribing: independent and dependent (subsequently known as supplementary) prescribers
- Role of the pharmacist
- Safety of medicines
- Product liability and drugs
- Misuse of drugs
- The future: personalised medicine
- National Prescribing Centre
- Availability of medicines within the NHS

Introduction

The main legislation controlling the supply, storage and administration of medicines is the Medicines Act 1968 and the Misuse of Drugs Act 1971 and many subsequent statutory instruments. Of particular importance were the Misuse of Drugs Regulations 2001.[1] This legislation has now been consolidated in the 2012 regulations (as amended in 2013 and 2014).[2] The Medicines Act 1968 set up a comprehensive system of medicine controls (as can be seen on pages 726 and 745–6). The Medicines Control Agency was absorbed into the Medicines and Healthcare Products Regulatory Agency (MHRA) in April 2003 and information on the regulation of medicines can be accessed via the MHRA website.[3] The main provisions of the Misuse of Drugs Act 1971 are set out in Statute Box 28.1 and the 2001 regulations in Statute Box 28.2.

Charges for prescriptions were the first charges to be introduced in the NHS and have grown steadily over the years with an increasing number of persons exempt. Wales abolished prescription charges in 2007 but the number of drugs handed out to persons in Wales has increased by 52 per cent over the last decade (74 million free drugs were handed out in 2012 in Wales.)[4]

Figure 28.1 illustrates the main areas of control of drugs that are the concern of the nurse. Any local policy must, of course, comply with the statutory framework. Further information on medicines, medicines management and related issues can be obtained from the Royal Pharmaceutical Society,[5] which ceased to be the registration body for pharmacists with the establishment of the General Pharmaceutical Council in 2010.[6]

General principles

Under the Medicines Act, drugs are divided into categories for the purposes of supply to the public. The Part III regulations cover the following:

1 *Pharmacy-only products* (P) i.e. these can be sold or supplied retail only by someone conducting a retail pharmacy business when the product must be sold from a registered pharmacy by or under the supervision of a pharmacist.
2 *General sales list* (GSL) i.e. medicinal products that may be sold other than from a retail pharmacy, as long as provisions relating to section 53 of the Medicines Act are complied with, i.e. the place of sale must be the premises where the business is carried out; they must be capable of excluding the public; the medicines must have been made up elsewhere and the contents must not have been opened since make-up.

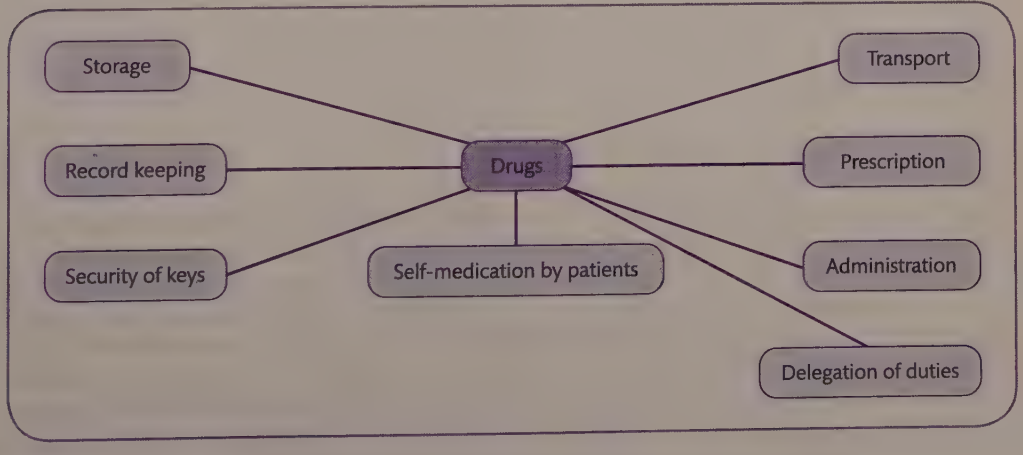


Figure 28.1 Areas that concern the nurse

3 *Prescription-only list* (POM) i.e. these medicines are available only on a practitioner's prescription. Schedule 1 of the subsequent regulations lists the prescription-only products and Part II of the schedule lists the prescription-only products that are covered by the Misuse of Drugs Act. Hospitals are exempt from these prescription-only provisions, as are midwives.

The Misuse of Drugs Act and the 2001 regulations make provision for the classification of controlled drugs and their possession, supply and manufacture.

Statute 28.1 Misuse of Drugs Act 1971

1 Lists and classifies controlled drugs
2 Creates criminal offences in relation to the manufacture, supply and possession of controlled drugs
3 Gives the Secretary of State power to make regulations and directions to prevent misuse of controlled drugs
4 Creates advisory council on misuse of drugs
5 Gives powers of search, arrest and forfeiture.

Statute 28.2 Medicines Acts 1968 and 1971

The Acts set up a comprehensive system of medicine controls covering:

1 administrative system
2 licensing system
3 sale and supply of medicines to the public:
   - pharmacy-only products
   - general sales list
   - prescription-only list
4 retail pharmacies
5 packing and labelling of medicinal products
6 British pharmacopoeia.

NB: Exception to Part III regulations on sale and supply of medicines to the public:

- Midwives: see chapter 14.
- Hospitals: 'Prescription medicines may be sold or supplied by a hospital, provided they are in accordance with the written instructions of a doctor, although these instructions need not be contained in a formal prescription.'

Administration of drugs

Box 28.1 shows a checklist that a nurse should go through before a drug is administered to a patient. There is no team liability for negligence, as was seen in the Wilsher case (page 72, Case 4.3). Each professional must ensure that she fulfils her duties according to the approved standard of practice expected of her. If something goes wrong, she is accountable in the criminal courts, the civil courts, before her employer and before the Conduct and Competence Committee of the NMC for her activities and would have to show that she followed the approved accepted practice. Prescription-only medicines can be administered without the direction of a doctor where the situation is an emergency for the purpose of saving a life. For example, a parent or teacher who needed to administer adrenalin when a child has suffered anaphylactic shock would be covered for such actions.

Box 28.1 Checklist for the administration of drugs

A *The correct patient. Consent?*
- Capacity to consent:
  - child
  - mentally ill or lacking mental capacity
- Pre-existing disability or contraindications
- Warnings about side effects, drowsiness, etc.

B *Correct drug*
- Side effects
- Timing
- Special precautions
- Any contraindications
- Expiry date.

C *Correct dose*
- Type of patient
- Physique of patient
- Allergy frequency.

D *Correct site and method of administration*
- Injection: skin, muscular, vein, artery, site on body.

E *Correct procedure*
- Level of competence of nurse
- Skill, training
- Appropriate delegation
- Safe equipment, sound sterile procedure
- Correct gauge of needle, form of drug and transport.

F *Correct record keeping of dose, time, drug and method*

Controlled drugs

The classification of controlled drugs by the Misuse of Drugs Regulations 2001 is shown in the Statute Box 28.3. Examples only are given here of the different schedules. The full list can be found in the *British National Formulary*. The nurse should be familiar with the procedure for access to the controlled drugs stock and the record keeping, the way in which any destruction of the drugs is recorded and the changes resulting from the Fourth Shipman Report. As a consequence of the Fourth Shipman Inquiry, the Health Act 2006 sections 17 to 25 introduced new laws in relation to the safe custody,[7] the supervision of management and use of controlled drugs, and regulations strengthened the governance and monitoring arrangements for controlled drugs[8]. These 2006 regulations were subsequently replaced by regulations in 2013.[9] An Accountable Officer must now be appointed within each trust to have responsibility for the safe use and management of controlled drugs. The guidance built on the safe and secure handling of medicines (known as the revised Duthie Report, March 2005). In addition, amendments to the Misuse of Drugs Regulations enabled all details on prescriptions for controlled drugs, except the signature, to be computer-generated and the computerisation of controlled drugs registers for drugs listed in Schedules 2 and 3. The final changes to record-keeping requirements can be obtained from the DH.[10] Powers were given to a constable or other authorised person to enter and inspect premises and stocks and records of controlled drugs. In May 2007 the Department of Health and the Royal Pharmaceutical Society of Great Britain published a paper on the safer management of controlled drugs.[11] In 2010 the Court of Appeal held that a person in possession of controlled drugs who intended to supply them outside the jurisdiction did not commit an offence under the Misuse of Drugs Act 1971

sections 4(1) and 5(3).[12] In April 2013 the 2006 regulations were revoked by new regulations.[13] The provisions of these regulations are set out in Statute Box 28.3.

Statute 28.3 Misuse of Drugs Regulations 2001[15]

Drugs are divided into five schedules, each specifying the requirements governing the import, export, production, supply, possession, prescribing and record keeping.

Schedule 1 e.g. cannabis, lysergide. Possession and supply prohibited except in accordance with Home Office authority.
Schedule 2 e.g. diamorphine, morphine, pethidine, glutethimide, amphetamine – subject to full controlled drug requirements relating to prescriptions, safe custody, the need to keep registers.
Schedule 3 e.g. barbiturates, diethylpropion, mazindol – subject to special prescription requirements but not safe custody requirements (except for diethylpropion) or to the need to keep registers.
Schedule 4 includes 33 benzodiazepines that are subject to minimal control. In particular, controlled drug prescription requirements do *not* apply and they are *not* subject to safe custody.
Schedule 5 preparations that, because of their strength, are exempt from most controlled drug requirements, other than retention of invoices for 2 years.

Makes provision for:

1 Certain exemptions from the Misuse of Drugs Act 1971 in relation to the production, importation, exportation, possession and supply of controlled drugs.
2 Prescriptions, records and furnishing of information concerning controlled drugs and for the supervision of the destruction of such drugs.

Examples of the Regulations

1 *Persons entitled* to have controlled drugs in their *possession* include under paragraph 6(7)(f): a person engaged in conveying the drug to a person who may lawfully have that drug in his possession.
2 *Administration of drugs* in Schedules 2, 3, 4 and 5, paragraph 7(3): any person other than a doctor or dentist may administer to a patient, in accordance with the direction of a doctor or dentist, any drug specified in Schedules 2, 3 and 4.

Production and supply of drugs

Paragraph 8(2)(e)

In the case of Schedule 2 and 5 drugs supplied to her by a person responsible for the dispensing and supply of medicines at the hospital or nursing home, the sister or acting sister for the time being in charge of a ward, theatre or other department in such a hospital or nursing home as aforesaid . . . may, when acting in her capacity as such, supply, or offer to supply any drug specified in Schedule 2 or 5 to any person who may lawfully have that drug in his possession, provided that nothing in the paragraph authorises:

(a) . . .
(b) a sister or acting sister for the time being in charge of a ward, theatre, or other department to supply any drug otherwise than for the administration to a patient in that ward, theatre or department in accordance with the directions of a doctor or dentist.

See Statute Box 28.4 below. Further information on the impact of these regulations and the role of the CDAO is given in the Department of Health information guide.[14]

The CQC has been asked to monitor progress on the implementation of the 2013 regulations and overall compliance with the requirements.

Statute 28.4 Regulations on supervision and management of controlled drugs

designate a number of healthcare providers that are required to appoint CDAOs;
set out who may be appointed to the CDAO role and under what circumstances they should be removed from this role;
set out the registration requirements for CDAOs;
set out the core duties and functions of the CDAO including the scrutiny of the relevant staff prescribing CDs;
set out the duties of the NHS Commissioning Board in appointing CDAOs to taken the lead in establishing Local Involvement Networks (LINs) for a particular area.

Regulation 6 sets out the bodies which can provide members for LINs.

Problems in the administration of medicine

Conflict with prescriber

Practical Dilemma 28.1 Challenging the doctor

Staff Nurse Johnson was a children's nurse with some two years' experience. One evening, a child was admitted with suspected meningitis. The house officer on call wrote the child up for antibiotics after having given an injection. Staff Nurse Johnson was surprised at the dosage and queried this with the house officer who was furious to find his treatment questioned by a nurse and confirmed that the nurse should administer that drug at the prescribed dose and at the intervals set out. Since Staff Nurse Johnson had not had many years' experience in paediatrics, she was uncertain what to do since she knew that the child was seriously ill and that a higher dose than usual might be justified in the circumstances. She also knew that it was imperative that there were no delays in administering the drug. She was in charge of the ward.

The nurse is personally accountable for her actions in administering any drug. Only in the most serious emergency where speed is of the essence could she rely on the fact that a doctor ordered her to give the drug and she did not have the opportunity to question the dosage because of the seriousness of the situation. In any case, where the nurse is not satisfied with some aspect of the drug she is instructed to administer, she must ensure the prescription is checked. She would have to do this despite considerable pressure brought by a junior doctor. The difficulties for Staff Nurse Johnson are that, at night, she may have to get someone in to check. She would inform her immediate nurse manager of her concern and would ask the registrar, and, if necessary, the consultant, to confirm that the medication, dosage, frequency and route are correct. If possible, she could obtain the advice of the pharmacist. In extreme circumstances, she is entitled to tell the doctor that she is refusing to administer the drug and the doctor then has the option of administering it him or herself or of rethinking the position. The nurse, of course, risks disciplinary action for her refusal, but if she has good grounds for her belief that the drug or dosage is inappropriate, she should have the support of her management.

Sources of information

The nurse should also be familiar with the *British National Formulary*. There should be an up-to-date copy on the ward and she should have easy access to it. There is some useful information at the beginning,

giving guidance on prescribing. The NMC published its *Standards for Medicines Management* in 2007,[16] (updated in 2010 with paragraph numbers[17]) replacing the earlier guidelines for the administration of medicines. There are 10 sections for which standards are set. The sections are:

Methods of supplying and/or administration of medicines
Dispensing
Storage and transportation
Standards for practice of administration of medicines
Delegation
Disposal of medicinal products
Unlicensed medicines
Complementary and alternative therapies
Management of adverse events
Controlled drugs.

The standards can be downloaded from the NMC website.[18]

Illegible writing

Nurses often complain that they are unable to read the doctors' writing on the drug charts. If they have any doubt about the drug prescribed, they should not administer it unless they have checked it with the doctor who wrote it, his superior or, in certain circumstances, the pharmacist. If the nurse fails to double-check illegible writing, she could herself become liable, as the following case illustrates.

Case 28.1 *Prendergast* v. *Sam Dee Ltd and Others* (1989)

Illegible writing[19]

One of three items on a prescription was for 21 Amoxil tablets. The pharmacist misread this as Daonil. The patient suffered hypoglycaemia and sustained permanent brain damage. The pharmacist said that he had read the 'A' for a 'D' and the 'x' for an 'n'. There were other indications from which the pharmacist should have realised that his interpretation was for the wrong drug, i.e. the other drugs that were prescribed, the dosage and the fact that the patient paid for his prescription. (Daonil is a drug used by diabetic patients, who do not have to pay prescription charges.) Both doctor and pharmacist were held liable for the harm that befell the patient. The doctor was held 25 per cent liable. Damages totalled £137,547.

In a case where a woman was prescribed a top-up epidural following a hysterectomy in a private hospital, the junior doctor mistook a dose of 3 ml of diamorphine for 30 ml. The woman collapsed following its administration and the doctor was unable to use the resuscitation equipment, as he had not had the necessary training. Although the consultant was able to revive her, she died a few days later.[20]

The CQC criticised the Manchester Children's Hospital in its inspection in December 2013 because 'we found that many entries in the medical notes were illegible'.[21]

Bad maths

The UKCC advised in 2000 that student nurses should be given more mathematics training following claims that drug calculation errors could be putting patients at risk. Professor Bryn Davis, a UKCC member, stated that the GCSE maths exam, which is a compulsory entry requirement for training, is

failing to prepare nurses for complex drug calculations.[22] An example of the fatal effects of miswriting decimals was seen in October 2000 when it was alleged that a baby in a neonatal unit died when a decimal point in a drug prescription was entered in the wrong place.[23] The death had been reported to the coroner. The issue of numeracy rose again in 2014 when it was reported that the NHS was rejecting 1 in 3 university-trained nurses because they were unable to do simple sums such as to calculate how many 15 mg tablets are required to make up 30 mg. University College London Hospitals NHS Foundation Trust found that 15 per cent of nursing applicants failed similar drug calculation tests.[24]

Management of errors or incidents in the administration of medicines

The NMC in the guidance it provides on Standard 24 (the management of adverse events in its standards for medicines management) states:

> 2 **The NMC supports the use of a thorough, open and multi-disciplinary approach to investigating adverse events, where improvements to local practice in the administration of medicinal products can be discussed, identified and disseminated.**
> 3 **It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents in the administration of medicines.**
> 4 **The NMC believes that all errors and incidents require a thorough and careful investigation at a local level, taking full account of the context and circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed . . .**[25]

The NMC emphasises the importance of reporting the error speedily through the local risk management systems and for midwives to notify their supervisors.

In 2004 the Department of Health published a new guide to improve safety in the prescribing, dispensing and administration of medicines.[26] The guide examines the causes and frequency of medication errors, highlights drugs and clinical settings that carry particular risks and identifies models of good practice for health professionals and NHS organisations.

The National Patient Safety Agency (NPSA) in its annual report for 2006/7 stated that in partnership with the DH and the Welsh Assembly it had initiated a safe medication practice work programme for 2007/8 which aimed to improve the safe use of medicines in the NHS. Patient safety alerts cover five distinct areas of medicines management: anticoagulant medicines management; liquid medicines administered via oral and other enteral routes; injectable medicines; epidural injections and infusions; and paediatric intravenous infusions. In March 2007 the NPSA published *Safety in Doses: improving the use of medicines in the NHS*. It is also looking at preventing medication errors by improving the packaging design. These reports are available on the NPSA website.[27] The NPSA graded patient safety incidents in terms of no harm (including where the incident has been prevented and where it has not been prevented), low harm where the incident required extra observation or minor treatment, moderate harm, severe harm and death. In 2009 the NPSA stated that at least 100 patients are dying or suffering serious harm each year after healthcare workers give them the wrong medication. The number of alerts relating to errors or near misses in the supply or prescription of medicines had more than doubled in two years, with 86,000 incidents regarding medication being reported in 2007. Of the cases, 96 per cent were cases of no or low harm. Causes of the mistakes were workload pressures, long hours, fatigue and reduced staff levels. The figures are based on the voluntary reporting of incidents, but it is thought that probably only about 10 per cent of incidents were being reported, so the actual figure of errors could be vastly more – perhaps 860,000. Over 82 per cent of the incidents occurred in the administration or dispensing of medicines by nurses or pharmacists. Of the deaths, 41 were caused in the administration of drugs to patients by nurses and 32 were due to prescribing.[28]

In June 2009 the NPSA published its first report into health and safety incidents involving children and stated that 61,000 alerts related to patients under 18 years with 18,200 involving babies under 1 month. A quarter of the cases were the result of misuse of medication with some patients being given 10 times too much of a drug owing to a dose miscalculation. More than 2,800 alerts involved a wrong or unclear dose or strength, and children under the age of 4 were particularly affected.[29] The most frequently reported types of medication incidents involved: wrong dose, omitted or delayed medicines and wrong medicine.[30] In August 2009 it was reported that an out-of-hours GP administered six times the correct dosage of diamorphine to two patients during the same shift, killing one and causing the other to stop breathing.[31] He was given a suspended sentence for manslaughter in Germany and appeared before the GMC which removed him from its Register on the grounds that his fitness to practise was impaired because of his misconduct.[32] An article in the *British Journal of Nursing* analyses medication errors by nursing staff and suggests ways in which nursing practice can be improved to prevent their occurrence.[33] NICE together with the National Reporting and Learning Service published guidance on medicines reconciliation to ensure that patients on admission were prescribed medicines which corresponded to those the patients were taking before admission.[34] Alerts on the safety of medicines and medicinal products are published by the Medicines and Healthcare Products Regulatory Agency (MHRA).[35] In 2014 the MHRA and NHS England worked together to simplify adverse incident reporting. Further information on patient safety alert on improving medication error incident reporting and learning can be found on the website.[36]

The Department of Health publishes a list of 'never events', i.e. incidents which are considered unacceptable and eminently preventable. The list for 2012/13 obtainable on the government website[37] contains 25 such events (see page 444), many of which relate to the administration of medicines, e.g. wrongly prepared high-risk injectable medication, maladministration of potassium-containing solutions, wrong route administration of chemotherapy, and intravenous administration of epidural medication.

NICE in its guidance in May 2014 on hospital staffing levels suggested that when nurses forget to give patients medication it should be seen as a 'red flag' that a ward is dangerously understaffed (see chapter 5). In 2014 the Secretary of State initiated a 'Sign up to Safety' campaign for trusts to identify serious mistakes and take action to halve the incidence. Reducing the number of serious avoidable mistakes such as medication errors could save 6,000 lives over the next three years (see chapter 12).

Shared liability

It may happen that several different practitioners are involved in an incident that causes harm to a patient. The court has to determine the respective responsibility of each person and their employer (if any). Under the Civil Liability (Contribution) Act 1978, a successful claimant can obtain compensation from any one of several defendants and that defendant can then claim from the other defendants reimbursement according to their responsibility for the harm. An example of this is given in Case 28.2. The case does not involve a nurse, but if the situation were in a hospital context rather than in the home, one can imagine a nurse being involved.

Case 28.2 *Dwyer v. Roderick* (1984)

Over-prescribing[38]

It was alleged by Mrs Dwyer that Dr Roderick prescribed a particular drug (Migril) and was negligent in choosing the number and frequency with which the relevant tablets should be taken, so that within a relatively short time she had received a dangerous overdose. The manufacturers had warned that not more than four tablets should be taken for any one attack of migraine and that no more than 12 tablets should be taken in the course of 1 week. Dr Roderick's prescription was for two tablets to be taken every 4 hours as necessary. He prescribed a total of 60 tablets. Dr Roderick admitted that

this was utterly wrong: 'I have no satisfactory explanation. It was a mental aberration.' When the prescription was taken for dispensing, there were two qualified pharmacists in the shop, neither of whom noticed the error and simply repeated Dr Roderick's instructions on the label. They in turn accepted some liability. Over the next six days, Mrs Dwyer took 36 Migril tablets. As a result of this overdose, she suffered serious personal injuries, i.e. irreversible ergotamine poisoning which resulted in constriction of the blood vessels and gangrene of her toes and lower limbs. As well as suing the chemists and Dr Roderick, Mrs Dwyer sued as second defendant Dr Roderick's partner, Dr Jackson, who saw her three days after the prescription had been given and who failed to discover the fact that his partner had over-prescribed the drug and failed to stop her taking it.

In Case 28.2, the trial judge decided that each defendant was liable: Dr Roderick was 45 per cent liable, Dr Jackson was 15 per cent liable and the pharmacists were 40 per cent liable. The Court of Appeal held by a majority that Dr Jackson was not negligent. It accepted his evidence that it was his usual practice to enquire what medication a patient was on. Liability was thus divided between Dr Roderick and the pharmacists. Mrs Dwyer received £92,000 compensation.

One particularly interesting aspect of this case is that the incident occurred in November 1973, but did not come to court until 1982. Thus the actual evidence of what happened was scanty and undoubtedly made Mrs Dwyer's case against Dr Jackson very difficult. The court commented adversely on the delay and suggested that the time might be ripe for changes designed to enable the court and the judiciary to play a greater part in encouraging the parties and their advisers to speed up the process of litigation. These changes have now taken place (known as the Woolf Reforms) and are discussed in chapter 6. Cases may still commence many years after an incident (see chapter 6 on limitation of time) and therefore nurses must be aware of the importance of record keeping (see chapter 9). In any such incident, the nurse is likely to have very little personal recall, but will be heavily dependent on the clarity and comprehensiveness of the records.

Fitness to practise case

Case 28.3 Fitness to practise[39]

A registered general nurse who was employed first as the lead nurse in an ophthalmology department, then on a care of the elderly ward, faced allegations that she put an instruction to 'dilate both eyes' on a patient's notes without medical authorisation, that she administered a drug via the wrong route and while she was not competent to do so, and made a false entry on a patient's fluid balance chart relating to that drug error. The nurse admitted all the charges except that of making the false entry.

In hearing Case 28.3 the Professional Conduct Committee of the NMC found the facts proved and were convinced by the evidence that the nurse had added the letters SC (subcutaneous) at a later date. It found that the proved facts of all the charges amounted to misconduct. It decided that the nurse's name should be removed from the Register.

PRN medication

PRN medication (*pro re nata* – 'as required, whenever necessary') enables a doctor to write the patient up for medication, but leaves to the nurse the discretion as to when, if at all, the drug should be administered, depending on the patient's condition.

The value of this system is that it allows the patient to have a drug when necessary, without calling the doctor for the specific purpose of prescribing the drug for it to be administered immediately. Thus pain relief drugs, sleeping tablets and indigestion drugs can be prescribed in case the patient might need such help. Unfortunately, the doctor does not always ensure that sufficient information is given on the drugs sheet. He or she might, for instance, fail to give the maximum amount that can be given in any 24-hour period. He or she might also fail to specify the dose and the intervals at which it can be given. The hospital pharmacist should check the drugs sheets regularly to ensure that all the relevant information is present and the nurse should not administer these drugs without first checking the limitations. It is also essential that every drug that is administered PRN should be recorded when given, as overdoses could easily occur if a record is not kept. Each hospital should have a policy relating to PRN medication.

Infusion therapy

Since 1968 there have been many cases of inadvertent intrathecal injection of the vinca alkaloid drug vincristine reported around the world (and around half of these have been in England). One of the targets of the National Patient Safety Agency (see chapter 12) was to reduce the number of patients dying or being paralysed by maladministered spinal injections to zero by the end of 2001. A junior doctor in Nottingham pleaded guilty to manslaughter following the administration of a chemotherapy drug by epidural rather than IV to a patient suffering from leukaemia (see chapter 2). Standard 20 of the NMC Standards of Medicines Managements covers intravenous administration of medicines. The RCN published guidance for administering IV drugs in the community to children.[40] Guidance on standards for infusion therapy in hospitals and the community was published by the RCN in 2003.[41] These provide information on standards on:

- infection control
- most appropriate infusion devices and infusion-related equipment
- infusion-related complications
- infusion therapies, including chemotherapy, analgesia, transfusion and epidural
- placement, care and maintenance of vascular access devices.

The RCN has subsequently provided guidance for community nurses on advance preparation of insulin syringes for patients to administer at home.[42] This aims to assist elderly patients to manage their insulin injections. Further publications from the RCN include *Guidance on Competences: an education and training competency framework for administering medicines intravenously to children and young people*[43] and *Right Blood, Right Patients, Right Time. RCN guidance for improving transfusion practice*.[44]

Updated national guidance on the safe administration of intrathecal chemotherapy was issued by the Department of Health in 2003 and updated in 2008.[45] The guidance contained in the annexe to the circular was to be fully complied with by NHS trusts by 30 November 2003. A training toolkit and video were issued to support local induction and training programmes. Under the guidance, the chief executive of a trust is required to identify a designated lead to oversee compliance within the trust; trusts that undertake fewer than 10 procedures a year (low-volume trusts) should carry out a risk assessment to decide if they should continue to provide the service; high-volume trusts (500+ procedures a year) should carry out a risk assessment to check the capacity and safety of the service; a written local protocol should be drawn up and a register established to identify personnel who have been trained and are authorised to prescribe, dispense, issue, check or administer; automatic inclusion in a hospital's register on the transfer of staff should not occur. There should be annual reviews of competence and a certificate or other written confirmation of competence should be issued. The guidance also includes advice on those eligible to prescribe, documentation, storage, administration of intrathecal chemotherapy after intravenous chemotherapy has been administered, an area should be designated for the administration of intrathecal chemotherapy and it should only be administered in normal working hours. Guidance on waivers is also given.

Instructions by telephone and remote assessment and prescribing

The situation highlighted in Practical Dilemma 28.2 is not uncommon.

Practical Dilemma 28.2 Night orders

Ward Sister Dury was the night sister at a small hospital that was served by GPs. One night she was very worried about the condition of a frail patient whose blood pressure and temperature were raised. She telephoned the duty GP and expressed her anxieties to him. He was of the opinion that she need not be concerned and suggested that the patient should be given paracetamol. She was reluctant to take instructions over the telephone, but decided that, since he would not visit, there was little else she could do for the patient. She gave the dose of paracetamol, but unfortunately the patient's condition deteriorated and she again telephoned the GP, who did not visit until 9.00 a.m. the next day, by which time the patient had died.

What is the position of the ward sister? Should she have taken instructions over the telephone?

Practice Standard 20 of the NMC standards of proficiency for nurse and midwife prescribers covers remote prescribing via telephone, email, fax, video link or website and states:

20.1 From time to time it may be appropriate to use a telephone or other non face-to-face medium to prescribe medicines and treatment for patient/clients. Such situations may occur where:

- **(a) You have responsibility for the care of the patient/client**
- **(b) You are working in remote and rural areas**
- **(c) You have prior knowledge and understanding of the patient/client's condition and medical history**
- **(d) You have authority to access the patient/client's records and you are working within the scope of a supplementary prescriber, but the doctor/dentist required to authorise the clinical management plan works at a distance.**

20.2 In all circumstances, you must ensure that you:

- **(a) Establish the patient/client's current medical conditions, history and concurrent or recent use of other medications including non-prescription medicines**
- **(b) Carry out an adequate assessment of the patient/client's condition (in line with Practice Standard 3)**
- **(c) Identify the likely cause of the patient/client's condition**
- **(d) Ensure that there is sufficient justification to prescribe the medicines or treatment proposed. Where appropriate you should discuss other treatment options with the patient/client**
- **(e) Ensure that the treatment and/or medicine is not contra-indicated for the patient/client**
- **(f) Make a clear, accurate, legible and contemporaneous record of all medicines prescribed**
- **(g) Are competent to make a prescribing decision.**

20.3 Where you cannot meet all of these requirements you must not use remote means to prescribe medicine for a patient/client.

The NMC set out its position on remote assessment and prescribing in 2008.[46] It sets out its support of the use of remote assessment and prescribing and lays down the procedure which should be followed. See also section 4 Standard 11 of the Standards for Medicines Management.[47]

It would now be possible for patient group directions to be drawn up so that, following appropriate training, the ward sister could prescribe and administer against an agreed protocol (see page 739).

Misprescribing of antibiotics

Research carried out by University College London using the NHS General Practice Research Database showed that family doctors are persisting in prescribing antibiotics for conditions against which they do not work. Even patients who were aware that antibiotics were ineffective against viral conditions still pressed GPs for prescriptions for antibiotics.[48] In law patients do not have the right to insist on being given treatment which the professional considers is inappropriate[49] (see chapter 29). The Chief Medical Officer of Health, Dame Sally Davies, warned in May 2014 that the threat to humanity from drug-resistant infections is worse than that of climate change and that the world is facing an apolcalyptic scenario in which people die from routine infections because effective drugs have run out.[50] The creation of an organisation comparable to the Intergovernmental Panel on Climate Change was called for to coordinate action against the threat of anti-microbial resistance. The Science and Technology Select Committee recommended in July 2014 that doctors must stop prescribing antibiotics as placebos to keep patients happy since this was contributing to the escalating problem of drug-resistant infections.[51]

Self-administration by patients

The involvement of the patient in his own medication is increasingly being adopted as a form of rehabilitation and as a move towards discharge and the assumption by the patient of responsibility for his own health and care. The NMC welcomed this development in its standards for medicines management.[52] It states (Standard 5 section 2) that:

3 where the patient is using their own medicines, herbal preparation and other OTC preparations, the registrant has a responsibility to:
- **3.1 ask to see the medicinal products**
- **3.2 check for suitability of use**
- **3.3 explain how and why they will or won't be used**
- **3.4 establish if they are prescribed**
- **3.5 ascertain if they meet the criteria for use.**

Guidance on Standard 9 (section 4) advises the registrant on the assessment of the patient's capability to self-administer on a regular basis and requires records appropriate to the environment to be kept. Three levels of administration are identified:

Level 1 where the registrant is responsible for the storage and administration
Level 2 where the patient is responsible for storage but the registrant opens the cupboard and supervises the administration by the patient and
Level 3 where the patient is fully responsible for storage and administration.

The guidance on self-administration states:

7 Where patients consent to self-administration of their medicines the following points should be considered:
- **7.1 Patients share the responsibility for their actions relating to self-administration of their medicines.**
- **7.2 Patients can withdraw consent at any time.**
- **7.3 The pharmacy will supply medicines fully labelled, with directions for use, to every patient who is involved in self-administration.**

8 Information given and supervision should be tailored to individual patient need.

9 The following information should be provided to a patient before commencing self-administration:
- **9.1 the name of the medicine**
- **9.2 why they are taking it**
- **9.3 dose and frequency**

9.4 common side effects and what to do if they occur
9.5 any special instructions
9.6 duration of the course or how to obtain further supplies.

The registrant must ensure that the patient is able to open the medicine containers or is offered assistance, e.g. compliance aid.

Although the registrant has a duty of care towards all patients, the registrant is not liable if a patient makes a mistake self-administering as long as the assessment was completed as the local policy describes and appropriate actions were taken to prevent re-occurrence of the incident.

Guidance has been published by the Royal Pharmaceutical Society of Great Britain on medicines management during patient admission to the ward, which includes guidance on the self-administration of medicines.[53] The Care Quality Commission published a report in 2009 on the management of patients' medicines after discharge from hospital[54] raising many concerns, including the fact that of those researched only 14 per cent of GPs gave information on medicines which should be stopped. In 47 per cent of the GP practices visited, discharge summaries from hospitals were not received in enough time to be useful and 81 per cent of practices reported that details of prescribed medicines were incomplete or inaccurate all the time or most of the time.

Covert administration of medicines

It is a basic principle of law that the consent of an adult to treatment including medication is required. However, problems can arise when an adult lacks the mental capacity to give consent. The UKCC published a position statement in 2001[55] on the covert administration of medicines disguised in food or drink. The guidance was republished by the NMC in the form of a position statement within its A–Z advice sheets.[56] (These A–Z sheets are no longer in use.) The advice was updated in 2007.[57] It makes clear that covert administration would not apply to a patient who had the mental capacity to make his or her own decisions even in a life-saving situation and could only be justified where the patient lacked the mental capacity to make his or her own decisions and the administration of medicines in this way was in the best interests of the patient. The NMC stated:

> **The covert administration of medicines is only likely to be necessary or appropriate in the case of patients or clients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal.**

The NMC recommends that any local policies on covert administration should be revised in the light of its statement.

A review carried out for the Department of Health in November 2009[58] found that over 144,000 patients suffering from dementia were being given anti-psychotic drugs unnecessarily. It estimated that only 36,000 of the 180,000 people being given the drugs derive any benefit from them. The drugs are misused as a chemical cosh to suppress the anxiety and distress common in people with dementia.[59] (See also chapter 19.) Fundamental flaws in the protection provided by the Mental Capacity Act and the Deprivation of Liberty Safeguards was found by the House of Lords in its report published in March 2014[60] on the post-legislative scrutiny of the Mental Capacity Act 2005.

In February 2014 it was announced that some of the largest drugs companies have formed an alliance (the Accelerating Medicines Partnership) to accelerate the discovery of new medicines to treat Alzheimer's, type 2 diabetes, rheumatoid arthritis and lupus.[61]

Medicines and the operating department practitioner (ODP)

Operating department practitioners (ODP) are now a registered profession under the aegis of the Health and Care Professions Council (HCPC). Employers should check with the HCPC that any prospective

or actual ODP in their employment is on the Register. The HCPC includes in the standards for proficiency of the ODP the following key concept:

> **3a.1 Understand how to store, issue, prepare and administer prescribed drugs to patients and monitor the effects of drugs on patients.**

They are not as yet identified as one of the registered professions able to become independent prescribers.

Nurse as prescriber

There have been major developments in the scope of professional practice of the nurse, which are considered in chapter 24. Of these developments, one of the most significant ones is nurse prescribing. This section looks at the current situation in relation to nurse prescribing following the Crown Report. The prescribing powers of the midwife are considered in chapter 14.

Community nurse prescribing

Prescribing by community nurses was recommended by the Cumberlege Report in 1986[62] and these conclusions were supported in the report of the advisory group on nurse prescribing (known as the First Crown Report) to the Department of Health in December 1989. Legislation was passed to give specified practitioners the power to prescribe specified medicines (Medicinal Products (Prescription by Nurses) Act 1992). Health visitors and community nurses who had had the requisite training could prescribe in the community from a nursing formulary. In February 2000,[63] prescribing powers were given to nurses employed by a doctor on the medical list (i.e. GP) and also to nurses working in walk-in centres, defined in the regulations as 'A centre at which information and treatment for minor conditions is provided to the public under arrangements made by or on behalf of the Secretary of State'.

Practical Dilemma 28.3 Holding stocks in the community

Brenda was a community nurse who was eligible to prescribe medicines in the community. Often patients would, when the treatment had ended, offer her dressings and other medicines that they had been prescribed and were left over. She was happy to take them since to dispose of them would be a waste. She thus built up a considerable stock, which she kept in the boot of her car, and would issue to new patients before their prescriptions had been dispensed. She is now concerned to know the legality of what she is doing.

There are considerable dangers in the practice followed by Brenda. In the first place, the medicinal products obtained on prescription for one patient should be used for that patient and not for others. Second, by supplying these medicinal products to others, she could be seen as the supplier under the Consumer Protection Act 1987 (see chapter 12) and become liable for any defects. In addition, there is the security and safety aspect of keeping such products in the boot of her car. To ensure that a safe practice is followed, she should discuss with her manager and the pharmacist the possibility of the pharmacist taking the unwanted goods back into stock.

Supplying medicines in hospital and primary care

The legal changes permitting nurse prescribing in the community brought into focus the situation in hospitals and family practitioner centres where supplying medicines by nurses was taking place according

to protocols or written instructions signed by the delegating doctor. The anomalies raised by this quasi-legal situation led the government to appoint Dr June Crown to review the position on prescribing, supply and administration of medicines and make recommendations (First Crown Report).[64]

Group protocols or patient group directions

The Crown Committee first considered the arrangements for and legality of group protocols and reported in March 1998 and recommended legislation to ensure that their legal validity was clarified. The criteria against which any group protocol should be tested were set out in the Report. It recommended that certain products should be excluded from group protocols. These included:

1 new drugs under intensive monitoring and subject to special adverse reaction reporting requirements (the Black Triangle scheme)[65]
2 unlicensed medicines
3 medicines used outside their licensed indications
4 medicines being used in clinical trials.

As a consequence of the Crown Report on group protocols (see Box 28.2), new regulations came into force on 9 August 2000.[66] These provided for patient group directions to be drawn up to make provision for the sale or supply of a prescription-only medicine in hospitals in accordance with the written direction of a doctor or dentist. To be lawful, the patient group direction must cover the particulars that are set out in Part I of Schedule 7 of the Statutory Instrument. These particulars are shown in Box 28.3.

Box 28.2 Criteria for group protocols

Group protocol criteria are as follows:

- should ensure that patient safety is not compromised or put at risk
- should specify clear arrangements for professional responsibility and accountability
- should contribute to the effective use of resources
- should be consistent with the summary of product characteristics, which is part of the marketing authorisation granted for the product
- content of the protocol should state the clinical need which it is intended to address and the objectives of care which it will provide; the characteristics of staff authorised to take responsibility for the supply or administration of medicines under a group protocol
- description of treatment available; management and monitoring of group protocols
- development of group protocols: by whom? approval; employer's final approval; date and signature and monitoring
- implementation of group protocols.

The classes of individuals by whom supplies may be made are set out in Part III of Schedule 7 and include the following:

1 ambulance paramedics (who are registered or hold a certificate of proficiency)
2 pharmacists
3 registered health visitors
4 registered midwives
5 registered nurses
6 registered ophthalmic opticians
7 state registered chiropodists/podiatrists

8 state registered orthoptists
9 state registered physiotherapists
10 state registered radiographers.

The person who is to supply or administer the medicine must be designated in writing on behalf of the authorising person for the purpose of the patient group direction. In addition to compliance with the particulars set out in Box 28.3, a patient group direction must be signed on behalf of the authorising person. The Department of Health has developed patient group directions for certain chemical and biological countermeasures in emergency situations, such as atropine, and these can be downloaded from its website.[67] The Royal Pharmaceutical Society of Great Britain updated in 2008 a resource pack for pharmacists on patient group directions which would also be of interest to NMC-registered practitioners and this is available on its website. In 2009 the NMC published guidance for student nurses and student midwives on the Patient Group Directions making it clear that these students could not administer medicines using PGDs even if under direct supervision.[68] Guidance is also available from the Medicines and Healthcare Products Regulatory Authority and the National Prescribing Centre (now in NICE).

Box 28.3 Particulars for patient group direction

- Period during which the direction shall have effect.
- Description or class of prescription-only medicines to which the direction relates.
- Whether there are any restrictions on the quantity of medicine which may be supplied on any one occasion and, if so, what restrictions.
- Clinical situations that prescription-only medicines of that description or class may be used to treat.
- Clinical criteria under which a person shall be eligible for treatment.
- Whether any class of person is excluded from treatment under the direction and, if so, what class of person.
- Whether there are circumstances in which further advice should be sought from a doctor or dentist and, if so, what circumstances.
- Pharmaceutical form or forms in which prescription-only medicines of that description or class are to be administered.
- Strength, or maximum strength, at which prescription-only medicines of that description or class are to be administered.
- Applicable dosage or maximum dosage.
- Route of administration.
- Frequency of administration.
- Any minimum or maximum period of administration applicable to prescription-only medicines of that description or class.
- Whether there are any relevant warnings to note and, if so, what warnings.
- Whether there is any follow-up action to be taken in any circumstances and, if so, what action and in what circumstances.
- Arrangements for referral for medical advice.
- Details of the records to be kept of the supply or the administration of medicines under the direction.

Nurse prescribing: independent and dependent (subsequently known as supplementary) prescribers

In March 1999 the Final Crown Report was published.[69] Its terms of reference included the requirements:

1 to develop a consistent policy framework to guide judgements on the circumstances in which health professionals might undertake new responsibilities with regard to prescribing, supply and administration of medicines
2 to advise on the likely impact of any proposed changes
3 to consider possible implications for legislation, professional training and standards.

Its most significant recommendation was that there should be two types of prescriber:

- The *independent prescriber* who is defined as the person who is responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing. This group would include doctors, dentists and certain nurses who are already legally authorised prescribers. Other health professionals may also become newly legally authorised independent prescribers.
- The *dependent prescriber* (now known as the *supplementary prescriber*) who is defined as the person who is responsible for the continuing care of patients who have been clinically assessed by an independent practitioner. The continuing care can include prescribing that will be informed by clinical guidelines and will be consistent with individual treatment plans. Dependent prescribers may also be involved in continuing established treatments by issuing repeat prescriptions, with authority to adjust the dose or dosage form according to patients' needs. There should be provision for regular clinical review by the assessing clinician.

Nurse independent prescribing

Legislation implementing the Final Crown Report recommendations was contained in section 63 of the Health and Social Care Act 2001, which amended the Medicines Act 1968 and enabled the Secretary of State to draw up regulations to lay down the conditions on which prescribing powers can be extended to specified health professionals. A nurse independent prescriber means a person (a) who is a registered nurse or registered midwife and (b) against whom is recorded in the professional register an annotation signifying that she is qualified to order drugs, medicines and appliances as a nurse independent prescriber or a nurse independent/supplementary prescriber. A qualified nurse independent prescribers are now able to prescribe any licensed medicine for any medical condition within their competence, including some controlled drugs.

Nurse independent prescribers were only able to prescribe or administer a limited range of controlled drugs as set out in Schedule 3A of the Statutory Instrument. However, this was extended in 2012 when the Department of Health announced changes to nurse and pharmacist independent prescribing. As a result of changes to the Misuse of Drugs Regulations appropriately qualified nurses and pharmacists are able to prescribe, supply, offer to supply and administer controlled drugs like morphine, diamorphine and prescription strength co-codamol. (This does not apply to the supply to people addicted to cocaine, diamorphine or dipipanone to addicts otherwise than for the purpose of treating organic disease or injury.) The changes apply to midwives who are registered as independent prescribers. Changes include the authority to mix drugs listed in Schedules 2–5. In addition nurses and pharmacists working under a PGD can supply or administer diamorphine and morphine where administration of such drugs is required for the immediate and necessary treatment of sick and injured persons (excluding the treatment of addiction). (Previously a nurse could only supply diamorphine under a PGD for the treatment of cardiac pain in patients admitted to a coronary care unit or A&E department of a hospital.)[70]

The NMC has issued guidance on Criminal Records Bureau checks, and the educational and training requirements for independent prescribing and for specialist community public health nursing programmes.[71]

Additional criteria for eligibility to become an independent nurse prescriber

In its guidance on implementation the Department of Health has advised that, in addition to fulfilling the legal criteria, applicants for the prescribing preparation will need:

- the ability to study at level 3 (degree level)
- at least 3 years' post-registration clinical nursing experience (or part-time equivalent): nominees will usually be at E grade or above
- a medical prescriber willing to contribute and to supervise the nurse's 12-day learning in the practice element of preparation
- the support of the employer and confirmation of certain conditions.

The three key principles to prioritise potential applicants for training as independent nurse prescribers are seen by the DH as being:

- patient safety
- maximum benefit to patients in terms of quicker and more efficient access to medicines for patients
- better use of nurses' skills.

Supplementary prescribing

This is defined by the NMC as:

> **A voluntary partnership between an independent prescriber (doctor/dentist) and a supplementary prescriber, to implement an agreed patient/client-specific clinical management plan with the patient/client's agreement.**

Following the recommendations of the Final Crown Report in 1999 the Department of Health[72] in April 2002 announced its intention of introducing supplementary prescribing by a nurse or pharmacist in 2003. The aim was to enable the pharmacists and nurses to work in partnership with doctors and help treat such conditions as asthma, diabetes, high blood pressure and arthritis. The doctor would draw up a plan with the patient's agreement – known as the clinical management plan – laying out the range of medicines that may be prescribed and when to refer back to the doctor. This early announcement was followed by a press release in November 2002,[73] which gave further details of the patient conditions and the medicinal products that would be the subject of supplementary prescribing. In April 2005 chiropodists and podiatrists, physiotherapists and radiographers were added to the list of those who could become supplementary prescribers, and restrictions on their prescribing controlled drugs or unlicensed medicines were removed.[74]

The clinical management plan must be agreed with the patient in relation to specified conditions. It must state the name of the patient, the condition being treated, the class or description of medical products that can be prescribed or administered and the circumstances in which the supplementary prescriber should refer back to the independent prescriber.

NMC guidance on prescribing

The NMC has published Standards of *Proficiency for Nurse and Midwife Prescribers*.[75] Sections cover:

> the educational and training provision to prepare nurses and midwives to prescribe;
> standards for prescribing practice;
> additional guidance;
> annexe 2 sets out the principal areas, knowledge, skills and competencies required to underpin prescribing practice.

The guidance sets down 21 Practice Standards which cover such topics as accountability, consent, communication, record keeping, prescribing and dispensing, clinical management plans for supplementary prescribing, evidence-based prescribing and continuing professional development. The document can be downloaded from the NMC website.

Implications of nurse prescribing for the scope of professional practice

The Crown Report and subsequent developments have, in a sense, given approval to a controlled development of professional competence in areas formerly the sole preserve of medical staff. However, clear checks are in place to ensure that these developments take place with well-defined precautions to secure patient safety and also to secure efficient use of resources. While nurses are likely to be the most numerous group to develop prescribing skills, other professionals, such as physiotherapists, radiographers, orthoptists, dietitians, speech therapists and many others, have found that the new legislation has facilitated professional development or at the minimum validated activities already taking place. The need to obtain a doctor's personal attendance on a patient in order that a specific drug could be prescribed has placed an unnecessary obstacle in the advancement of professional practice for many health professionals and this has now been lifted. (Issues relating to the scope of professional practice and the role of the clinical nurse specialist and the consultant nurse are discussed in chapter 24.)

Perhaps the most important of the recommendations in the final Crown Report is that to individual practitioners:

> **All legally authorised prescribers should take personal responsibility for maintaining and updating their knowledge and practice related to prescribing, including taking part in clinical audit, and should never prescribe in situations beyond their professional competence.**

Electronic prescriptions

Regulations were enacted in 2001 to allow the use of an electronic signature for the electronic transmission of prescriptions in pilot studies and this is extended to PCTs to facilitate the use of electronic prescriptions.[76] The system allows the patient's prescription to be sent electronically from their GP to a pharmacy. Further information on the current stage of the initiative can be obtained from the Department of Health website or from the Health and Social Care Information Centre (which took over the functions of Connecting for Health in March 2013.)[77]

Mixing of medicines prior to administration

Following the recommendations of the Commission on Human Medicine regulations were amended[78] to enable doctors and other prescribers to mix medicines themselves and to direct (in writing) others to mix medicines (mixing is seen as manufacturing which is closely regulated). The Department of Health issued guidance in May 2010.[79] The NMC has also provided advice for its registrants.[80]

Role of the pharmacist

In January 2014 heads of 23 health groups including the Royal College of Nursing and the Royal College of GPs urged patients to seek advice from pharmacists instead of going to the GP.[81] Professor Darracott of Pharmacy Voice estimated that 51 million GP visits could have been dealt with at a pharmacy. As a consequence of the changes made by the Human Medicines Regulations in 2012[82] pharmacists are able to make changes to prescriptions in the exercise of their professional skill and judgement if they believe it appropriate to do so, including the name of the product or its common name, the directions for use of the product and precautions relating to the use of the product.

Safety of medicines

The Committee on Safety of Medicines was one committee set up under section 4 of the Medicines Act on the advice of the Medicines Commission to the Minister. It is regulated under Schedule 1 of the Medicines Act and under Statutory Instrument.[83] It can in turn set up its own subcommittees. Like all

other section 4 committees and the Medicines Commission itself, it must submit an annual report about its work to ministers. The Medicines Control Agency was the licensing authority under the Medicines Act and the European Regulations and had the function of monitoring the safety and quality of medicines. It operated a Defective Medicines Report Centre. On 1 April 2003 the Medicines Control Agency was amalgamated with the Medical Devices Agency to form the Medicines and Healthcare Products Regulatory Agency (MHRA). The MHRA and the Committee on the Safety of Medicines publish a drug safety update bulletin which provides information on adverse drug reactions. For example doctors were advised by the MHRA not to prescribe codeine for children under 12 years.[84] The MHRA has the responsibility of pharmacovigilance (safety of medicines) in accordance with Directives from the EU[85] and supervises the yellow card adverse drug reaction scheme. Directive 2012/26/EU of the European Parliament amending regulations on pharmacovigilance were incorporated into UK law by regulations which came into force on 11 November 2013.[86]

The yellow card scheme

A yellow card adverse drug reaction (ADR) reporting scheme is a voluntary scheme, through which doctors, dentists, coroners and pharmacists notify the Medicines Control Agency (MCA)/Committee on Safety of Medicines (CSM) of suspected adverse drug reactions. The yellow cards for completion can be found at the back of the *BNF/NPF*. The MCA/CSM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring (identified by a ∆ symbol both on the product information for the drug and in the *BNF* and *MIMS*), and all serious suspected adverse drug reactions to all other established drugs. Serious reactions include those that are fatal, life-threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. The yellow card reporting scheme was extended to nurses, midwives and health visitors in 2002. At the same time an electronic reporting system was introduced to enable quicker and easier submission of reports. Patients are able to report adverse medicinal reactions through NHS Direct (which is gradually being replaced by NHS 111). In 2013 the Chief Nursing Officer issued a bulletin emphasising the importance of nurses reporting adverse drug reactions.[87] A Freedom of Information inquiry by *The Times* found that figures for the reporting of adverse drug reactions had dropped, with the Chair of the Royal College of GPs suggesting that family doctors found it difficult to make time to use the yellow card scheme.[88] In 2013 there were 116,348 reports of suspected adverse reactions with 2,715 from the public and 13,633 from healthcare professionals. (See also chapter 12 and the role of the National Patient Safety Agency.) Rules relating to the sale of herbal medicines and recent EU Directives are considered in chapter 30.

Product liability and drugs

The case brought against the manufacturers of Opren has shown the difficulties and expense of suing a company for harm caused by medication. Initially, a judge decided that a class action could not be brought on behalf of all those who claimed to have suffered side effects, but each person claiming compensation would have to sue individually and contribute his share to the total costs. This led to a demand for changes in the procedure in respect of such actions involving thousands of litigants. Class actions have now been initiated in respect of several drug products.

Under the present laws of negligence it is in any case difficult to show that a firm failed to take all reasonable care in testing and manufacturing its products. The victims of thalidomide did not establish negligence by the Distillers Company in this country, but agreed an ex gratia settlement, which was subsequently increased. It is possible that the Consumer Protection Act 1987 Part I, which is applicable to damage suffered after the Act came into force, will make any action for liability by someone harmed by drugs easier on the basis that, provided the patient can prove that he has suffered injury as a result of a defect in a particular drug, it is then up to the manufacturer to show that one of the many defences open to him under the Act was present. (This is further discussed in chapter 12.)

Misuse of drugs

Nurses may sometimes encounter patients in their work who are addicted to various substances. They should know the law relating to such persons and how it affects their own position. In the past, there was a requirement that doctors should send to the Home Office particulars of drug addicts. However, this requirement was revoked by the Misuse of Drugs (Supply to Addicts) Regulations 1997 in May 1997.[89] Doctors are now expected to report on a standard form cases of drug misuse to their local Drug Misuse Database (DMD). Phone numbers are set out in the *BNF*. The notification to the DMD should be made when a patient first presents with a drug problem or re-presents after a gap of six months or more. All types of problem drug misuse should be reported, including opioid, benzo-diazepine and CNS stimulant misuse. The data held on the databases is anonymised, so it cannot be used to check on multiple prescribing. Under the Misuse of Drugs (Supply to Addicts) Regulations 1997, only medical practitioners who hold a special licence issued by the Home Secretary may prescribe, administer or supply diamorphine, Diconal or cocaine in the treatment of drug addiction. Other practitioners must refer any addict who requires these drugs to a treatment centre. Guidance on notification is provided in the *BNF*. The Crime and Justice Act 2013 amends the Road Traffic Act 1985 by adding section 5A to make it an offence to drive or be in charge of a motor vehicle with concentrations of specific controlled drugs above set limits. It is a defence if the drug had been prescribed for medical or dental purposes, but the defence fails if the person had been warned not to drive.

A National Treatment Agency (NTA)[90] for substance abuse was established in 2001 as a special health authority to exercise on behalf of the Secretary of State such functions in connection with the treatment of drug misusers and such other functions as he may direct it to perform.[91] Its overall purpose was to improve the availability, capacity and effectiveness of treatment for drug misuse in England. Regulations relating to membership, termination of office and the appointment of committees and the duty to furnish reports and certain other information to the Secretary of State have been passed.[92] Further information is available from its website.[93] In 2004 the change of status of cannabis from a Class B to a Class C drug was implemented despite considerable pressure from organisations such as the British Medical Association and others alleging a link between cannabis usage and psychosis. The Advisory Council on the Misuse of Drugs had concluded that there was no evidence that cannabis caused mental illness.[94] The Home Office launched a £1 million campaign to explain to parents and young people the new law on the possession of cannabis. However, in 2008 legislation led to its reclassification as Category B.[95] The Department of Health has set up an A–Z guide on all its substance misuse guidance and publications which can be accessed via its website.

In September 2009 Jack Straw, then Minister of Justice, called for heroin to be made available on the NHS to addicts at regulated clinics on the grounds that this would reduce criminal behaviour.[96] His proposals led to considerable controversy on the grounds that this would not wean addicts off the drug, and there was no indication that the Coalition government was inclined to support this development. In July 2010 the Centre for Social Justice recommended that the National Treatment Agency should be abolished and replaced by an Addiction Recovery Board with the aim of getting addicts off drugs altogether, and that methadone should only be used as part of a wider treatment programme aiming at abstinence.[97] In August 2010 DrugScope called for illicit substances to be decriminalised[98] and this is in line with a paper from the United Nations Office of Drugs and Crime which calls for a move from a sanction-based approach to a health-oriented one.

A White Paper published in December 2010 on *Drugs Strategy* and the White Paper in November 2010 *Healthy Lives, Health People* envisaged a locally led, recovery-oriented system under which most drugs and alcohol services would be commissioned by local authorities through Directors of Public Health supported by Health and Wellbeing Boards. The NTA was abolished as part of these developments and its functions transferred to the new national service Public Health England set up in April 2013 but its website is still in use.[99] (See chapter 26.)

The aim of the drugs strategy is:

To prevent drug taking, disrupt drug supply, strengthen enforcement and promote drug treatment with the focus on enabling people to become free of their addictions, including alcohol, to recover fully and contribute to society.

In response to the drug strategy consultation Lord Patel produced a report[100] on reducing drug-related crime and rehabilitating offenders. The report focuses on drug treatment and interventions for people in prison, people moving between prisons and the continuity of care for people on release from prison.

There have been several prosecutions of persons who have used cannabis to relieve symptoms of multiple sclerosis. In June 2010 the MHRA approved the use of the mouth spray Sativex which is licensed to treat involuntary spasms and cramps associated with MS and which contains active ingredients known as cannabinoids.[101]

Two charity workers were jailed for knowingly permitting or suffering the supply of a Class A drug on the premises.[102] Concerns about breach of confidentiality are considered in chapter 8. Nurses who remove illegal drugs from patients on admission and who ensure that these drugs are immediately handed into the pharmacy department should be protected from charges of illegal possession of drugs.

NICE published a quality standard for drug use disorders in November 2012 which is available on the NICE website.[103] The NHS Choices website[104] offers advice for drug users and professionals. A free information phoneline named Frank[105] provides information about drugs and the different options available for help and support. The confidential helpline is open every day for 24 hours a day. It also runs a website.[106] In Scotland, Know the Score offers information and advice about drugs.[107] In Wales, Dan is a free and bilingual helpline[108] and Northern Ireland also has a helpline.[109]

Concern has been expressed about a sharp rise in the number of deaths from 'legal highs' with deaths from mephedrone and Spice rising from 29 to 52 in 2012.[110] In addition the number of deaths involving Tramadol rose to a record 175 more than double the number recorded in 2008. However, the overall number of deaths linked to drug misuse continue to show a long-term fall, down from 1,941 in 2008 to 1,496 in 2012, possibly in part due to a heroin drought in the UK and the provision of treatment. There have been calls for ketamine to be upgraded to a Class B drug because of an increase in the number of people going to hospital after taking it.[111] Baroness Meacher who chairs the House of Lords all-party group on drug policy called for the creation of a Class D category of legal regulated substances that could include weak cannabis and low-risk new highs.[112] She held that the war on drugs has failed. In December 2013 the Home Office announced a full review of the law regulating legal highs.[113]

The Advisory Council on the Misuse of Drugs was asked by the government in December 2013 to draw up an action plan to combat the addiction to prescription and over the counter drugs.[114] Prescription drug addiction is considered in a *Sunday Times* feature[115] warning of the dangers in particular of Tramadol. GPs have been given new guidance on how addicts can be weaned off prescription drugs such as benzodiazepines.[116] The Home Affairs Select Committee reported that GPs should collect information and draw up a list of patients who are suspected of being addicted to prescription drugs to prevent them doctor shopping to get more supplies.[117]

In March 2014 the International Narcotics Control Board of the United Nations stated that moves to liberalise drug laws around the world including decriminalising cannabis use, pose a grave danger to public health.[118] It said that the commercial use of cannabis for medical reasons in Colorado had led to an increase in car accidents and in cannabis-related hospital admissions.

The future: personalised medicine

The developments within the field of genetics have shown that in future there will be considerable benefits from creating individual medicines to match the genetic properties of an individual patient. Genomic medicine will change the way in which drugs are used: medicines will be targeted on those

patients whose genetic status shows that they will be effective. New medicines in the fight against cancer are available but it is suggested that they should only be used after DNA tests have been carried out. However, at present there is no system in the NHS for commissioning the genetic tests.[119] Companies such as 23andMe and Pathway Genomics are selling genome scans directly to consumers for between £300 and £600.[120] A pilot scheme to personalise cancer care by tailoring the therapy genetically to an individual's tumours was announced by Cancer Research UK.[121] The cost of such developments has not been calculated and, while the costs per patient may escalate, that increase may be offset by a decrease in the wastage of ineffective treatments which occur at present. The Lords Science and Technology Committee[122] concluded that the NHS is not ready for the genetic revolution in medicine. It emphasised the importance of widespread genetic testing to aid the diagnosis and prevention of disease and allow doctors to prescribe targeted drugs according to patients' individual genetic profiles. It recommended that a White Paper on genomic medicine should be prepared. A project at the Royal Brompton Hospital has begun sequencing the DNA of patients to investigate how genetic factors contribute to cardiovascular disease.[123] It has been predicted that in 10 years' time there could be DNA sequencing for everyone.[124] (See chapter 22 for further consideration of the use of genetic testing.)

Generic prescribing is being encouraged by the government to decrease the costs of medicines in the NHS but has been strongly opposed.[125] The Court of Justice of the European Union has ruled that incentives to provide cheaper medicines do not breach EU law.[126]

National Prescribing Centre

In 2011 the National Prescribing Centre[127] became part of NICE and works to integrate its products and services into the overall NICE programme. It published Patient Group Directions in December 2009 which is a practical guide and framework of competencies for all professionals using patient group directions. It has also published a single competency framework for all prescribers which has been incorporated into the medicines optimisation guideline scheduled for publication in February 2015.

Availability of medicines within the NHS

The National Institute for Health and Care Excellence has the function of gatekeeper to patient access to new medicines through the NHS and has been criticised for its slowness in approving new medicines. For example in August 2013 it rejected for use in the NHS the drug Xalkori (also known as crizotinib, and used to treat a rare form of lung cancer and costing from £37,512 for a course.) It is one of a new generation of drugs tailored to specific genetic make-ups.[128] In 2013 the Public Accounts Committee expressed concern that drug companies were not publishing the full trial results, with favourable results more likely to be published than negative ones. It urged NICE to make sure it studied all the trial results in its review of medicines.[129]

In January 2014 the HSCIC published data on the use of NICE-appraised medicines in the NHS in England.[130] While it could not conclude that lower figures of observed against expected use indicated a failure to follow NICE guidelines, with further improvements to its data collection and with the requested feedback from readers, future reports will be useful in determining the extent to which NICE has removed the post code lottery from medicines prescribing. A dispute between the government and NICE over the evaluation of new medicines arose in February 2014 when it was proposed that NICE should take wider societal benefits into account when considering whether to pay for a drug. The head of NICE Sir Andrew Dillon expressed concern that this would tilt funding away from the old because younger patients had more time to gain from treatment and more to give back.[131] On 25 January 2014 the Chairman of NICE David Haslam is reported as urging patients to be more proactive in their treatment and learn more about the drugs on offer. 'When products have been approved for use by the NHS by NICE, patients have a legal right to those drugs – as long as they are clinically appropriate.'[132]

In May 2014 NICE said that it could not recommend abiraterone, a drug for prostate cancer, prior to chemotherapy, since there was not enough evidence that the £3,000 per month drug is cost-effective. Even though NICE has ruled not to recommend a specific drug, it may be available to patients through the Cancer Drugs Fund. For example NICE has ruled out Enzalutamide, a prostate cancer drug as not being value for money, yet it is available through the Fund. The Fund, which is worth £289 million a year, ends in 2016.

In June 2014 NICE recommended that doctors should stop prescribing aspirin for a heart condition since any benefit conferred by the drug could be cancelled by the increased risk of bleeding. In contrast in the same month a dispute has broken out over NICE recommendations that statins should be prescribed to a wider group of the at risk population leading to arguments that there is no real benefit in extending their use and the side effects are being ignored.

Figures produced in January 2014 on prescribing patterns across the NHS showed that there was a 29-fold difference in the likelihood of patients getting new drugs in different areas of the country suggesting that Britain is a slow adopter of new science.[133] The DH is to announce a scheme to cut the time lag between early clinical research and widespread use to as little as five years compared with the current industry average of 10 to 15 years. The scheme also includes plans to grant promising new drugs a special 'breakthrough' status.

Media campaigns have developed behind specific medicines: Michael Parkinson, for instance, supported the lifting of restrictions on a prostate cancer drug enzalutamide. NICE had decided that it should only be available for men who have not been prescribed abiraterone and who have stopped responding to other treatments.[134]

In February 2014 NICE stated that children should be taking part in clinical trials since it is an important factor that has contributed to improved survival rates on childhood cancers. NICE published new guidance on 27 February 2014.

In Scotland an initiative has given patients and doctors a greater say in which drugs will be approved for use in the NHS. The Scottish Medical Consortium held a meeting with Patient and Clinical Engagement (PACE) to discuss which drugs would be approved. In addition, drugs companies can discuss prices if the SMC states that they are above an acceptable level.[135]

Conclusions

Following the implementation of the Crown Reports, prescribing by nurses has developed rapidly. The ability of nurses in hospitals and in primary care to issue prescriptions has a major impact on the development of their scope of professional practice. The regulatory impact assessment of the Statutory Instrument abolishing the extended formulary[136] stated that

> **enabling nurses to prescribe any licensed medicine for any condition subject to clinical competence will not be at the expense of endangering public health.**

This can only be achieved if the additional responsibilities are coupled with adequate resources and training. The significance of NICE rulings on medications and the availability of certain medications within the NHS continues to be a major concern (see chapter 5). Even where NICE has recommended a particular medicine as being effective there is evidence that these medicines are not universally available and the postcode lottery still exists.[137] A five-year agreement has been reached by drugs companies and the NHS whereby the cost of any drugs over a £12 billion annual cap will be paid back by the drug companies. They say that this should enable patients to get new drugs more quickly and believes NICE will be under pressure to approve more new medicines. The drugs bill for the NHS will be frozen for the next two years and then rise by just under 2 per cent for the next two years. The legal right to healthcare is considered in chapter 5. Developments within the field of genetics and patient-specific medications may eventually have a significant impact on this whole field. The way forward on the control

of illegal substances is uncertain, with some anxious to see the field reviewed and decriminalised, and others seeking to maintain the existing regime.

Lord Saatchi has put forward a Medical Innovation Bill which would enable doctors to prescribe treatments which had not been tested without fear of legal action (see chapter 29).

Reflection questions

1 A patient is concerned at the possibility of having suffered side effects from medication. What is the relevant law? (Refer also to the duty of care to inform the patient) (See chapter 7).

2 In your hospital, when a patient is admitted, any drugs that he brings from home are immediately taken from him and destroyed. One patient complains about this practice because it is wasteful and because he paid the prescription price for those drugs. What do you consider should be the correct practice?

3 What are the advantages and disadvantages of administering controlled drugs PRN?

Further exercises

1 Review your practice in the administration of drugs. Are there any ways in which you consider you might not be meeting the legal requirements? Consider any advice and guidance issued by the person in your trust identified as the Accountable Officer for the safe use and management of controlled drugs.

2 Design a policy for handling medicines to be learnt by a first-year student.

3 What safeguards do you consider should be laid down to protect the patient as nurse prescribing extends?

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Chapter 29

End-of-life care and death

This chapter discusses

- End-of-life care
- Definition of death
- Importance of exact time of death
- Legality of switching machines off
- Not for resuscitation
- Patients refusing treatment
- Relatives and treatment of the patient
- Living wills/advance decisions
- Certification and registration of death
- Disposal of the body
- Post-mortems
- Deaths that have to be reported to the coroner
- Inquests
- Recommendations of the Shipman Inquiry
- The Coroners and Justice Act 2009: overview
- Property of the deceased
- Wills

Introduction

Nurses inevitably encounter death in their work. It can be a distressing time and uncertainties surrounding legal issues and numerous questions from troubled relatives can add to the nurse's difficulties. It is important that the nurse should have confidence in her knowledge and be well acquainted with the procedures and the law so that she can answer questions or know from where further information is available. This chapter looks at issues arising from end-of-life care, the definition of death, the difference between killing and letting die and the provisions of the Mental Capacity Act 2005 in relation to advance decisions. Significant recommendations on the certification of and procedures following death have been made by the inquiry set up following the conviction of Dr Shipman which have led to the changes contained in the Coroners and Justice Act 2009, and these are also considered. For more detail on the topics in this chapter see the author's work.[1]

End-of-life care

Palliative care nurses may work in the community visiting patients in their own homes or in a hospice/hospital or both. Issues relating to resuscitation and DNAR (do not attempt resuscitation) instructions and the distinction between killing and letting die are considered in this chapter. In the case of Bodkin Adams, where an Eastbourne doctor was prosecuted for the death of the patient on the grounds that he had prescribed an overdose of morphine, the judge, in directing the jury on the law that applied to the case, said:

> **There has been a good deal of discussion about the circumstances in which a doctor might be justified in giving drugs which would shorten life in cases of severe pain. It is my duty to tell you that the law knows no special defence of this character. But that does not mean that a doctor aiding the sick or dying has to calculate in minutes or hours, or perhaps in days or weeks, the effect on a patient's life of the medicines which he administers.**
>
> **If the first purpose of medicine – the restoration of health – can no longer be achieved, there is still much for the doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life . . . It remains a fact, and remains a law, that no doctor has the right to cut off life deliberately . . . [the defence counsel] was saying that the treatment given by the doctor was designed to promote comfort; and if it was the right and proper treatment of the case, the fact that incidentally it shortened life does not give any grounds for convicting him of murder.**[2]

Dr Adams was found not guilty of murder.

To prescribe medication to control pain is not an offence. However, the level of prescribing must be consistent with the reasonable practice of a competent medical practitioner and any nurse who was concerned about the levels of analgesics given to a patient could check the prescription with another registered medical practitioner or ask a pharmacist for advice in the light of the previous medicinal history of the patient. There have been disputes over the use of end-of-life care pathways, particularly the one known as the Liverpool Care Pathway (LCP).[3,4] Some have argued that sedation of dying patients was being used inappropriately and the LCP encouraged a tick box approach to patient care and dehydration of the patient. Further criticism of the LCP in 2013 was made in an independent review chaired by Baroness Neuberger which found that in too many cases the LCP was so badly implemented that it became a byword for negligence.[5] It recommended that the LCP should be phased out and replaced with an individual end-of-life care plan.[6] As a consequence of the review the government decided to scrap the pathway and to move towards a more personalised end-of-life care plan in which decisions about treatment rest with senior clinicians, in consultation with relatives. Incentive payments for use of an end-of-life plan were withdrawn. Further research reported in *The Times*[7] suggested that the Liverpool Care Pathway provides little better than standard care for cancer patients in hospital. The LCP was phased out by 14 July 2014.

In its place, NHS England published five new priorities for care which was based on the work of the Leadership Alliance for the Care of Dying People.[8] The priorities are:

1 the possibility that a person may die within the coming days and hours is recognised and communicated clearly and decisions about are made in accordance with the person's needs and wishes and these are reviewed and revised regularly;
2 sensitive communication takes place between staff and the person who is dying and those important to them;
3 the dying person, and those identified as important to them, are involved in decisions about treatment and care;
4 the people important to the dying person are listened to and their needs respected;
5 care is tailored to the individual and delivered with compassion – with an individual care plan in place.

The NMC in the process of redrafting its Code of Practice has incorporated its fundamental care standards into the draft. An audit carried out by the Marie Curie Palliative Care Institute in Liverpool and the Royal College of Physicians found that 1 in 4 families are not informed when doctors decide that a patient in hospital is dying.[9] End-of-life care was the cause of more than half of the NHS complaints about acute hospital care between 2004 and 2006. A study by the National Council for Palliative Care later found that 300,000 people died each year without receiving the specialist care and pain management which they needed.[10] Further discussion on the law relating to pain management can be found in the author's book.[11] A website has been set up by a clinical nurse specialist in pain management to provide a forum for information giving and discussion on pain management.[12] Revised guidance[13] was issued in October 2007 by the BMA, the Resuscitation Council (UK)[14] and the RCN on resuscitation which envisaged that a registered nurse could be the responsible clinician making the decision over cardiopulmonary resuscitation (CPR) (see page 763). A Palliative Care Bill introduced by Baroness Finley into the House of Lords in 2007 received its third reading but failed to progress. See also the author's book on legal aspects of death.[15] In 2013 Lord Falconer tabled a Bill on assisted suicide following the report of his Commission on Assisted Dying (see page 770).

The government's 10-year End-of-Life Care Strategy (2008) aimed to shift public attitudes to death and dying, invest in local workforce training and create 'rapid response' nursing teams to provide care and support to those who wish to die in a hospice or at home. Extra funds were provided in 2008 as part of this strategy to help people who wanted to die in their own homes. However, a year later, because the funds were not ring-fenced, they could not be traced as having been spent on palliative care.[16] Furthermore, research by the charity Macmillan Cancer Support showed that shortage of nursing staff meant that patients were not able to choose to die at home.[17] A Freedom of Information inquiry by Macmillan in November 2010 found only 58 per cent of PCTs had a system in place to record people's wishes about where they wanted to die.[18] Guidelines from the National Audit Office (NAO) and from NICE advised that all patients should have access to 24-hour nursing services, but the NAO reported in 2008 that only just over half (53.2 per cent) of local health authorities provided such a service to all patients seven days a week and the situation had not improved by 2014.[19] Coalition government plans published on 18 October 2010 recommended that everyone should be given a choice over their place of death with the appropriate support, and that patients should be in control and involved as much as they want to be. There are clearly concerns that, in a time of budget deficits and public expenditure cuts, palliative care services are likely to suffer and the End-of-Life Care Strategy will not be implemented.

Macmillan Cancer Support has recommended that free social care should be granted to terminally ill patients so that they had the option to die at home. It was estimated that £1,000 per patient could be saved if he or she were to die at home, potentially saving the NHS millions,[20] with 36,000 cancer patients a year saying they would prefer to die at home. The charity accused the government of dragging its heels over the issue.

A report by the Royal College of Physicians published in May 2014 stated that deeply disturbing research found that patients were dying without making their own decisions on food, drink and pain relief, and some were not told that they were dying.[21]

NICE is to provide guidance on the care of the dying adult and end-of-life care for infants, children and young people.

A coroner criticised the interrogation under caution of a patient in intensive care following a road accident. He died two days later. The coroner who held that the patent died of natural causes said that he did not think 'conducting an interview under caution was appropriate'.[22]

A woman who lacked the mental capacity to determine where she lived was allowed to return home to spare her a daily life without meaning or happiness in the care home, despite fears that she would die. In the Court of Protection Mr Justice Jackson upheld her challenge to the Deprivation of Liberty authorisation (see chapter 17) which had been imposed upon her in 2012 and held that her desire to live at home should be respected.[23] He held that the right to life and the state's obligation to protect it are not absolute and that prioritising the longevity of life could not always be justified at the cost of happiness. The woman had threatened to take her own life if she could not return home. In another case[24] Judge Eldergill described applying the 'best interests' test as a balancing exercise in a case where an 80-year-old woman with dementia and a short-term memory of 1 minute wanted to leave the care home and return to her own home. He concluded that it was in her best interests to attempt a one-month trial of home-based care.

Lord Saatchi has put forward a Medical Innovation Bill which would enable doctors to prescribe treatments which had not been tested, without fear of legal action. The proposals have been criticised[25] by many including Healthwatch and the Action against Medical Accidents. They fear that the Bill does not adequately protect patients, in particular vulnerable patients whose conditions might lead them to seek obscure or untried treatments. The Bill, which at time of writing was still making its passage through Parliament, was defended by Daniel Greenberg, parliamentary counsel to the Medical Innovation Bill team, in a letter to *The Times*.[26]

Definition of death

There is no statutory definition of death but the courts rely on guidance issued by the professional bodies. The traditional method for the determination of whether life has ceased was to check whether breathing had stopped by checking the pulse, the heart beat and placing a mirror in front of the mouth, i.e. the cessation of circulatory and respiratory functions as evidenced by an absence of heart beat, pulse and respiration. For most cases, this was satisfactory. However, if the patient was on a ventilator where breathing was maintained artificially, this traditional definition was inappropriate. In addition, the advance in medical technology, particularly in transplant surgery, meant that it was essential to use the organs as soon as possible after respiration had ceased and, if there was likely to be a delay, to keep the body ventilated, i.e. artificially breathing, until such time as the organs required for transplant could be taken. In these cases, 'brain death' became the criterion for whether death had taken place. If the traditional definition of death was used, there was an 88 per cent incidence of postoperative renal failure in kidney transplants, whereas if the criterion of brain death was used on a patient maintained on a ventilator, the postoperative failure rate was 10–20 per cent. The same percentage occurs when kidneys from living donors are used.

What is brain death?

A conference of the Royal Colleges in 1976 set out the diagnostic tests to be used for the determination of brain death; these were circulated in 1978 and also included in the Code of Practice for the Removal of Cadaveric Organs for Transplantation, which was distributed to doctors in January 1980. The British Paediatric Association produced guidelines in 1991 on the diagnosis of brainstem death in infants and children. A definition of brainstem death was adopted by the Department of Health in 1998[27] which accepted that, while there was no statutory definition of death, 'irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe' should be regarded as the definition of death. A revised Code of Practice for the Diagnosis and Certification of Death was prepared by a working

party on behalf of the Royal College of Anaesthetists in 2006. It sought to separate the diagnosis of death from any subsequent events, allowing patients in whatever situation to be diagnosed and treated appropriately. It also gave considerably more detail than the previous guidelines, in some areas, particularly in stating the relevant biochemical values and other data.[28] Subsequently, in 2008 the Academy of the Medical Royal Colleges prepared a Code of Practice for the diagnosis and confirmation of death.[29] The criteria it gives in respect of death following irreversible cessation of brainstem function are shown in Box 29.1.

In a case in 1992 where parents wished their child to be kept on a ventilator, the judge ruled that A, who had been certified as brainstem-dead, was for all legal as well as all medical purposes dead and that a doctor who disconnected the ventilator was not acting unlawfully.[30] (See also chapter 14 for cases where severely disabled children have been allowed to die.) See section 47 of the Human Tissue Act 2004 for the law relating to the ventilation of a body for organ transplant is relevant here (see chapter 16, page 450).

Box 29.1 Diagnosis of death following irreversible cessation of brainstem function

Code of Practice of Academy of Medical Royal Colleges

6.1 Absence of brain-stem reflexes

6.1.1 The pupils are fixed and do not respond to sharp changes in the intensity of incident light.

6.1.2 There is no corneal reflex – care should be taken to avoid damage to the cornea.

6.1.3 The oculo-vestibular reflexes are absent. No eye movements are seen during or following the slow injection of at least 50 ml of ice cold water over one minute into each external auditory meatus in turn. Clear access to the tympanic membrane must be established by direct inspection and the head should be at 30° to the horizontal plane, unless this positioning is contraindicated by the presence of an unstable spinal injury.

In the case of 6.1.1, 6.1.2 and 6.1.3, testing of these reflexes may be prevented on one or other side by local injury or disease but this does not invalidate the diagnosis of death as a result of cessation of brain-stem reflexes. In the case of bilateral injury or disease, ancillary testing should be considered.

6.1.4 No motor responses within the cranial nerve distribution can be elicited by adequate stimulation of any somatic area. No motor response can be elicited within the cranial nerve or somatic distribution in response to supraorbital pressure.

6.1.5 There is no cough reflex response to bronchial stimulation by a suction catheter placed down the trachea to the carina, or gag response to stimulation of the posterior pharynx with a spatula.

The Code of Practice of the Academy of Medical Royal Colleges covers the diagnosis in many different circumstances and can be downloaded from its website.[31]

Case 29.1 *Re A* (1992)

Definition of death[32]

An infant aged 19 months was placed on a ventilator following serious head injuries sustained at home. He showed no signs of recovery. The hospital followed the guidelines laid down by the Medical Research Council in carrying out various diagnostic tests and was satisfied that he was dead. It then applied to court for a declaration that the child could be removed from the ventilator. The Family Court judge, Judge Johnson, identified the results of the tests carried out by the doctors and stated that he had 'no hesitation at all in holding that A has been dead since Tuesday of last week, 21 January'. (It was then 27 January.)

Importance of exact time of death

The actual timing of death can be a significant feature in a variety of court actions. A few examples are set out in Box 29.2.

Box 29.2 Causes of action where the time of death has considerable significance

Civil law

(A) Survivorship. The rules of inheritance depend on the order in which people die. If, therefore, there are incidents leading to multiple deaths, which victim died first can be very significant for inheritance. There are certain presumptions in law relating to the order of deaths in such circumstances, i.e. the oldest died first. However, if one of the victims is supported on a life support machine and kept 'alive' longer, the presumption would no longer operate.

(B) Insurance policies often require that where death follows an accident it must be established that the death occurred within a fixed time limit to claim under the policy.

(C) Where the machine is switched off this could lead to claims for compensation for negligence by professional staff, especially where organs are used for transplantation.

(It used to be a requirement that to constitute the offence of murder, the victim had to die within a year and a day of the act leading to the death. This time limit was removed in 1996.)

Missing persons

The Presumption of Death Act 2013 introduces into the law for England and Wales a new court-based procedure enabling those left behind to obtain a declaration from the High Court that the missing person is deemed to have died. The court will make a declaration if it is satisfied that the missing person has died or has not been known to be alive for a period of at least seven years. The person's name will be listed on a new register of presumed deaths and property will pass to those entitled as if that person had died. The Act follows comparable provisions in Scotland (Presumption of Death (Scotland) Act 1977) and Northern Ireland (Presumption of Death (Northern Ireland) Act 2009).

Criminal law

In the past, to constitute murder the victim must have died within a year and a day of the act. In 1996, this time limit requirement was removed. However, issues of causation may still arise. If the victim is taken off the machine, is that the cause of death or is the cause of death the original assault on the victim? If he is kept on a machine for longer than that, is it murder? Several defendants have tried to argue that it was not.

Case 29.2 *R* v. *Malcherek; R* v. *Steel* (1981)

Causal link[33]

Malcherek was convicted of the murder of a victim of assault who had been connected to a life support machine that had been disconnected by medical practitioners. He was sentenced to life imprisonment. In a similar case, Steel was also convicted and sentenced to life imprisonment. Malcherek appealed against this decision and Steel applied for leave to put in further medical evidence as to the sufficiency and adequacy of tests by the doctors to determine brain death. They were both effectively challenging that there was a causal link between the assaults and the deaths of the victims. The judge in each case had withdrawn the issue of causation from the jury.

The Court of Appeal held that in each case it is clear that the initial assault was the cause of the grave head injuries in the one case and of the massive abdominal haemorrhage in the other. In each case, the initial assault was the reason for the medical treatment being necessary. In each case, the medical treatment given was normal and conventional. The court looked in detail at the tests carried out by the doctors and stated:

> **It is not part of the task of this court to inquire whether the criteria, the royal colleges' confirmatory tests, are a satisfactory code of practice. It is not part of the task of this court to decide whether the doctors were, in either of these two cases, justified in omitting one or more of the so called 'confirmatory tests'. The doctors are not on trial: the applicant and the appellant were.**

The Court of Appeal concluded that all the evidence suggested that at the time of death the original wound or injury was a continuing, operating and, indeed, substantial cause of death. The fact that the victim's life support treatment had been discontinued did not break the chain of causation between the initial injury and death. The issue of causation had therefore properly been withdrawn from the jury. The convictions were confirmed. Amendment to the defences to a charge of murder made by the Coroners and Justice Act are considered in chapter 2.

Legality of switching machines off

In an article by Ian Kennedy[34] three different circumstances are described where a professional might be concerned about the legality of switching off a life support machine. These are set out in Box 29.3 and modified in the light of the Ms B case where a mentally competent adult was held to be entitled in law to ask for her ventilator to be switched off. Kennedy also makes the point that there should be no difference in law between the legality of switching on the machine and of switching it off. The law does not expect a doctor to place every dying patient on a life support machine, only where there is a hope of recovery and the facilities exist.

Box 29.3 Switching off a life support machine

(A) The unconscious dying patient

1. The machine can be switched off if the patient is brain-dead.
2. If the patient can breathe without it but weakly, then the decision to put the patient back on the machine depends on the medical prognosis. If treatment is futile then there is unlikely to be an obligation to put the patient back on again.
3. Where the patient can breathe on his own and the respirator is not needed, then the machine can be switched off. If the patient needs to have assistance again and the prognosis is hopeless, then there is unlikely to be a legal obligation to reconnect the respirator.

(B) The chronically dependent patient such as a polio victim

1. If a mentally competent patient refuses to be ventilated, it would not be a criminal offence for anyone to disconnect it. (However, it would be necessary to seek a declaration of the court.) (See the case of Ms B[35] and chapter 7.)
2. If the machine is turned off against the wishes of the patient this would, of course, be murder.

(C) Temporarily dependent emergency patient

If the ultimate prognosis is recovery and improvement, then switching off the machine would be murder. However, if the ultimate prognosis is extremely poor and hopeless, then the considerations in A1 above would apply.

Where a person has the requisite mental capacity he or she is entitled to request that the artificial ventilation be switched off or to refuse any further life-saving treatment[36] (see chapter 7). Also, where

a person has made a living will, which complies with the requirements of the Mental Capacity Act 2005 in relation to the refusal of life-sustaining treatment, then that will be binding on health professionals, as Case 29.3 shows.

Case 29.3 AK *(Adult Patient: medical treatment: consent) Re* (2001)

Letting die[37]

The health authority responsible for the treatment of AK, a patient who suffered from motor neurone disease, sought a declaration that it would be lawful to comply with AK's request to discontinue, two weeks from the date that he lost the ability to communicate, the artificial ventilation and the artificial nutrition and hydration which was being provided to him. AK was able to communicate solely by the movement of one eyelid but this movement would shortly cease. In communicating his wish by this means to have the ventilator removed, he had been aware that such action would lead to his death. The court granted the declaration. It held that a patient's refusal to consent to medical treatment had to be observed where that patient was an adult of full capacity. An advance indication of a patient's wishes should be observed by those treating him, although care should be taken to ensure that such indication continued to be the wish of the patient. It was not an unlawful termination of life to cease invasive treatment; rather it would be unlawful to treat a patient in the face of a wish not to be treated. Care should be taken to ensure that the patient was of full capacity and that his wishes had been effectively communicated, particularly where communication was difficult. AK was of full capacity and had clearly communicated his wishes. It was therefore lawful to cease treating him in the event that he lost the ability to communicate. Nothing in the Human Rights Act 1998 was against such a conclusion.

Were the facts in Case 29.3 to re-occur, the situation would now be covered by the Mental Capacity Act 2005 in relation to living wills or advance decisions (see page 771).

Persistent vegetative state

Case 29.4 *Airedale NHS Trust* v. *Bland* (1993)

Ending tube feeding[38]

Tony Bland was crushed in the Hillsborough football tragedy and for three and a half years was in a persistent vegetative state, being artificially fed but breathing unaided. He could not see, hear, taste, smell, speak or communicate in any way. The trust, in agreement with the parents, applied for the withdrawal of nasal-gastric tube feeding. The House of Lords held that medical treatment, including artificial feeding, could be withdrawn from a patient in a persistent vegetative state, if this were in the patient's best interests and it did not amount to a criminal act.

Another application to the courts in similar circumstances was made in January 1994 in respect of a patient in Bristol.[39] In 2007 an application by a hospital that it was in the best interests of a patient in a persistent vegetative state to be allowed to die was granted.[40] W had suffered profound brain damage in a cycling accident. The withdrawal of artificial hydration and nutrition involved no breach of her human rights. The decision was supported by her husband and family.

In a case where the parents objected to ending life support, because they had witnessed signs of awareness, the doctors all agreed that the patient who suffered from mitochondrial cytopathy was in a

persistent vegetative state and the court granted the declaration sought, i.e. it was in the best interests of the patient to be allowed to die.[41]

Relatives appealed against a decision that life-sustaining medical treatment (including the insertion of a new line in his groin for haemofiltration) for X could be discontinued. The son argued that, as Muslims, they believed that discontinuing the treatment would be contrary to the principles of Islam and the patient's religious beliefs and therefore was not in his best interests. The Court of Appeal held that it was for the court ultimately to determine what was in the best interests of X, the judge had been correct in concluding that the key question was if there was any chance that X could recover a quality of life to justify his continued discomfort. The medical evidence for this was to the contrary and therefore it was difficult for the religious views of X and his family to overcome the fact that continued treatment was not in X's best interests. The judge had correctly considered the position of the son and the family and the religious beliefs, and the appeal was dismissed.[42]

These situations would now be covered by the Mental Capacity Act 2005 (MCA). Under the MCA, decisions must be made in the best interests of a person who lacked the requisite mental capacity. Extremely serious decisions such as whether life support should be ended would be referred to the Court of Protection to determine if this would be in the best interests of the patient (see chapter 7). In the case of *An NHS Trust* v. *AW* who had suffered a severe intra-cerebral haemorrhage in July 2008[43] the judge made the following findings (on 23 January 2013): that AW was in a permanent vegetative state; there will be no change or improvement in her condition; there is no treatment available which could confer any benefit; and that accordingly her treatment regime is futile and the suffering caused by withdrawal of artificial nutrition and hydration will be managed by appropriate use of pain relief in accordance with the plan created for her. He then made the following declaration:

> **AW lacks capacity to litigate in these proceedings or make decisions about her medical treatment; it is lawful and in her best interests for life-sustaining treatment in the form of artificial nutrition and hydration to be withdrawn and it is AW's best interests to receive such treatment and nursing care as may be appropriate to ensure that she retains the greatest dignity until her life ends. (Judge Jackson)**

Minimally conscious state

In a case in 2011[44] the mother of a brain-damaged woman known as M applied for the withdrawal of her daughter's life-sustaining treatment. She was in a minimally conscious state (MCS). She had suffered from serious brain damage since 2003 when she was afflicted by encephalitis. Mr Justice Baker decided:

1 that it would not be in her best interests for artificial nutrition and hydration (ANH) to be withdrawn,
2 there should be a radical review of her care, and
3 the current DNR order should be continued.

Case 29.5 *An NHS Trust* v. *DJ and others* [2012][45]

Mr Justice Peter Jackson refused to grant a declaration that it is lawful and in DJ's best interests for certain specified treatments to be withheld in the event of clinical deterioration. The specified treatments included cardiopulmonary resuscitation, invasive support for circulatory problems, renal replacement therapy and IV antibiotics. DJ was a talented musician who had complications following cancer of the colon. He had multi-organ failure and was placed on a ventilator. He suffered deterioration of brain function and was considered to lack the mental capacity to make his own decisions. The judge felt that it would not be appropriate at that time to make the declarations sought, even though they have unanimous medical support and the backing of the Official Solicitor. The judge was not persuaded that the treatment would be futile or overly burdensome, or that there was no prospect of recovery.

Not for resuscitation

In intensive care units, where the patient has not made a living will, it is usually the consultant who will decide whether it is in the best interests of a patient for a ventilator to be turned on or off. However, it is sometimes the practice for doctors to mark the patient's notes 'NFR' (not for resuscitation) or 'DNAR' (do not attempt resuscitation) and the nurse is then in a quandary as to what she should do. She may feel that she is in an impossible, no-win situation: if she does not initiate resuscitation procedures following a collapse, she could possibly be criticised by relatives or even face criminal charges; if, contrariwise, she ignores the letters 'NFR' and starts resuscitation procedures, she could be criticised by the medical staff and face disciplinary proceedings. It is vital in these circumstances that the nurse is involved in the discussions over the patient's prognosis so that she can understand the likely outcome and the reasons for the doctor's decision. If she is in any doubt, she should seek expert advice and always err on the side of saving life. An example of the confusion that can arise is illustrated by a situation at the BMI Mount Alvernia private hospital in Surrey.[46] An emergency nurse stated that he was ordered to stop trying to revive a patient by a resident medical officer who could not produce a 'Do Not Resuscitate' (DNR) form. The form was only completed after the woman had died. The Consultant who had admitted the patient, and had discussed resuscitation with her stated that no forms were available. This incident followed a critical report by the Care Quality Commission into concerns over patient safety.

See also the case of *Tracey* v. *Cambridge University Hospital*.[47] Following the death of his wife after a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) notice, the husband sought judicial review of the use of the two DNACPR notices. The judge found that the clinicians involved were unanimous in believing the notices to be in the interests of the patient but that the family were in denial as to her prognosis and had not allowed the clinicians to have a relevant discussion with the patient. In January 2014 the Court of Appeal overruled a High Court decision which refused a legal review of a DNR instruction and said that it would hear the case being of some general importance.[48] In June 2014 the Court of Appeal[49] held that there was a violation of the patient's Article 8 right to respect for private life and also her rights at common law, in failing to involve her in the process which led to the first notice. The doctor should not have signed a DNACPR notice without consulting her unless he thought that she would be distressed by being consulted and that that might have caused her harm. The Court of Appeal quoted the guidance given by the court in the case of *R (Burke)* v. *General Medical Council* (see pages 771–2).[50]

In May 2014 the Equality and Human Rights Commission called for clear national and local guidance on the Do Not Resuscitate Notices.[51]

Unfortunately, the nurse is sometimes informed orally of the doctor's wishes, which are not written down, and this places the nurse in an even more vulnerable situation. A joint statement from the British Medical Association, Resuscitation Council (UK) and the Royal College of Nursing[52] provided revised guidance on decisions relating to cardiopulmonary resuscitation in 1999 (updated in 2001 and 2007). It was followed in 2009 with guidance on recording the DNAR decisions.[53] This guidance was commended to NHS trusts in September 2000 by the NHS Executive[54] in an NHS circular. By this circular, chief executives of NHS trusts are required to ensure that appropriate resuscitation policies that respect patients' rights are in place, are understood by all relevant staff and are accessible to those who need them, and that such policies are subject to appropriate audit and monitoring arrangements. In the revised guidance, published in 2007, it states that the responsibility for the decision making on CPR rests with the most senior clinician in charge of the patient's care as defined by local policies. This could be a consultant, GP or suitably experienced nurse.[55] This has led to some debate over the appropriate responsibility of a nurse practitioner, but it is a natural development of the scope of professional practice of a nurse (see chapter 24).

The action required to be taken by NHS trusts was set out in the circular and included ensuring that there was a clear policy on resuscitation which was made available to staff and patients, and that there

was regular audit of the implementation of the policy under the responsibility of a non-executive director of the Trust. The Commission for Health Improvement (CHI) (now the Care Quality Commission) was asked by the Secretary of State to pay particular attention to resuscitation decision-making processes as part of its rolling programme of reviews of clinical governance arrangements put in place by NHS organisations. Guidance emphasises that there must be no blanket policies, each individual patient must be assessed personally and policy cannot depend solely on the age of the patient. The NHS circular was the result of growing concern that there was anecdotal evidence that old people were being deprived of intravenous foods and fluid drips. The police were investigating deaths of 60 elderly persons in such circumstances.[56] In 2009 the CQC issued guidance for ambulance paramedics on the management of patients with cardiac arrest.

A decision that a patient should not be resuscitated should only take place where:

1 The mentally competent patient has refused resuscitative treatment.
2 A valid living will (advance decision) covering such circumstances has been made by the patient and complies with the requirements set out in the Mental Capacity Act (MCA).
3 Effective CPR is unlikely to be successful.
4 Where successful CPR is likely to be followed by a length and quality of life that would not be in the best interests of the patient to sustain.

Under section 4(5) of the Mental Capacity Act 2005 in decisions about life-sustaining treatment when determining what are in the best interests of a person lacking the requisite mental capacity to make his or her own decisions, the person making the decision must not be motivated by a desire to bring about his or her death.

Patients cannot insist that treatment is provided to them, when it is contrary to the professional discretion of those caring for him or her. This is the outcome of the Burke case (see pages 771–2).

Patients refusing treatment

Since the Suicide Act 1961, suicide has not been a crime, as set out in Statute Box 29.1.

Statute 29.1 Sections 1 and 2(1) of the Suicide Act 1961 as amended by the Coroners and Justice Act 2009

Section 1 The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.

Section 2(1) A person ('D') commits an offence if –

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide.

2(1)(A) The person referred to in subsection (1)(a) need not be a specific person (or class of persons) known to, or identified by, D.

2(1)(B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.

2(1)(C) An offence under this section is triable on indictment and a person convicted of such an offence is liable to imprisonment for a term not exceeding 14 years.

2(2) If on the trial of an indictment for murder or manslaughter of a person it is proved that the deceased person committed suicide, and the accused committed an offence under subsection (1) in relation to that suicide, the jury may find the accused guilty of the offence under subsection (1).

2A Acts capable of encouraging or assisting

(1) If D arranges for a person ('D2') to do an act that is capable of encouraging or assisting the suicide or attempted suicide of another person and D2 does that act, D is also to be treated for the purposes of this Act as having done it.

(2) Where the facts are such that an act is not capable of encouraging or assisting suicide or attempted suicide, for the purposes of this Act it is to be treated as so capable if the act would have been so capable had the facts been as D believed them to be at the time of the act or had subsequent events happened in the manner D believed they would happen (or both).

(3) A reference in this Act to a person ('P') doing an act that is capable of encouraging the suicide or attempted suicide of another person includes a reference to P doing so by threatening another person or otherwise putting pressure on another person to commit or attempt suicide.

2B Course of conduct

A reference in this Act to an act includes a reference to a course of conduct, and a reference to doing an act is to be read accordingly.

The effect of section 1 repealing the offence of committing suicide coupled with the right of a person to consent to treatment, means that it is possible for a seriously ill person to refuse consent to, say, antibiotics and staff have to accept that refusal. Only where there is a doubt over the person's mental competence to refuse treatment could the medication be given under the provisions of the Mental Capacity Act 2005 (see chapter 7). While it is no longer a crime for a person to decide on and bring about their own death, it is still, however, a crime for anyone to aid and abet in the suicide of another, as shown in section 2.

The effect of the changes made by the Coroners and Justice Act 2009 is to create a wider ambit for the offence of assisting a suicide so that persons giving advice to others over the internet could now be committing an offence under the Act.

Although the Debbie Purdy case (see Case 29.7) was being heard at the same time as the Coroners and Justice Bill was being debated in Parliament, Parliament did not clarify the law on whether escorting persons to a clinic in Switzerland to meet their deaths were guilty of a criminal offence under the Suicide Act 1961 and it was left to the Director of Public Prosecutions at the request of the House of Lords to clarify when a prosecution would be brought. Two people were found dead in a fume-filled car in September 2010, having met on the internet and agreed to commit suicide ('catch the bus' (ctb)). It was reported that the police were looking on websites for those who had encouraged the pair to commit suicide.[57]

The position is clear for professional staff. Even though they sympathise with a patient's wish to die, they are prohibited by the criminal law in taking any steps or giving any advice to the patient to help him carry out this wish. Where a patient is clearly refusing medication because of this desire, it is essential for staff to record detailed accounts of the patient's attitude, his level of competence, the advice given to him and, preferably, where the patient takes his own discharge contrary to professional advice, to obtain the patient's signature to that effect. In a case in 2004 the judge held that a woman, who had a degenerative brain condition, could not be prevented from travelling to Switzerland for her life to be ended, since she had the mental capacity to make that decision.[58] Clearly, however, anyone assisting such travel in this country is in danger of committing an offence under section 2(1) of the Suicide Act 1961 (see Statute Box 29.1). In 2013 it was estimated that 29 Britons travelled to the Swiss Dignitas Clinic to end their lives. In a news item on 19 August 2013 it was stated that police had arrested a mother and her son after police suspected that they were planning to take the woman's 71-year-old husband to the Dignitas Clinic to commit suicide. Police confirmed that the mental capacity of the man was being assessed.

Euthanasia is not recognised by law in this country. The courts recognised that in law there is a distinction between letting die and killing a person (see Case 29.4), even though this is not accepted by some philosophers. Decisions sometimes have to be made in special care baby units and in intensive care or renal dialysis units, or over transplants, on who may be treated. This effectively means that those not selected for treatment may eventually die. This is, however, a very different matter from taking an action that will bring about or assist in bringing about another person's death.

The House of Lords Select Committee on Medical Ethics in 1994[59] did not support any proposals to change the law that makes euthanasia illegal and several attempts to pass an Assisted Suicide law since then have failed. Supporters of euthanasia point to the situation in the Netherlands and Switzerland where assisted suicide is lawful. Lord Joffe has stated that, despite the failures of his attempts to change the law, he has not given up (see Assisted Dying Bill, page 770).

Relatives and treatment of the patient

Practical Dilemma 29.1 The relatives say 'no'

Katy Brown was 85 and just recovering from a particularly serious hiatus hernia operation. She was very weak and there was considerable likelihood that she would not survive. The relatives discussed her case with the doctors and asked that, in the possible event of a collapse, she should not be resuscitated since they did not want her to continue as an invalid and felt sure that this is what Katy would have wished. What is the doctor's position?

Where the patient is mentally incapacitated, the only criterion that can determine whether or not treatment should proceed is the best interests of the patient, unless the patient has created an advance decision or living will (see pages 771–2). There is a legal requirement under the Mental Capacity Act 2005 that in determining what are the best interests of the patient, the views of relatives and others should be obtained on what would have been the wishes of the patient. Nor can those making the decision about life-sustaining treatment be motivated by a desire to bring about the death in deciding what are the best interests (s. 4(5) of 2005 Act). In Practical Dilemma 29.1 it is not the wishes of Katy's relatives which should prevail, but the best interests of Katy and in determining these, consideration must be given to any wishes which she had expressed or statement she had made. Clearly, had Katy drawn up an advance decision which complied with the requirements of the Mental Capacity Act 2005 and was applicable to the situation, then that would prevail.

Practical Dilemma 29.2 To let go

Harry Judd, aged 84, had told his daughter that if he became ill and suffered a cardiac arrest he did not want to be resuscitated. His wife had died two years before and he had become increasingly depressed and frail, with failing eyesight caused by his diabetes. He was still managing to cope on his own with a home help, but it was becoming more and more of a struggle. One day, the home help found him in a coma and he was rushed into hospital. He remained seriously ill for several days and then slowly improved. His consultant physician, Dr Jones, discussed Harry's prognosis with his daughter and son-in-law. It appeared unlikely that he would be able to manage on his own. The daughter reported Harry's views about not being resuscitated. The next evening, Harry suffered a cardiac arrest. The staff nurse summoned Dr Jones, who was unwilling to use resuscitative machinery. Is he obliged to do so?

From the above discussion, it will be evident that it is essential to clarify two issues: first, the mental capacity of Harry when he stated that he would not want to be resuscitated; and, second, the medical prognosis of Harry. In addition, since 1 October 2007 the provisions of the Mental Capacity Act 2005 in relation to advance decisions must be complied with. If Harry were mentally competent when he asked not to be resuscitated, his views should be respected. If, however, his wishes were the result of extreme depression caused by his bereavement and illness, then it may be concluded that he was not mentally capable when he made that request. He must then be treated according to his best interests. If it were absolutely clear that Harry's prognosis is hopeless, then there is no legal duty to resuscitate. If, however, there is any chance that Harry could recover and would have a reasonable prognosis, then Dr Jones's duty would require him to resuscitate him. If Harry is considered to lack the requisite mental capacity, the situation is covered by the Mental Capacity Act 2005. The BMA have issued guidelines on withdrawing treatment.[60] The GMC revised its guidelines in 2010.[61]

In 2013 the widow of a man who had died in December 2012 appealed against a decision of the Court of Appeal that it was in his best interests to have life-sustaining treatment withheld. The Supreme Court dismissed her appeal. It ruled that the focus should be on whether it was in the patient's best interests to give the treatment, rather than on whether it was in his best interests to withhold or withdraw it. In determining his best interests, decision makers had to look at his welfare in the widest sense, not just medical, but social and psychological. The guidance in the Mental Capacity Code of Practice and that given by the General Medical Council in its booklet 'Treatment and care towards the end of life: good practice in decision making' was applicable.[62]

Case 29.6 Diane Pretty[63]

Helping to die

Diane Pretty, a sufferer of motor neurone disease, appealed to the House of Lords that her husband should be allowed to end her life, and not be prosecuted under the Suicide Act 1961. The House of Lords did not allow her appeal. It held that if there were to be any changes to the Suicide Act to legalise the killing of another person, then these changes should be made by Parliament. As the law stood, the Suicide Act made it a criminal offence to aid and abet the suicide of another person and the husband could not be granted immunity from prosecution were he to assist his wife to die. The House of Lords held that there was no conflict between the human rights of Mrs Pretty as set out in the European Convention on Human Rights.

Mrs Pretty then applied to the European Court of Human Rights in Strasbourg, but lost. The court held that there was no conflict between the Suicide Act 1961 and the European Convention on Human Rights. The Council of Europe issued a press release entitled 'Chamber judgment in the case of *Pretty* v. *the United Kingdom*', published on 29 April 2002.[64]

Case 29.7 Debbie Purdy[65]

An MS sufferer, Debbie Purdy brought an action on the law on assisted suicide. She wished her husband to take her to a Belgian clinic or Switzerland to commit suicide if her condition became unbearably painful and wanted to ensure that he would not be prosecuted for aiding and abetting her suicide. The High Court dismissed her application for further guidance from the Director of Public Prosecutions as to when a prosecution for assisted suicide would be brought. She was given leave to appeal but the Court of Appeal dismissed her appeal.[66] It held that she was not entitled to have the

specific guidance she was seeking, but that there were broad circumstances in which aiding and abetting suicide would not be prosecuted. She appealed to the House of Lords which heard the case on 3 June 2009 and gave its judgment on 30 July 2009.[67] The House of Lords unanimously held that the DPP should be required to promulgate a policy identifying the facts and circumstances he would take into account in considering whether to prosecute persons such as the claimant's husband for aiding and abetting an assisted suicide abroad. The lack of clarity on whether there would be a prosecution of relatives who took someone abroad to die was an infringement of Article 8 rights.

Director of Public Prosecutions guidance

As a consequence of the direction by the House of Lords, the DPP (after interim guidance and a consultation) issued final guidance in February 2010[68] clarifying the factors which should be taken into account in deciding whether or not there should be a prosecution under the Suicide Act 1961 as amended. The public interest factors for and against prosecutions are shown below.

Director of Public Prosecution policy on assisted suicide prosecutions

The public interest factors against prosecution

1 The victim had reached a voluntary, clear, settled and informed decision to commit suicide.
2 The suspect was wholly motivated by compassion.
3 The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.
4 The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.
5 The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.
6 The suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

The public interest factors which make prosecution more likely

In contrast, the public interest factors which mean a prosecution is more likely to be required are:

1 The victim was under 18 years of age.
2 The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.
3 The victim had not reached a voluntary, clear, settled and informed decision to commit suicide.
4 The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.
5 The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative.
6 The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim.
7 The suspect pressured the victim to commit suicide.
8 The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.
9 The suspect had a history of violence or abuse against the victim.

10 The victim was physically able to undertake the act that constituted the assistance to him or herself.
11 The suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication.
12 The suspect gave encouragement or assistance to more than one victim who were not known to each other.
13 The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance.
14 The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care.
15 The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.
16 The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

The guidance from the DPP does not change the law; assisted suicide or voluntary euthanasia is a criminal offence. In January 2010 Kay Gilderdale was found not guilty of the attempted murder of her daughter who suffered from myalgic encephalomyelitis (ME), but received a 12-month conditional discharge after admitting assisting an attempted suicide. She had given her daughter two syringes of morphine and then injected her with three syringes of air. In contrast, Frances Inglis was found guilty of the murder of her brain-damaged son when she injected him with a lethal dose of heroin.[69] In his summing up the judge said that there was in law no concept of mercy killing and it was still a killing 'no matter how kind the intention'. The mother's appeal to the Court of Appeal failed. It held that the law did not distinguish between murder committed for malevolent reasons and murder motivated by familial love. However, the factors relating to mercy killing could be taken into account in sentencing and the court reduced the minimum term from 9 to 5 years.[70] A man who watched his partner of 15 years (who was wheelchair bound after contracting Lyme's disease) die after taking tranquilisers purchased on the internet and who was arrested on suspicion of assisting a suicide and released on bail, killed himself by the same method[71]. In an inquest on the death of an elderly couple in a suicide pact, the coroner in a narrative verdict held that the daughter, who had a lethal drug from the internet and helped prepare it for her parents, 'was motivated by compassion and a genuine desire to carry out her parents' wishes'. The Crown Prosecution Service decided that it was not in the public interest to charge the daughter. (The father had become bed-ridden and the wife found out that she had dementia and they decided to end their lives.[72])

A 50-year-old man who pleaded guilty to the attempted murder of his terminally ill mother was sentenced to 2 years' imprisonment suspended for 18 months.[73] He had attempted suicide after her death and told a psychiatrist that he was consumed with guilt after killing his mother by suffocating her. The CPS said that it could not prove he had killed her, but his confession was the basis for a charge of attempted murder.

Three tragic cases

Tony Nicklinson (who suffered from locked-in syndrome following a stroke) sought declarations from the High Court[74] that

(a) It would not be unlawful on the grounds of necessity for a doctor to terminate his life,
(b) The current law of murder and assisted suicide was incompatible with Article 8 of the Human Rights Convention, and
(c) Existing domestic law and practice failed adequately to regulate the practice of active euthanasia in breach of Article 2.

He succeeded in being allowed to proceed in seeking the first declaration, but failed on the other two.

Subsequently, Tony Nicklinson and Martin (who also suffered from locked-in syndrome following a brain-stem stroke) sought judicial review from the High Court[75] which ruled in favour of Martin, but not of Nicklinson, holding that it could not give the doctors immunity from prosecution were they to assist him to die. It was for Parliament to change the law. Nicklinson died by starving himself after he heard that he had lost the case, but his widow vowed to continue the legal battle and appealed the decision. Martin sought a declaration that if doctors helped him to die, they would not be prosecuted. His wife was not prepared to take him to the Dignitas Clinic in Switzerland, and he would therefore need the help of non-family members who would probably not be covered by the DPP guidelines. The High Court was not prepared to require the DPP to clarify further its guidelines, considered that only Parliament could change the law and refused the application for judicial review.

Paul Lamb who was paralysed after a car accident 24 years earlier also brought a case to seek the right of a doctor to end his life at the time of his choosing. The accident left him with only the slightest flicker of movement in the claw of his right hand, which was fading.[76]

Following Tony Nicklinson's death, his widow, Martin and Paul Lamb appealed to the Court of Appeal.[77] The Court of Appeal dismissed the appeals of Nicklinson and Lamb but allowed the appeal of Martin holding that the DPP failed to provide sufficient clarity as to its prosecution policy with respect to those persons who fall into what the court described as the class 2 category (i.e. those seeking help from persons with no close or emotional connection with the victim).

The Supreme Court in a majority judgment ruled that it was not yet prepared to grant a declaration that section 2 of the Suicide Act 1961 (as amended) was incompatible with Article 8 of the European Convention on Human Rights and therefore the appeals must fail. It urged Parliament to consider whether section 2 should be amended.[78] Two judges dissented: Lady Hale and Lord Kerr, while agreeing that Parliament was the appropriate forum in which the issue should be decided, were prepared to issue a declaration of incompatibility that the current law against assisted suicide was contrary to Article 8. The judgment was published a week before second reading of the Assisted Dying Bill in Parliament.

Assisted Dying Bill

In 2012 Lord Falconer chaired a Commission on Assisted Dying which reported in January 2013 and concluded that the current laws were inadequate, incoherent and should not continue. He then tabled an Assisted Dying Bill which if enacted would legalise assisted suicide for the terminally ill, i.e. those who have less than six months to live. The text can be found on the UK Parliament website.[79]

Assisted suicide would only be allowed in strictly defined circumstances: only those over 18 years and who were terminally ill would be allowed to request help to end their lives. The individual would have to show that they had a clear and settled intention to end their own life and sign a declaration which must be countersigned by two doctors to the effect that the person is terminally ill, has the capacity to make the decision to end his/her own life and has a clear and settled intention to end their own life which has been reached voluntarily on an informed basis and without coercion or duress. The Bill includes a conscientious objection clause. Provisions are included for the issuing of a Code of Practice by the Secretary of State and for monitoring by the Chief Medical Officers of England and Wales.

In March 2014 the government declared that MPs would be given a free vote on the Assisted Suicide Bill. The first reading had taken place on 15 May 2013. The second reading took place on 18 July 2014 when many opponents chose not to oppose it, accepting that it should be fully considered at committee stage, which was ongoing at time of writing.

It should be noted that the Bill only covers terminally ill patients. Yet 16 per cent of those helped by right to die organisations such as Dignitas did not have an underlying illness.[80]

Living wills/advance decisions

In this country, the legality of a 'living will' (also known as an advance statement or an advance refusal or decision) was recognised at common law (i.e. judge-made law) and is now provided for in the Mental Capacity Act 2005. An 'advance decision' means a decision made by a person (P), who is over 18 years and has the capacity to make the decision, that if at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing healthcare for him, and at that time he lacks the capacity to consent to the carrying out or continuation of the treatment, then the specified treatment is not to be carried out or continued.[81] The advance decision can be written in layman's language and no formalities are required unless it is intended to cover a situation where life-sustaining treatment is necessary. Where the advance decision is intended to apply to life-sustaining treatment, then P, the maker, of the advance decision must make it clear that the advance decision is intended to apply to life-sustaining treatment and also:

(a) it is in writing;
(b) it is signed by P or by another person in P's presence and by P's direction;
(c) the signature is made or acknowledged by P in the presence of a witness; and
(d) the witness signs it, or acknowledges his signature, in P's presence.

As long as the maker of the decision has the requisite mental capacity to make decisions, the advance decision remains inapplicable. Only where the maker lacks the mental capacity to make decisions will the advance decision become relevant. The effect of a valid advance decision which applies to the treatment in question is that any person who carried out the treatment contrary to the advance decision could be guilty of an offence or civil wrong. An advance decision can be withdrawn or altered without any formality unless it relates to life-sustaining treatment, when the statutory provisions set out above must be followed. The minimum age for being able to create an advance decision is 18 years because a young person under 18 years cannot refuse life-sustaining treatment if such treatment is in his or her best interests. If there are doubts as to the validity or relevance of an advance decision, then an application can be made to the Court of Protection to determine such questions. In the meantime, any necessary action can be taken to keep the person alive.

The validity of advance directives drawn up by a person suffering from anorexia was considered in a case in 2012 set out in Case 29.8.

Case 29.8 *Re E* (2012)[82]

The local authority brought a case seeking authority to feed, if necessary by force, a 34-year-old woman suffering from extremely severe anorexia and other chronic health conditions including alcohol dependence. The woman had made advance decisions refusing treatment.

The judge held that E lacked the capacity to make the advance decisions and to refuse treatment. He did not consider future treatment to be futile and the presumption in favour of life should not be displaced. He made a declaration that E lacked capacity and that it would be lawful and in E's best interests for her to be fed, forcibly if necessary.

Requirement of treatment: the Burke case

It is not possible by means of a living will or advance decision to compel health service professionals to provide treatment at a later time when the patient lacks the mental capacity to make his or her own decisions. A living will can therefore only legally be a refusal of treatment. This is the ruling in the

case brought by Mr Burke, who challenged the guidance provided by the GMC on withholding or withdrawing treatment in respect of a mentally incapacitated adult and claimed the right to insist that specific treatments were provided for him, even though it was contrary to the professional discretion of the medical staff.[83] The Court of Appeal upheld the GMC's appeal against the High Court decision. The result is that a person has no legal right to insist on specific treatment being given at a later time, when he lacks the requisite mental capacity. Although a person can refuse specific treatments, a person cannot insist on specific treatments being given (this does not of course apply to direct oral nutrition and hydration).

The Mental Capacity Act 2005 also provides for the creation of a lasting power of attorney (LPA) by which the donor can give powers for decisions to be made on his or her behalf covering either personal welfare or finance/property. An LPA creating powers of decision making in personal welfare matters can only be exercised by the donee when the donor lacks the requisite mental capacity (see chapter 19).

Certification and registration of death

Certification of death is a medical task. In contrast, verification of death can be carried out by those who have had the necessary training.

Here we consider the nurse's role and the procedures to be followed generally.

Practical Dilemma 29.3 An expanded role?

Night porters at Roger Park Hospital had clear instructions that no body should be taken to the mortuary unless it had been certified dead. This resulted from an unfortunate incident some time before when a body was taken to the mortuary, but was seen to move and therefore quickly returned to the ward. An investigation revealed that the person had been certified dead by a nurse. The nurses were told always to call a doctor to certify death. However, junior doctors were not happy about being called out just to certify death and considerable pressure was put on the nursing staff. One night, it was clear that one patient was extremely ill. There were no immediate relatives, but a distant relative was notified of the situation. The patient died at 3 a.m. The nurse summoned the doctor, who said that he would not come down, but would see the patient in the mortuary and sign the certificate there in the morning. The nurse was asked by the bed bureau if she had a spare bed, as a GP had just phoned and was sending in an emergency case. The hospital had no spare beds at all, except the one occupied by the dead person. Could the nurse herself identify that death had occurred and arrange for the porters to remove the body?

The law at present requires a doctor to certify a death. Section 20 of the Coroners and Justice Act 2009 enables the Secretary of State to make regulations relating to the medical certification of death (see page 780). The certification cannot be undertaken by nurses. However, a nurse may have had the training to be able to confirm that a patient has died, i.e. to verify a death. In certain parts of the country, the local medical committees have advised nursing homes and residential care homes that the nurse or manager in charge of the home should, where death is expected, confirm that death has taken place and the doctor would sign the certificate at a later time. If the nurse considers that she is unable to confirm that death has taken place, she should not give way to any pressure, however reasonable it might appear. Should the nurse feel unable, she may be able to obtain help from another nurse who is competent or from a doctor who is prepared to come to the ward and verify that the patient is dead.

Case 29.9 Fatal diagnosis[84]

The son of Mrs Maureen Jones summoned a GP when he found his mother collapsed in her bedroom. The GP said that she had died and advised the relatives to notify the police. The undertakers were summoned. A policeman called to the scene saw the woman's leg move and applied mouth-to-mouth resuscitation until the paramedics arrived. She then made a full recovery in hospital. She had been in a diabetic coma. A county court judge found the doctor negligent in making a diagnosis of death. Damages were agreed with the Medical Defence Union at £38,500. Following an investigation, the health authority agreed that the doctor could continue in practice, but was given an official reprimand, told to comply more closely with her terms of service and was required to undergo educational assessment and support.

Verification of death is seen as an expanded role activity and the RCN has provided a paper on verification of death by registered nurses.[85] The NMC, in its guidance on confirmation of death,[86] stated that:

> **A nurse cannot legally certify death. This is one of the few activities required by law to be carried out by a registered medical practitioner; in the event of death, a registered nurse may confirm or verify when death has occurred, providing there is an explicit local policy or protocol in place to allow such an action, which includes guidance on when other authorities, e.g. the police or the coroner, should be informed prior to removal of the body.**
>
> **Nurses undertaking this responsibility must only do so providing they have received appropriate education and training and have been assessed as competent in accordance with the code which states:**
>
> **You must have the knowledge and skills for safe and effective practice when working without direct supervision**
>
> **You must recognise and work within the limits of your competence**
>
> **You must keep your knowledge and skills up to date throughout your working life**
>
> **You must take part in appropriate learning and practice activities that maintain and develop your competence and performance**
>
> **In addition you must be aware of their accountability, when performing this role.**

(Issues relating to the scope of professional practice and the expanded role of the nurse are considered in chapter 24.)

The general office of the hospital or the medical records department discusses with bereaved relatives the administrative details that must be dealt with. Sometimes there is a special office for dealing with the bereaved and during weekdays the relatives can be shown to this place. However, at night and during the weekends and bank holidays the nurse may have to deal with the administrative details. She should know the details relating to the registration of death and the disposal of the body. Box 29.4 sets out the procedure to be followed.

Box 29.4 Procedures for dealing with death

The medical certificate should be taken by the next of kin or, if not available, by any relatives living in the district or present at the death to the Registrar for births, marriages and deaths within five days of the death. He will require the following information: the full name of the deceased; the last known address; date of birth; occupation; and whether the deceased was in receipt of a pension. The Registrar will give the person registering the death a certificate of disposal form which can be handed to the undertaker. If the death has

been referred to the coroner, the relatives should be notified that they will not receive the certificate from the hospital. The coroner will issue his own disposal certificate.

The relatives will receive from the Registrar, in addition to the certificate of disposal form, a certificate of registration of death. This may be required by the Benefits Agency to claim any entitlements. (The death grant is no longer payable but other benefits are available to those who are eligible.) This certificate may also be required to obtain transfer of any bank accounts, etc. and further copies are available from the Registrar on payment of a fee. New rules relating to cremation came into force in January 2009.[87] There are new statutory forms for cremation and for stillbirths and a confirmatory medical certificate is not required where the patient died in hospital as an inpatient.

Changes to certification and registration of death under Coroners and Justice Act 2009

Under Chapter 2 of the Act, amendments are made to the law relating to the certification and registration of death. Regulations may be made for the registered medical practitioner who attended the deceased before his or her death (an 'attending practitioner') –

(i) to prepare a certificate stating the cause of death to the best of the practitioner's knowledge and belief (an 'attending practitioner's certificate'), or

(ii) where the practitioner is unable to establish the cause of death, to refer the case to a senior coroner.

Each Clinical Commissioning Group in England (in Wales the successors to the Local Health Boards) must appoint a medical examiner (a registered medical practitioner of at least five years' experience) who has the responsibility of receiving the death certificate from the attending doctor and is able to make whatever enquiries appear to be necessary to confirm or establish the cause of death. A medical examiner to whom a copy of an attending practitioner's certificate has been given can:

(i) confirm the cause of death stated on the certificate and notify a Registrar that the cause of death has been confirmed, or

(ii) where the examiner is unable to confirm the cause of death, refer the case to a senior coroner.

Once the cause of death has been confirmed, an attending practitioner's certificate can be given to a Registrar.

Where the senior coroner has referred a death to the medical examiner, he can issue a certificate stating the cause of death to the best of the examiner's knowledge and belief (a 'medical examiner's certificate') and notify a Registrar that the certificate has been issued, or where the examiner is unable to establish the cause of the death, to refer the case back to the coroner.

A medical examiner, if invited to do so by the Registrar, can issue a fresh medical examiner's certificate superseding the existing one.

In 2010 (updated in 2014) the Ministry of Justice published a Guide to Coroners which can be downloaded from the gov.uk website.[88]

New Coroners' Investigations Regulations in 2013[89] cover:

1 coroner availability, register of reported deaths, informing the deceased's next of kin or personal representative, delegation of admin functions, providing information to the registrar of births and deaths, interim certificate of fact of death, resumption of investigation
2 post-mortem examinations
3 transfer of investigations
4 powers in relation to bodies
5 disclosure and provision of information
6 action to prevent other deaths.

They can be downloaded from the legislation website.

Disposal of the body

Different arrangements exist according to the local hospital facilities. Some hospital mortuaries also double up as the public mortuary and it is possible for the body to remain there until collected by the undertakers for the funeral. Before the body is taken from the ward, the nurse must ensure that it is properly labelled and that a receipt is signed and that any property on the body, e.g. rings, are carefully noted and signed for. Similar procedures to check identification and property on the body and the giving of receipts must also be followed when the body is handed over by the porters, administrators or even nurses to the undertakers. Unfortunately, mix-up between bodies still occurs and the wrong body is released. A husband was given special planning permission by Gelding Council to bury his late wife in their front garden.[90] For further information on the disposal of the body see the author's work.[91]

Post-mortems

The coroner might require a post mortem to ascertain the cause of death and can direct a legally qualified medical practitioner to carry out the post mortem. A post-mortem ordered by a coroner may or may not precede an inquest. If the coroner orders a post-mortem, then the person in possession of the body has no choice but to agree. Sometimes, however, medical staff may request the relative's permission to confirm the cause of death or for research purposes. They require the consent of the person in possession of the body (Human Tissue Act 2004). This can be a distressing request to make to relatives and the request should be put to them with sensitivity. Organs should not be retained by hospital doctors without the relatives' consent. (The issue of retention of organs and the provisions of the Human Tissue Act 2004 are considered in chapter 16.) Part 3 of the regulations published in 2013[92] cover the following topics: delay in post-mortem examinations to be avoided; post-mortem examination where homicide is suspected; notification of post-mortem examination; preservation or retention of material from a post-mortem examination; post-mortem examination report and discontinuance of investigation where cause of death is revealed by post-mortem examination.

Deaths that have to be reported to the coroner

These are shown in Box 29.5.

Box 29.5 Deaths that have to be reported to the coroner

1 Where there is reasonable cause to suspect a person has died a violent or unnatural death.
2 Where the cause of death is unknown.
3 Where the person has died in custody or otherwise in state detention.

Those causes of death which should be reported to the coroner include: abortions; accidents and injuries; alcoholism; anaesthetics and operations; crime or suspected crime; drugs; ill-treatment; industrial diseases; infant deaths if in any way obscure; pensioners where death might be connected with a pensionable disability; persons in legal custody; poisoning; septicaemias if originating from an injury; stillbirths where there may have been a possibility or suspicion that the child may have been born alive; and where the person who died was not visited by a doctor during their final illness or the doctor who signed the medical certificate had not seen the person who died within 14 days of the death.

If it is likely to be a coroner's case, no unofficial post-mortem should be undertaken without the coroner's approval. The coroner can order a post-mortem examination to be carried out before deciding to hold an inquest.

Inquests

The Coroners and Justice Act 2009 which repeals the Coroners Act 1988 covers the appointment of coroners, the holding of inquests, and post-mortem examination. A decision by the coroner not to hold an inquest can be the subject of an application to the High Court. For example, in one case where a mother had suffered from a cerebral haemorrhage soon after giving birth in circumstances that suggested that had her blood pressure been properly monitored immediately after the birth her death might have been avoided, the coroner concluded that she had suffered a natural death. The High Court decided that he had erred in deciding not to hold an inquest. The coroner appealed to the Court of Appeal, which dismissed the appeal. The Court of Appeal held that for the purposes of the Coroners Act 1988 section 8(1)(a) a death by natural causes was an 'unnatural death' where it was wholly unexpected and would not have occurred but for some culpable human failing.[93] A breach of Article 2 rights was claimed when a coroner refused to resume an adjourned hearing (adjourned pending criminal proceedings) into the death of a man who was stabbed and killed in May 2000 even though the death had occurred before the Human Rights Act 1998 came into force in October 2000. The victim's mother claimed that there were failures by the police and local housing authority in failing to avert the death. The Court of Appeal held that the inquest should be resumed and the Commissioner of Police appealed against this decision. The House of Lords found that the coroner's decision was lawful and allowed the appeal.[94]

The House of Lords laid down the implications of Article 2 on the state's obligations to protect life. It stated that Article 2 of the Convention imposed on the state a substantive obligation to establish a framework of laws, precautions, procedures and means of enforcement which would, to the greatest extent reasonably practicable protect life.[95] This ruling was followed in a case where the claimant sought judicial review of the failure to conduct an independent and immediate investigation following the suicide of his wife who was a patient detained in a psychiatric hospital under section 3 of the Mental Health Act 1983. The inquest (which found that the wife had not committed suicide but was the outcome from self-harming) met the minimum standards required of the state.[96] The Middleton ruling was also applied in another case where a 14-year-old boy died after drinking methadone. The local authority, which had been aware of his drinking, drugs and shoplifting for the previous nine months, succeeded in its application for judicial review of the coroner's decision to hold a Middleton inquest. The High Court identified three possible obligations under Article 2 a general duty to protect the right to life; an operational duty which arose when the authorities had known of a real and immediate risk to life and a procedural duty to investigate any arguable breaches of the general duty. There was no operational duty in place and there was no breach of the general duty.[97] A GP, who had prescribed Heminevrin to a patient who took an overdose, failed in his application for judicial review of the conduct of an inquest which returned a verdict of unlawful killing. The Court of Appeal held that his role in the deceased's death was crucial to the investigation and justified the coroner authorising a full investigation of his prescribing history and his system of using repeat prescriptions.[98]

In December 2007 the European Court of Human Rights held that failure by the state to investigate credible allegations about unlawful killings could amount to a breach of Article 2 and the right to life in relation to alleged failings by the Royal Ulster Constabulary.[99] In another Northern Ireland case, the European Court of Human Rights held that excessive delay in investigating the deaths of people at the hand of the security forces in Northern Ireland amounted to a violation of the procedural aspect of the right to life, guaranteed by Article 2.[100]

Practical Dilemma 29.4 An unexpected death

Bill Arthur was undergoing a stomach operation when the anaesthetist reported that his pulse was becoming very weak. Resuscitative procedures were undertaken, but unfortunately Bill died. The death was reported to the coroner who decided that an inquest should be held.

What is the purpose of the inquest?

The Coroners and Justice Act 2009 section 5(1) states that the purpose of an investigation under this Part into a person's death is to ascertain –

1 **(a)** who the deceased was;
(b) how, when and where the deceased came by his or her death;
(c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
2 Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998, the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death).
3 Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
(a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
(b) the particulars mentioned in subsection (1)(c).

This is subject to paragraph 7 of Schedule 5 which covers the duty of the senior coroner to report to a person he believes may have power to take action on a matter of concern that the circumstances creating a risk of other deaths will occur or continue to occur.

Section 10(2) of the Coroners and Justice Act 2009 specifically states that a determination of the jury may not be framed in such a way as to appear to determine any question of –

(a) criminal liability on the part of a named person,
(b) or civil liability.

The Coroners (Inquest) Rules 2013[101] set out the procedures to be followed and cover the formalities: disclosure, management of the inquest hearing, jury inquests and record. A Schedule covers the form for juror summons and the form for record of inquest. There are nine short form conclusions or a narrative verdict. The standard of proof required for unlawful killing or suicide is the criminal standard of proof. For all other short form conclusions and a narrative statement the standard of proof is the civil standard of proof.

Who should attend?

The coroner has a duty[102] to examine on oath all persons who tender evidence as to the facts of the death and all persons having knowledge of the facts whom he considers it expedient to examine. Under the Coroners' Rules 2013[103] (which replace the 2008 Rules [104]) the coroner has considerable discretion in deciding who should attend. He must (Rule 9) notify the date, hour and place of an inquest within one week of setting the date) to:

1 the next of kin or personal representative of the deceased whose name and address are known to the coroner;
2 any other person who have made themselves known to the coroner;
3 the details must be made publicly before the hearing.

Examination of witnesses

Any of the persons listed in the second point under 2 above are entitled to examine the witnesses either in person or through a solicitor or barrister. The coroner has the power to disallow any question that, in his opinion, is not relevant or is otherwise not a proper question (Rule 19).

The procedure is for any witness to be examined by the coroner first and then by any interested person and then if the witness is represented at the inquest, by the representative last. No witness is obliged to answer any question tending to incriminate himself. Where it appears to the coroner that a witness has been asked such a question, the coroner must inform the witness that he may refuse to answer.

Nature of the inquest

The coroner's inquest is very different from the hearings in the other courts of law in this country. It is an **inquisitorial** hearing as opposed to those in the civil and criminal courts, which are **accusatorial** or **adversarial**. This means that in an inquest there are not two opposing parties with the coroner sitting back and hearing them argue out a case, intervening only to ensure fair play. At an inquest, the coroner takes the lead and is in control. It is up to him or her to obtain answers to the questions set out above. He or she calls the witnesses and decides the order in which they are to give evidence and generally controls the court and hearing. Under section 7 of the Coroners and Justice Act an inquest should be held without a jury unless subsections 2 and 3 apply. These state that:

2 An inquest into a death must be held with a jury if the senior coroner has reason to suspect –
- **(a)** that the deceased died while in custody or otherwise in state detention, and that either –
  - **(i)** the death was a violent or unnatural one, or
  - **(ii)** the cause of death is unknown,
- **(b)** that the death resulted from an act or omission of –
  - **(i)** a police officer, or
  - **(ii)** a member of a service police force,

  in the purported execution of the officer's or member's duty as such, or
- **(c)** that the death was caused by a notifiable accident, poisoning or disease.

3 An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so.

The decision of the coroner in the inquest into the death of Princess Diana and her companion not to hold a jury was held by the High Court to be wrong.[105]

Returning to Practical Dilemma 29.4, the coroner's officer will have requested statements from relevant people who were present in theatre and who were concerned with Bill's treatment. It is helpful if those making a statement can keep a copy. (Refer to chapter 9 for the making of statements.) The coroner will probably have requested a post-mortem examination to ascertain the cause of death. He will decide which people he requires to summon as witnesses. Clearly, in Bill's case, there will have to be evidence of identity and also of what took place in theatre. The surgeon, anaesthetist and the nurse are all likely to be called to give evidence. If detailed pathology laboratory results are not yet available, there could well be an adjournment until they are ready. Bill's family will obviously wish to be present in order that they can ask for the relevant questions to be put to prepare for a possible case of negligence in the civil courts. The coroner has the power to prevent any question that he does not consider relevant to the inquest. Schedule 5 paragraph 7 of the Coroners and Justice Act 2009 requires the coroner to send a report to a person who could take action to prevent a similar death. Regulation 28 of the 2013 Investigation Regulations expands on this duty.[106] The recipient is required to give a written response. Regulation 28 reports can be obtained from the Chief Coroner's office.[107]

Preparation for the theatre nurse before attending the inquest

The theatre nurse has, one hopes, kept a copy of the statement that she made for the coroner. The statement should have followed those guidelines discussed in chapter 9. She may be advised by a senior nursing officer who has had some experience in such matters on the sort of questions she can expect and how to cope. Preferably, she should be advised by the solicitor to the trust (see chapter 9). The importance of comprehensive, meaningful record keeping cannot, once again, be overstressed. Prior to the hearing, the solicitor to the trust should take her through her evidence and answer any concerns that she has.

Recommendations of the Shipman Inquiry

Following the conviction of Dr Shipman for murder an inquiry was set up under the chairmanship of Dame Janet Smith DBE. The First Report[108] considered how many patients Shipman killed, the means employed and the period over which the killings took place. The Second Report examined the conduct of the police investigation into Shipman that took place in March 1998 and failed to uncover his crimes.[109] The Third Report[110] considered the present system for death and cremation certification and for the investigation of deaths by coroners, together with the conduct of those who had operated those systems in the aftermath of the deaths of Shipman's victims. The Report noted that the present system of death and cremation certification failed to detect that Shipman had killed any of his 215 victims. Even though many of the deaths occurred suddenly and unexpectedly and should under the present procedures have been reported to the coroner, Shipman managed to avoid any coronial investigation in all but two of the cases in which he had killed. He did this by claiming to be in a position to certify the cause of death and by persuading relatives that no autopsy (and therefore no referral to the coroner) was necessary. The present system failed to protect the public. This Third Report made extensive recommendations, which are summarised in Box 29.6. The inquiry took into account feedback to a consultation paper published by the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland chaired by Mr Tom Luce and accepted the recommendations of the coroner's review on changes to the scope and conduct of inquests. The Fourth Shipman Report, which was published in July 2004,[111] considered the regulation of controlled drugs in the community (see chapter 28).

Box 29.6 Issues covered by the Shipman Inquiry into death and cremation certification and the role of the coroner

- Future of the coronial system
- Aim and purposes of the new coroner service
- Need for leadership, training and expertise in the coroner service
- Structure and organisation of the coroner service
- Death certification
- Registration
- Further investigation
- Pathology services
- Statutory duty to report concerns about a death
- Public education
- Audit and appeal
- Transitional arrangements
- The future.

The Fifth Report of this inquiry was published in December 2004.[112] It considered the handling of complaints against GPs, the raising of concerns about GPs, the procedures of the General Medical Council and the revalidation of doctors, and made significant recommendations for the more effective regulation of GPs. Many of the detailed changes for GMC procedures recommended in the Fifth Shipman Report could also apply, where appropriate, to the NMC as could the results from a review carried out by the Chief Medical Officer. The Sixth and final Shipman Report considered how many patients Shipman killed during his career as a junior doctor at Pontefract General Infirmary and in his time at Hyde.[113]

The inquiry recommended that a new coronial system should be established that would provide an independent, cohesive system of death investigation and certification, readily accessible and understood by the public. It should seek to establish the cause of every death and to record the formal details accurately for the purposes of registration and the collection of mortality statistics. It should seek to meet the needs and expectations of the bereaved and its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future. The legal and medical functions of the coroner's office should be carried out respectively by a judicial and medical coroner who should be independent officeholders under the Crown. The Coroner Service should have a corps of trained investigators, who would be the mainstays of the new system. The Coroner Service should be an executive non-departmental public body, independent of the Department for Constitutional Affairs (now the Ministry of Justice) and the Department of Health. A board should govern the service and formulate policy, strategic direction and the promotion of public education of its work. Three members of the board would be the Chief Judicial Coroner, the Chief Medical Coroner and the Chief Coroner's Investigator. There should also be an advisory council.

Recommendations for death certification are that there should be one system for death certification for all deaths, whether death is to be followed by burial or cremation. Two forms will need to be completed: Form 1 would provide an official record of the fact and circumstances of death and be completed by a doctor, accredited nurse or paramedic or a trained and accredited coroner's investigator who confirmed that death had occurred; Form 2 would be completed by the doctor who had treated the deceased person during the last illness or if no doctor had treated the deceased person in the recent past, by the deceased's usual medical practitioner. Form 2 would contain a brief summary of the deceased person's recent medical history and the chain of events leading to death and the doctor could express an opinion as to the cause of death. There would be a statutory duty on doctors to complete the death certificate and the General Medical Council should impose a professional duty for doctors to cooperate with the death certification system.

All deaths would be reported to the Coroner Service, which would have responsibility for certification of death and decide if further investigation were necessary. Where Form 2 stated the doctor's opinion as to the cause of death, the coroner's investigator would consult with the deceased's family and decide if certification could proceed. There should be random and targeted checks to consider whether fuller investigation is required. A new certificate of cause of death should be completed by the coroner's investigator or, if an investigation has been undertaken, by the medical coroner. There should only be an inquest in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case and decided by the judicial coroner. There would be a mandatory inquest in a few specified circumstances. Where an inquest was not held, a report of further investigations would be prepared by the medical and/or judicial coroner, explaining how and why the deceased died. Any recommendation of the medical or judicial coroner should be submitted to the Chief Coroners, who should take it forward. Statutory powers, including powers of entry, search and seizure of documents should be given to the coroners. The family should have the right to appeal against an autopsy being held or to make representations for one to be held. Detailed proposals are made for the investigations by the medical and judicial coroners. The relationship between criminal proceedings relating to a death and investigations by the Health and Safety Executive and the medical and judicial coroners are also spelt out. Deaths which were or might be caused or

contributed to by medical error or neglect should be investigated by the Coroner Service, initially by the medical coroner and if after investigation it appears that the death might have been caused or contributed to by medical error or neglect, the case should be referred to the regional coroner's office for investigation by the regional medical coroner and judicial coroner. The recommended statutory duty to report concerns about a death should be placed on any 'qualified' or 'responsible' person. Employers should encourage employees to report any concerns relating to the cause or circumstances of a death and should pass on these reports to the appropriate quarter without delay and without any possibility of the reporter being subject to criticism or reprisal. The public should be educated about the functions of the Coroner Service and should be encouraged to report any concerns about a death. The Report also recommended that there should be a systematic audit of the Coroner Service and rights of appeal.

Following the Third Shipman Report, a position paper was published by the Home Office[114] in March 2004 and constituted the government's response to the *Fundamental Review of Death Certification and Coroner Services*[115] and the Shipman Inquiry. In February 2006 the Minister of State for Constitutional Affairs announced the implementation of the first set of reforms: those relating to the Coroner Service.[116] Six key reforms were to be introduced:

- Bereaved people will have a right to contribute to coroners' investigations. They will be able to bring their concerns to coroners even where a death certificate has been issued. A coroners' charter will set out the service bereaved people can expect. (A draft was published in 2006 and revised in 2008.)
- A Chief Coroner (accountable to the government) and an advisory Coronial Council would be introduced to provide national leadership, guidance and support. Coroners would continue to be appointed and funded by their local councils and served by coroners' officers drawn from the local police or local authority. The Chief Coroner will have the power to commission audits and inspections and will be responsible for monitoring the coroners' charter for bereaved people. The Chief Coroner will also have power to appoint judges in complex cases. The Coronial Council will include independent lay members and representatives of voluntary groups. It will act as a further check on standards and will advise the Chief Coroner on what service and strategic issues may need further scrutiny.
- A body of full-time coroners would be created and current boundaries would be reshaped to create a smaller number of coroner jurisdictions. The full-time coroners would be supported by a pool of assistant coroners to act in their absence. All new appointments to the service will be required to have a legal qualification.
- The investigation and inquest processes would be modernised and coroners would be given new powers to obtain information to help their investigations.
- In limited and specific cases, such as some suicides and child deaths, coroners will have a new discretion to complete their investigations and decide on the facts without holding inquests, where no public interest is served by doing so.
- A Chief Medical Adviser will be appointed to support the Chief Coroner to give advice on medical best practice and medical issues related to coroners' investigations.

In addition:

- At local level funding will be provided to coroners to ensure appropriate local medical advice to support their investigation.
- Coroners will no longer have the task of determining whether a particular find should be classified as treasure. A new national coroner for treasure will be appointed to take on the work currently undertaken by coroners at local level.

A draft Coroner's Bill, together with a draft charter for the bereaved, were published in June 2006 to enable pre-legislative scrutiny to be undertaken by the Select Committee for the Department of Constitutional Affairs. The draft Bill was scrutinised by the DCA Select Committee[117] which made strong criticisms about the fact that many of the proposals contained in the Shipman Report and in the position paper were omitted from the Bill, in particular the changes to the death certification system and a national system for the office of coroner. The Select Committee was also concerned that there

was inadequate resourcing of the coronial service. The government responded to these recommendations in November 2006.[118] It did not accept the recommendation that all deaths should be reported to the coroner, since this could lead to unnecessary delays for families in preparing the funeral. It did accept the recommendation that there should be a positive statutory duty for doctors to refer certain categories of death to the coroner and suitable guidance and training to improve doctors' knowledge of death certificate requirements should take place with the GMC and the General Register Office.

The Coroners and Justice Act 2009: overview

The Coroners and Justice Act 2009 received royal assent on 12 November 2009 and included measures to:

- Reform and clarify the law on homicide, in particular to the partial defences (see chapter 2)
- Update the language of the offence of assisting suicide
- Establish a new Sentencing Council for England and Wales, with a strengthened remit to promote consistency in sentencing practice
- Create a new national coroner service, led by a new chief coroner
- Create a new system of secondary certification of deaths that are not referred to the coroner, covering burials and cremations
- Enable the courts to pass an indeterminate sentence for public protection for certain terrorist offences
- Prevent criminals from profiting from publications about their crimes
- Amend the Data Protection Act to strengthen the Information Commissioner's inspection powers
- Re-enact the provisions of the emergency Criminal Evidence (Witness Anonymity) Act 2008 so that the courts may continue to grant anonymity to vulnerable or intimidated witnesses where this is consistent with a defendant's right to a fair trial
- Allow the courts to grant Investigative Witness Anonymity Orders in certain gun and knife crime cases
- Extend the use of special measures in criminal proceedings, such as live video links and screens around the witness box, so vulnerable and intimidated witnesses give their best evidence.

The full Act can be accessed on the legislation website.[119]

Peter Thornton was appointed as Chief Coroner in 2012 and set out his focus of driving up standards and tackling delays.[120] Changes include the formulations of new rules and regulations which will speed up inquests and families will receive information earlier and have greater access to documents and evidence; coroners will be able to release bodies earlier for burial and cremation with the overall number of inquests being reduced. There is to be compulsory training courses for coroners and their officers and for local authorities, police, pathologists, lawyers, charities and others. Changes are also being made to the appointment system to ensure a more open, transparent and fair system. There will be a retirement age of 70 and coroners cannot appoint their spouses and partners as assistant coroners. Guidance is being provided to coroners on the appointment of coroners, location of inquests, recording hearings, a cadre for service deaths, reports to prevent future deaths, post-mortem imaging and oaths and robes.

Guidance and law sheets including Regulation 28 reports can be obtained from the Chief Coroner's office.[121]

Property of the deceased

When a patient has died, there is an obligation on the staff to ensure that the property is listed and accounted for. Usually, the next of kin will arrange for clothes and small personal items to be taken away. However, any property that looks as though it might be of some value should be handed over to the executor or personal representative only on production of the grant of probate or letters of administration relating to the estate. A form of indemnity may be required to protect the NHS trust. This is

the only way in which the NHS trust can defend itself if it is challenged for handing the property over to the wrong person. (See chapter 25 on property.)

Case 29.10 Property of the deceased[122]

A patient was brought into hospital following a heart attack at a garden centre and was found to be dead on arrival. His widow realised that he was carrying the house keys in his pocket and asked for them so that she could return home. The nursing sister stated that the keys had to be left in the safe until after the post-mortem, even though the widow told her that she would not be able to get into her house without them. She returned to the house with her daughter, but was unable to get in and had to hire a locksmith the next day.

Even though the hospital was probably following the set procedure for handling property following an unexpected death which was reported to the coroner, there would appear to be reasonable grounds for permitting the widow to receive the keys, perhaps on receipt of an indemnity. There were no suspicious circumstances relating to the death and the hospital could have safeguarded its position by obtaining the consent of the coroner to the handing over of the keys.

Wills

The best advice to nursing staff in relation to the drawing up or signing of wills for patients is: *do not get involved*. Ideally, if a patient makes it known that he wishes to make his will (the person making a will is known as the *testator*), the unit manager should be advised and the patient's solicitor called. The nurse should not be involved. If there is likely to be any dispute as to the patient's competence to make a will, medical opinion should be obtained to confirm that the patient is mentally competent, since one of the grounds for challenging a will's validity is that the patient lacked the competence to sign it, since he was unaware of the implications of his act. Another ground on which its provisions can be challenged is that the patient was subjected to undue influence at the time of signing it so that its provisions do not represent his real intent. Nursing and medical evidence thus becomes crucial in any such legal dispute. If there is a statement in the medical records that the patient signed his will on such and such a day and that his state of mind was rational, clear and unconfused, while that is not in itself evidence of the truth of what is stated, it should at least contain sufficient information to assist professionals in the recall of events, should they be subjected to cross-examination on the patient's competence or independent state of mind.

Practical Dilemma 29.5 Execution at night

Florence Evans was convinced that she was dying. She fretted that she had not made her will and asked the night sister if she would sign a piece of paper declaring how she would like her property disposed of. The night sister was very reluctant to become involved, although she knew that Florence was, in fact, very ill. Florence showed her the paper on which everything was written and asked her to sign it with the auxiliary as a witness. Just to settle Florence, the night sister agreed and she and the nursing auxiliary together watched Florence sign the piece of paper and then they signed their own names. Florence died that same week.

A few weeks later the sister was told that Florence's daughter was disputing the will which left everything to her two brothers and nothing to her. She said that the formalities were not complied with and that it was not a proper will.

Practical Dilemma 29.5 gives an example of one reason why nursing staff are advised not to become involved with will making. Hospitals should provide advice on what staff should do in this situation. In some hospitals, it would be possible for a sister in this situation to summon the on-call manager to take care of Florence's will. The actual signing and witnessing of the will is known as the *execution* of the will and strict rules are in force in relation to the validity of the process. These have been eased slightly since 1982, but the revised procedures must be strictly followed. Any irregularity in the execution of the will may lead to the will being declared invalid. There are no special forms to be used although these are available. The legal requirements are set out in Statute Box 29.2.

Statute 29.2 Administration of Justice Act 1982 section 17 amending section 9 of the Wills Act 1837

No will shall be valid unless:

- It is in writing and signed by the testator, or by some other person in his presence and by his direction.
- It appears that the testator intended by his signature to give effect to the will.
- The signature is made or acknowledged by the testator in the presence of two or more witnesses present at the same time.
- Each witness either:
  - **(i)** attests and signs the will or
  - **(ii)** acknowledges his signature in the presence of the testator (but not necessarily in the presence of any other witness), but no form of attestation shall be necessary.

Additional requirements:

- the testator must be over 18 (unless in the armed forces or the merchant navy)
- the testator must have the required mental competence at the time he signs the will.

Any person who signs the will as a witness is prevented from being a beneficiary under the will and this applies to the spouse as well. (In one case where the solicitor allowed the beneficiary's spouse to sign the will, the solicitor was liable for the lost inheritance.) If the testator intends leaving a gift to the NHS trust or its staff, then no one from the NHS trust should be involved in the drawing up or signing of the will, otherwise the gift could be invalidated on the grounds of undue influence. The Supreme Court allowed the rectification of a will when it was discovered that wills signed by husband and wife and been signed by the wrong spouse. The error had not been noticed when the wife died, but was realised when the husband died. The Supreme Court held that this was a clerical error capable of rectification and those who would have inherited on intestacy lost.[123]

The Court upheld the Vegetarian Society's claim that the deceased had testamentary capacity when he left his substantial estate to the Society rather than to his sister. The deceased suffered from schizophrenia but the court accepted expert evidence that he was able to comprehend what was required of him when making a will.[124] In contrast, claimants who alleged that the deceased lacked the requisite competence when she made two wills and sought a declaration that she died intestate succeeded. Evidence from care home staff and expert and other evidence suggested progressive dementia.[125]

In Practical Dilemma 29.5, where the sister and the nursing auxiliary witnessed the will, it is unlikely that the will could be declared invalid on the grounds of its actual execution even though it might be challenged on other grounds (the lack of mental competence, undue influence, etc.). However, the possibility of involvement in litigation does illustrate the advantages of nursing staff ensuring that, where possible, the experts are involved.

Conclusions

The government's End-of-Life Care Strategy is likely to suffer from the cuts in public expenditure, and palliative care nurses will continue to face many resource challenges. Parliament has resisted any change in the law to permit voluntary euthanasia but at the time of writing a Bill was being considered in Parliament. The guidance provided by the DPP on when there is likely to be a prosecution following assisted suicide has not resolved all the uncertainties, and cases demanding further clarity are likely to continue to arise. The implications of the Coroners and Justice Act 2009 have still to be seen and it is possible that more radical changes to the system of certification and coroners' inquests may eventually be made. Certification by registered nurses is still not an option at present but training in verification of death as an expanded role is likely to increase. Controversy over the right to receive assistance in a suicide attempt is likely to continue even if legislation is enacted. In September 2013 Stephen Hawking joined the ranks of the proponents of assisted suicide, arguing from his own experience of motor neurone disease, that those who help the terminally ill to die should not be prosecuted.[126]

Reflection questions

1 What is meant by brain death? What problems arise from recognising this as opposed to the traditional definition of death?

2 A patient who is being ventilated asks you to switch off the machine. What is the legal position?

3 Consider any patient whose death you have witnessed and whose relatives you have had to comfort and assist. Was there any information of which you were ignorant? Could you answer all their questions?

4 In what ways would an inquest differ from a hearing in the criminal or civil courts?

Further exercises

1 Obtain a copy of the local policy and guidelines on end-of-life care and compare it with the government's strategy. To what extent has it been implemented?

2 In what circumstances would an advance decision drawn up by a patient be applicable and relevant? What are the statutory requirements for its validity?

3 Draft a procedure for preparing a nurse who has been asked to give evidence at an inquest.

4 Obtain a copy of your NHS trust's leaflet for the guidance of patients on the care of property. Does it consider the procedure to be followed at the death of a patient? What precautions would you as a ward sister take to ensure that the property of the deceased was cared for?

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Chapter 30

Complementary and alternative therapies

This chapter discusses

- Definitions of complementary and alternative therapies
- The NMC practitioner as a complementary therapist
- Liability for using complementary therapy at work
- Patients receiving complementary therapies
- House of Lords Select Committee
- Herbal medicines and acupuncture
- Complementary and Natural Healthcare Council (CNHC)

Introduction

Complementary and alternative therapies have enjoyed considerable growth over the past 20 years and it is estimated that one in every five adults has tried such therapies, spending about £1.6 billion on them.[1] The Department of Health has provided an information pack for primary care.[2] Increasingly, the focus has been on the proven effectiveness of such therapies and the extent to which the NHS would provide free access to them. More recently, there have been moves to encourage national registration for the practitioners to ensure that the public obtained greater protection.

This chapter looks at the legal implications of complementary therapy practice for nurses and midwives in two respects: one as a practitioner of a complementary therapy alongside the skills for which they are registered with the NMC; the other as a carer of patients who may be receiving complementary therapies as well as care from orthodox medicine. For more detailed information on the legal aspects of complementary therapies, see the author's work.[3] Reference should also be made to the many books written by nurses about individual complementary therapies. Further information can be obtained from the website of the Complementary Healthcare Information Service.[4]

Definitions of complementary and alternative therapies

It is perhaps easier to define complementary and alternative therapy negatively in the sense that it is treatment for which health-giving or disease-repelling properties are claimed that are not yet accepted by those who practise orthodox medicine. If this definition is used, it could be argued that chiropractic and osteopathy were once, but are no longer, complementary therapies, but by becoming state-registered professions are now accepted as part of orthodox medicine and there are referrals funded by the NHS. If this definition is used, it would also follow that homeopathy has long been part of orthodox medicine; since the Faculty of Homeopathy was established in 1848, five schools of homeopathy have been established and both the schools and the hospitals receive state support. The Cochrane Collaboration defines complementary and alternative medicine as:

> **A broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical period.[5]**

The term 'complementary and alternative therapy' covers a wide range of practices, from the well-established field of homeopathy to claims in respect of dowsing, radionics and astrology.

The NMC practitioner as a complementary therapist

The NMC has provided guidance in the use of complementary and alternative therapies. In its Code of Practice, under the heading 'You must provide a high standard of practice and care at all times', it states that:[6]

> **You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care.**

The NMC also advises (updated May 2012) that

> **It is the responsibility of the nurse or midwife to judge whether the qualification awarded in a complementary therapy has brought them to a level of competence to use that skill for the people in their care and to work within their organisation's local operating procedures, and governance framework.**

In its standards of proficiency for nurse and midwife prescribers,[7] paragraph 3.5 on complementary medicinal products requires the following of its registered practitioners:

> **Nurses and midwives need to be familiar with a range of complementary medicinal products that their patient or clients may be using, or may wish to be used, in their treatment. These include homeopathic remedies, herbal remedies, aromatherapy oils, flower essences and the broad area of vitamin and mineral supplements. Nurses should not prescribe any complementary medicinal products unless they have undertaken appropriate recognised training to do so. Where a nurse or midwife considers that complementary medicinal products could be a substitute for, or a complement to, conventional medication then patient or clients should be referred to appropriately qualified practitioners to receive such treatment.**

Standard 23 of its standards for medicines management[8] states:

> **Registrants must have successfully undertaken training and be competent to practise the administration of complementary and alternative therapies.**

An NMC practitioner who has been trained in a complementary therapy may wish to use it for the benefit of her NHS patients. She may, for example, have acquired skills in aromatherapy, reflexology or acupuncture and believe that these may be more effective in reducing pain or relaxing the patient than medication. What restrictions would there be on her practising her additional skills?

The NMC suggested[9] that employers may wish to establish local policies to provide a framework for the use of complementary therapies by nurses and midwives in their employment.

Employers would need to have information about insurance cover, and complementary and alternative medicine (CAM) practitioners should notify their employers about their qualifications and membership of the relevant associations. Unfortunately, there are considerable variations in the standards of training required and many therapies do not have a single overall professional body that sets standards. The consent of the employer must be obtained by any employee wishing to use CAM therapies, as the following situation indicates.

Practical Dilemma 30.1 Aromatherapy without consent

Brenda was an ITU nurse who had undertaken a course in aromatherapy. She knew that it would be relaxing and beneficial to the ventilated patients she was caring for and wished to use aromatherapy oils on them. Her employers were prepared to give consent to her using aromatherapy, but their policy on the use of complementary and alternative therapies required employees to obtain the consent of patients before initiating any treatment. Since most of Brenda's adult patients were unconscious and relatives could not give a valid consent on their behalf, she was thwarted in her plans. What is the law?

It is entirely reasonable for the employer to lay down instructions and protocols for the use of non-orthodox treatments. The requirement of the patient's consent is also consistent with the legal situation. Brenda, therefore, has to accept that until such time, if ever, aromatherapy becomes a recognised part of traditional nursing and medicine and could therefore be used in the best interests of a mentally incompetent patient, she would be unable to use it in ITU, unless she has the patient's consent when mentally capable.

Liability for using complementary therapy at work

If consent is not obtained from the employer but the nurse practises her complementary therapy skills during her work, there could be serious consequences for the nurse. On the one hand, she has disobeyed the reasonable instructions of the employer and she therefore faces disciplinary action, including dismissal. On the other hand, if she causes harm to the patient, she may face personal liability for the harm that she has caused, since the employer might deny that it is vicariously liable for an employee who is disobeying reasonable instructions and who is not therefore acting in the course of employment (see chapter 4). Even if this argument by the employer did not succeed, since it could be held that the employee is still acting in the employer's interests, the employer might claim from the employee an indemnity for any compensation that it has to pay to the injured patient.

In contrast, if the employee *has* obtained consent from the employer and is working within the guidelines set by the employer, not only would there be no justification for disciplinary action for

working outside her job description, but if harm were to occur to the patient as the result of negligence by the practitioner, the employer would be vicariously liable for that harm.

Different issues arise if the practitioner wishes to use her complementary therapy skills out of working hours but on the employer's premises, as the following case shows.

Case 30.1 *Watling v. Gloucester County Council* (1995)

Private practice in working hours[10]

An occupational therapist was dismissed when he saw private patients for alternative therapy during working hours. His application for unfair dismissal failed. He had been warned by his employers not to conduct his private business during his working hours and that lunchtimes were for a break, not for private work.

It may be that as the clinical effectiveness of certain therapies is established, then employers will fund study leave for practitioners to develop these new skills as part of the scope of their professional practice (see chapter 24). At this point, some of these therapies might be seen as part of the reasonable standard of care to be provided to a patient and could then be given to mentally incapacitated adults in their best interests.

Notifying the patients of risks of complementary therapy

There appears to be a common fallacy that complementary and alternative therapies, being natural, can do only good and not harm and that there are no risks attached. However, this is not correct, as some of the cases reported in the author's work show.[11] Any significant risks, which reasonable professional practice would suggest should be made known to the patient, must be explained to the patient before consent is obtained. Exactly the same principles apply in complementary therapies to the obtaining of consent and the information to be given to a patient as apply in orthodox medicine (see chapter 7). If, for example, a patient were to be given acupuncture and suffered harm, it would be a defence if the defendant could show that there was no negligence on the part of the practitioner, that the patient had given a valid consent and that information about significant risks of substantial harm had been notified by the practitioner to the patient. There are obviously advantages if this information could be conveyed both in writing as well as by word of mouth. The Bolam Test[12] standard would apply as to what information should be given. It may, however, be more difficult to establish this in non-orthodox medicine.

Could liability for harm in complementary therapies be excluded by reference to a notice? The Unfair Contract Terms Act 1977 would prevent any exclusion of liability if negligence by the therapist caused personal injury or death (see chapter 6).

Patients receiving complementary therapies

If it is found that the patient, in addition to being treated by orthodox medicine, is also in receipt of complementary and alternative therapies, then care must be taken to ensure that there are no contraindications between the two treatments and as much information as possible is obtained about the other treatment. The patient may agree to give the name of the complementary therapist who could be contacted for details of their treatment and treatment plan. It may be, for example, that the patient is given conflicting advice: in such a situation, good communication is essential between the orthodox practitioners and the complementary therapist. There are considerable advantages in NMC practitioners

obtaining a good understanding of the complementary therapies that their patients are most likely to be using, so that the practitioner can understand the implications for orthodox medicine and know where to obtain further advice and information.[13] The RCN provided guidance to its members on complementary therapies in 2003, updated in 2007 and 2013.[14] A study of pregnant women in Switzerland showed that none of the women had requested acupuncture during labour but accepted it when offered it by the midwife, confirming similar results in Germany.[15]

The consent of the client must be obtained, as the following situation indicates.

Practical Dilemma 30.2 Herbal medicine

Daphne asked a patient about the various bottles that she saw on her bedside locker. The patient explained that she was receiving herbal medicine for her arthritis. Daphne asked for details about what she was taking, but the patient said it was nothing to do with Daphne or her stay in hospital because she was being treated for a heart condition. Where does Daphne stand in law?

There are clear dangers here, since it could be that the herbal preparations could react against any medication given for the patient's heart condition or could even exacerbate the condition. Daphne should ensure that the medical staff are aware of the situation and it might be advisable to arrange for the pharmacist to see the patient and try to persuade her to disclose sufficient details about the herbal preparations and the herbalist advising the patient so that any necessary action can be taken to ensure that the patient is safe.

The NMC reported in its news service in January 2004[16] that cancer patients may be risking dangerous side effects by taking herbal remedies or supplements alongside their conventional treatment. A study at the Royal Marsden Hospital in London found that more than half the 300 patients studied took some form of complementary medicine. The NMC reminded practitioners of their Code of Professional Conduct, which requires practitioners to ensure that the use of complementary and alternative therapies is safe and in the interests of patients and clients, and referred them to more detailed guidance in the advice section on its website.[17] Researchers in America found that certain herbal remedies could work against drugs prescribed for heart disease. Patients did not always tell their doctors they were taking herbal supplements and doctors did not always ask.[18] Further information should be sought from the Medicines and Healthcare Products Regulatory Agency[19] which publishes adverse warnings on medicines and healthcare products.

Case 30.2 *Shakoor (Deceased) v. Situ* (2000)

Standard of care of a complementary therapist[20]

S, who was suffering from a skin condition, consulted a practitioner of traditional Chinese herbal medicine. After taking nine doses of the herbal remedy, S became ill and later died of acute liver failure, which was attributable to a rare and unpredictable reaction to the remedy. His widow brought proceedings against the practitioner, but failed. The High Court held that on the evidence before it the actions of the practitioner had been consistent with the standard of care appropriate to traditional Chinese herbal medicine in accordance with established requirements.

The mother of a boy, Neon Roberts, who had a cancerous brain tumour, lost her battle to refuse radiotherapy. She wanted time to research alternative therapies for him. The father had agreed to the boy having radiotherapy.[21]

Case 30.3 Criminal proceedings against a retailer of Chinese herbal medicines

Criminal proceedings were commenced against a Chinese herbalist who sold dangerous pills to a woman who then developed kidney failure and cancer.

Ying 'Susan' Wu pleaded guilty to selling pills that contained a banned substance and was given a 2-year conditional discharge.[22] The pills which the victim took to resolve a skin complaint were described as 'safe and natural' but contained aristolochic acid which should only have been given under prescription and was subsequently banned. The judge, in sentencing, stated that it was unfortunate that there was no system in this country to regulate Chinese herbal medicine retailers with an appropriate professional body or trade association. Such a registration would mean that retailers would be alerted to regulations. A registration system has been in force since May 2011 (see page 795, MRHA).

Case 30.4 Professional Conduct proceedings against a GP practising ozone therapy

A retired GP Dr Jack, faced proceedings before the Medical Practitioners' Tribunal Service in Manchester following his administration of ozone therapy to a patient with a rare form of non-Hodgkin's Lymphoma. In more than 120 consultations he treated for 80 or 90 times the patient by taking out blood, mixing it with ozone and then re-injecting it into the vein. The treatment has not been subjected to any peer-reviewed papers. A spokesman for the GMC stated that the procedure exposed the patient to the risk of fatal septicaemia.[23] A hearing before the Medical Practitioners Tribunal Service found that his treatment amounted to misconduct. It may lead to a striking off order by the GMC.

House of Lords Select Committee

In November 2000, the Science and Technology Committee of the House of Lords[24] reported that there should be regulations of complementary and alternative medicines (CAM) and there should be further research to evaluate their effectiveness.

The Select Committee of the House of Lords considered that some remedies such as acupuncture and aromatherapy should be available on the NHS, and that NHS patients should have wider access to osteopathy and chiropractic. The implementation of these recommendations led to the establishment of working groups by the Department of Health.

Herbal medicines and acupuncture

Working groups established by the Department of Health to consider the regulation of herbal medicine practitioners and acupuncturists[25] put forward proposals that herbalists will have to register with a new governing body to be eligible to practise and some herbal treatments will only be available from licensed practitioners.[26]

The Health and Care Professions Council (from 2009)

The Health Professions Council, which replaced the Council for the Professions Supplementary to Medicine in 2002 and became the Health and Care Professions Council in 2009, has the capacity to recognise new registered professions. The HPC has published guidelines setting criteria on opening new parts of the register.[27] Each applicant organisation must:

- cover a discrete area of activity displaying some homogeneity;
- apply a defined body of knowledge;
- practise based on evidence of efficacy;
- have at least one established professional body which accounts for a significant proportion of that occupational group;
- operate a voluntary register;
- have defined routes of entry to the profession;
- have independently assessed entry qualifications;
- have standards in relation to conduct, performance and ethics;
- have fitness to practise procedures to enforce those standards; be committed to continuous professional development.

Over 53 organisations have sought statutory registration from the HCPC, including the Acupuncture Regulatory Working Group, the British Society of Clinical Hypnosis and the Craniosacral Therapy Association of the UK. Once the Council has approved an application, an HCPC recommendation and an accompanying report to regulate the profession is submitted to the Secretary of State. If the Secretary of State agrees with the application, an order will be drawn up under section 60 of the Health Act 1999, submitted for consultation, if necessary amended and then placed before Parliament. The establishment of the Complementary and Natural Healthcare Council is likely to reduce the role of the HCPC as the registration body for CAMs.

Medicine and Healthcare Products Regulatory Agency (MHRA)

State registration is not the only form of regulations and where medicinal and other healthcare products are concerned the MHRA is the enforcement agency. It carried out a public consultation on the regulation of herbal medicines at the same time as the Department of Health[28] and warned in September 2004 of the dangers because of the quality of traditional Chinese medicines. A European Directive on Traditional Herbal Medicinal Products[29] setting out the safety and quality of over-the-counter traditional herbal medicines[30] was implemented in October 2005.[31] Further details of the implications and the regulations on trademarks can be obtained from the website of the MHRA. In February 2007 a Chinese woman was prosecuted for selling customers bear bile, antelope and rare orchids as Chinese cures.[32] (See also Case 30.3 and chapter 28.) Since 2011 each EU state has been required to set up a traditional herbal registration scheme for manufactured herbal medicines that are suitable for use without medical supervision.[33]

Concern was expressed about hidden dangers to consumers because of adulterated herbal ingredients.[34] The Medicines and Healthcare Products Regulatory Agency stated that it was imposing a deadline of December 2013 for companies to meet the new EU quality standards, which requires companies to submit products for testing.

The Department of Health announced a new consolidated, multi-purpose, 'pick and mix' set of model byelaws that can be used for one, several or all types of skin-piercing/skin-colouring that are currently regulated.[35]

Complementary and Natural Healthcare Council (CNHC)

The Prince of Wales suggested the setting up of a group to consider the current positions of orthodox, complementary and alternative medicine in the UK and how far it would be appropriate and possible

for them to work more closely together. Four working groups looking at research and development, education and training, regulation and delivery mechanisms were established under a steering group chaired by Dr Manon Williams, Assistant Private Secretary to HRH the Prince of Wales. It reported in 1997 and made extensive recommendations.[36] These included encouraging more research and the dissemination of its results; emphasising the common elements in the core curriculum of all healthcare workers, orthodox and CAM; establishing statutory self-regulatory bodies for those professions that could endanger patient safety; and identifying areas of conventional medicine and nursing that are not meeting patients' needs at present. It also recommended the establishment of an Independent Standards Commission for Complementary and Alternative Medicine.

In December 2004 the Prince's Foundation for Integrated Health was given £900,000 by the Department of Health to support its work in developing robust systems of regulation for the main complementary healthcare professions. The Commission published its report in February 2008.[37] It recommended developing a federal structure for the voluntary self-regulation of complementary healthcare professions, i.e. a single regulatory body rather than a series of regulators for each complementary healthcare profession. The new body is called the Complementary and Natural Healthcare Council and is made up of four elements:

- Federal Regulatory Council
- Profession-Specific Boards
- Functional Boards
- Practice Advisory Panel.

In May 2009 the CHNC Board agreed to amalgamate the work of the Registration Committee with the Education and Standards Committee.

CNHC has four main functions:

- To establish and maintain a voluntary Register of complementary healthcare practitioners in the UK who meet its standards of competence and practice
- To make the Register of practitioners available to the general public and to educate them about the CNHC quality mark as a quality standard
- To operate a robust process for handling complaints about registered practitioners
- To work with professional bodies in the complementary healthcare field to further develop and improve standards of professional practice.

The CNHC describes its key function as follows:

> **Our key function is to enhance public protection, by setting standards for registration with CNHC. We anticipate that obtaining the CNHC 'quality mark' will swiftly be recognised as the hallmark of quality for the sector. Over time, the general public and those who commission the services of complementary healthcare practitioners will be able to choose with confidence, by looking for the CNHC quality mark.**

The CNHC describes itself as the UK voluntary regulator for complementary healthcare practitioners. The Members of the Council and the functional boards are lay people, appointed independently; each Profession-Specific Board (one for each profession) has a lay Chair and four registrants from the appropriate profession. Each Profession-Specific Board selects one of its practitioner members to sit on the Practice Advisory Panel which provides a pool of expertise to support the Council. The report recommended robust procedures for handling complaints and fitness to practise issues, along with a Code of Conduct and Ethics based on the code used by the Health Professions Council. The complementary healthcare professions that were part of the Foundation for Integrated Health's regulation programme developed the competencies necessary for entry to the Register. Full public and professional liability insurance will be mandatory, as will continuing professional development. The Federal Working Group has suggested that an independent, external organisation be invited to review the work of the CNHC from time to time, to ensure that it remains fit for purpose and that it meets the needs of all who have

an interest in its work. The Department of Health has provided start-up funding but the aim is for the CNHC to be financed solely by registration fees. The Department of Health will also ensure that the principles underpinning professional regulation as set out in its White Paper, 'Trust, Assurance and Safety',[38] are implemented (see chapter 3). The Council's Register was in place in January 2009 with massage therapy and nutritional therapy.

To be eligible for registration, a practitioner must have undertaken a programme of education and training which meets, as a minimum, the National Occupational Standards for that profession/discipline or achieved competency to the same level by means of relevant experience, training and assessment. They must also confirm that they do not have a criminal record, or have any health issues. The Register can be checked on the CNHC's website.[39] The overall intention is that the Council will provide enhanced consumer confidence and safety through a credible, robust and professional voluntary regulatory structure for the practice of complementary healthcare in the UK.

The CNHC aimed to register at least 10,000 complementary healthcare practitioners around the UK in its first year and achieve recognition of the CNHC quality mark by healthcare practitioners and commissioners as the quality benchmark for NHS referrals, as the benchmark for reimbursement for private healthcare companies and for advertising of practitioners' services.

Registrants are able to make use of the CNHC logo next to their own logo on headed paper or business cards. They are also able to put on display a certificate, incorporating the CNHC quality mark which provides an independent indication of quality to those wishing to use complementary and natural health services. The quality mark can also be used on websites, promotional literature and elsewhere as confirmation to the public that the CNHC registrant meets the standards set by the CNHC. It has published a Code of Conduct Performance and Ethics for registrants who must agree to be bound by the code before their name is added to the CNHC Register.

In 2013 the CNHC registered persons who worked in the following professions:

- Alexander Technique teaching
- aromatherapy
- Bowen Therapy
- healing
- hypnotherapy
- microsystems acupuncture
- massage therapy
- craniosacral therapy
- naturopathy
- nutrional therapy
- reflexology
- reiki
- shiatsu
- sports therapy
- yoga therapy

Further information can be obtained from the CNHC website.[40]

In 2013 the CNHC Register was accredited by the Professional Standards Authority for Health and Social Care (formerly known as the Council for Healthcare Regulatory Excellence) as an Accredited Voluntary Register[41] (see chapter 11).

Clinical effectiveness and CAMs

A petition to the government criticised the fact that CNHC registrants would use the certificate provided by the CNHC to imply efficacy and safety, yet the CNHC's approval of the therapy did not involve any actual evidence of efficacy and safety. The government responded to this petition by stating that:

> **The CNHC does not promote the efficacy of disciplines practised by its registrants. The aim of the CNHC is protection of the public. Registration means that the practitioner has met certain entry standards (in terms of having an accredited qualification or relevant experience) and that they subscribe to a set of professional standards. The public will have the reassurance that the practitioner they choose meets these standards and will be subject to fitness to practise procedures should they behave inappropriately.**
>
> **Regulation, whether statutory or voluntary, is about protecting the public. For this reason, the Government fully supports the work of the CNHC. If patients choose to use complementary or alternative therapy, the Government's advice is to choose a practitioner registered with a reputable voluntary registration body such as the CNHC.**

Registration with the CNHC does not therefore mean that a particular CAM is clinically effective other than through a placebo effect and there has been considerable discussion about the clinical effectiveness of many CAMs. Professor Ernst, Professor of Complementary Medicine at the University of Exeter, has been critical of the claims made by some alternative remedies such as homeopathy and chiropractic, and has asserted that his clash with the Prince of Wales's Private Secretary has led to the lack of funding support for his unit.[42] He retired in 2011. Criticisms by a science writer, Simon Singh, of chiropractic led to his being sued in a libel case. Although he won the case[43] he still stood to face £60,000 in legal costs.[44] The judgment of the Court of Appeal (which reversed a ruling in the High Court) noted that 'Scientific controversies must be settled by the methods of science rather than by the methods of litigation' (see page 233). The law on defamation has now been changed to protect scientific research. (See also chapter 18.)

Conclusions

The establishment of the Complementary and Natural Healthcare Council marks a significant step in the protection of the public. As more and more therapies come under the umbrella of the CNHC, professional codes of practice and sanctions against those who fail to comply will become the norm. However, as the Department of Health noted in its reply to the criticism of the CNHC, the Council does not guarantee the clinical effectiveness of the therapies it regulates and there is likely to be continuing concern with their validity. Professor Ernst, Professor of Complementary Therapy at Exeter University, has challenged the value of chiropractic as a treatment option and voiced concern over the effectiveness of other therapies. It is essential that those involved in CAMs are prepared to answer such challenges with randomised controlled trials to establish their clinical effectiveness. The RCN published in 2007 guidance on the integration of complementary therapies into clinical practice.[45] Some of the concerns which it highlighted may gradually be resolved by the CNHC. There are likely to be increasing demands for CAM therapies to be available within the NHS, but their success will depend considerably on the extent to which research can show that there is clear clinical evidence to establish their effectiveness over orthodox medicine alternatives and their endorsement by NICE. In May 2007 it was reported that more than half of the PCTs in England were refusing to pay for homeopathy and other CAMs, on the grounds that their treatments are unproved or disproved.[46] From April 2013 clinical commissioning groups can determine their own policies in relation to the availability of complementary therapies for their patients. It remains to be seen whether there is an increase in their availability on the NHS. It is essential that all health professions registered with the NMC follow its guidance in the application of complementary and alternative therapies.

Reflection questions

1 You have decided that you would like to undertake training in aromatherapy and eventually use it as part of your practice as a clinical nurse specialist in intensive care. What actions would you take to ensure that your plans are compatible with your role as a registered nurse?

2 Identify the ways in which the knowledge that a patient was receiving complementary therapy treatment could affect the care that you give that person.

Further exercises

1 Do you consider that those complementary therapists who so wished should be permitted to have registered status under the Health and Care Professions Council or the Complementary and Natural Healthcare Council? What criteria would you lay down for a profession to receive registered status? (Refer also to chapter 11)

2 Do you consider that patients should be under an obligation to inform their NHS carers if they are receiving complementary therapies?

3 Access the website of the Complementary and Natural Healthcare Council and consider the implications of its functions for your own professional development.

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Chapter 31
The future

It is a frustrating time to publish a book. So much legislation has been enacted in the past few years – the Health and Social Care Act 2012, the Care Act 2014 and the Children and Families Act 2014, and several sections are still due to be implemented with many regulations still under consultation. These include regulations to place a duty of candour on organisations. Will this be the signal for the change, openness and accountability recommended by the Bristol Inquiry in 2001 and repeated in the Francis Inquiry or just another damp squib?

Revolutionary changes are to take place in the role of local authorities in care in the community and the personal funding of services in 2016. Significant recommendations from the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust and the Berwick Report on patient safety are in the process of being implemented. The effects of the Alexis Jay Independent Inquiry into the child sexual exploitation in Rotherham between 1997 and 2013 have only just started to resonate with serious concerns about child protection safeguards and the accountability of senior officers in the local authority and police. The call for an enforceable duty to report child abuse is understandably renewed.

The reverberations of landmark decisions from the Supreme Court on the deprivation of liberty of disabled persons and the human rights of those receiving community services are still being felt.

Major changes have taken place in the powers and role of monitoring and quality control organisations: the Care Quality Commission, the National Institute of Health and Care Excellence, and the Professional Standards Authority.

Public health responsibilities have been transferred to local authorities together with the nurses associated with public health: the school nurse and the specialist community public health nurse. The implications of this transfer are not yet apparent.

Reports from Parliamentary scrutiny committees suggest that major changes are necessary in the Deprivation of Liberty Safeguards for those without the mental capacity to make their own decisions. A review of section 135 and 136 of the Mental Health Act 1983 is still taking place. Meanwhile, the Assisted Dying Bill has progressed beyond the second reading and is to be considered in detail by Parliament in the autumn of 2014.

Recommendations are being made for a new grade of physician associate to be used even though demands for regulating healthcare assistants have not yet been implemented.

NHS England is still feeling its way ahead against a background of rising waiting times and lists, a call for seven-day NHS services and pressures for GPs to provide an extended service. In September

2014 the Baker Commission published its final report on the future of Health and Social Care, and a month later The NHS Five Year Forward View was published by Simon Stevens CE, NHS England in conjunction with Monitor, the Trust Development Authority, the CQC, Health Education England and Public Health England, which indicated that radical changes over the next five years are necessary for the NHS to survive[1]. The NMC has published a draft of its revised Code of Practice and is in the process of consulting on revalidation. Subsequently, it is to publish further guidance on selected topics, including the duty of candour and raising concerns which will underpin the new Code. The Assisted Dying Bill has progressed beyond the second reading and is still being considered in detail by Parliament.

These are perhaps good reasons to delay publication, but on the other hand so much has already taken place since the 6th edition of this book was published in 2011 that an update was overdue.

It is hoped that an awareness of all the changes which have taken place over the past four years and the changes which are in progress will be of value to a nurse in understanding the changing legal context within which she practices.

As we go to press commencement orders have been issued bringing into force many sections of the Care Act to enable regulations to be drafted, so that by 1 April 2015 most of the legislation should be in force[2]. The Social Care Institute for Excellence has published guidance for those involved in the commissioning of advocacy services[3]. The Court of Appeal has decided that a fetus is not 'any other person' for the purpose of Section 23 of the Offences Against the Person Act 1861 and the mother was not criminally liable. Also of great significance is the decision of the Supreme Court that the protection of conscientious objection to taking part in termination of pregnancy applied to actual hands on care and treatment. However, the management midwives would take their case to the employment tribunal to determine if their rights not to be discriminated against in respect of their religion had been recognised[4].

The website to the book will provide an on-going update to these many changes.

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Glossary

acceptance an agreement to the terms of an offer which leads to a binding legal obligation, i.e. a ***contract***

accusatorial a system of court proceedings where the two sides contest the issue (contrast with ***inquisitorial***)

Act of Parliament, ***statute***

action legal proceedings

actionable per se a court action where claimant does not have to show loss, ***damage*** or harm to obtain compensation, e.g. an action for ***trespass to the person***

actus reus essential element of a crime that must be proved to secure a conviction, as opposed to the mental state of the accused (***mens rea***)

adversarial approach adopted in an ***accusatorial*** system

advocate a person who pleads for another: it could be paid and professional, such as a ***barrister*** or ***solicitor***, or it could be a lay advocate either paid or unpaid; a witness is not an advocate

alternative dispute resolution methods to resolve a dispute without going to court such as mediation

approved mental health professional a person recognised under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) as having responsibilities in relation to the admission and detention of persons under the Mental Health Act (replaces the ***approved social worker***)

approved social worker a social worker qualified for the purposes of the Mental Health Act (whose former role is now undertaken by an ***approved mental health professional***)

arrestable offence an offence defined in section 24 of the Police and Criminal Evidence Act 1984 that gives to the citizen the power of arrest in certain circumstances without a warrant

assault a threat of unlawful contact (***trespass to the person***)

balance of probabilities standard of proof in ***civil*** proceedings

barrister a lawyer qualified to take a case in court

battery an unlawful touching (*see* ***trespass to the person***)

bench magistrates a bench consists of three magistrates known as ***justices of the peace*** who sit in the magistrates' court

Bolam Test test laid down by Judge McNair in the case of *Bolam* v. *Friern HMC* on the standard of care expected of a professional in cases of alleged ***negligence***

burden of proof duty of a party to litigation to establish the facts or, in criminal proceedings, the duty of the prosecution to establish both ***actus reus*** and ***mens rea***

cause of action facts that entitle a person to sue

citation each case is reported in an official series of cases according to the following symbols: *Re F* (i.e. in the matter of F) or *F* v. *West Berkshire Health Authority* 1989 2 All ER 545 which means the year 1989 volume 2 of the All England Law Reports page 545. Each case can be cited by means of this reference system. In the case of *Whitehouse* v. *Jordan* (*Whitehouse* v. *Jordan* [1981] 1 All ER 267), Whitehouse is the claimant, Jordan the defendant and 'v.' stands for versus, i.e. against. Other law reports include: AC, Appeals Court; EWCA, England and Wales Court of Appeal; EWHC, England and Wales High Court; EWHL, England and Wales House of Lords; QB, Queens Bench Division; and WLR, Weekly Law Reports

civil action proceedings brought in the civil courts

civil wrong an act or omission which can be pursued in the civil courts by the person who has suffered the wrong (*see* ***tort***)

claimant person bringing a ***civil action*** (originally ***plaintiff***)

committal proceedings hearings before the ***magistrates*** to decide if a person should be sent for ***trial*** in the Crown Court

common law law derived from the decisions of judges, case law, judge-made law

conditional fee system a system whereby client and lawyer can agree that payment of fees is dependent on the outcome of the court ***action***; also known as 'no win, no fee'

conditions terms of a contract (*see* ***warranties***)

constructive knowledge knowledge that can be obtained from the circumstances

continuous service length of service an employee must have served to be entitled to receive certain statutory or contractual rights

contract an agreement enforceable in law

contract for services an agreement enforceable in law whereby one party provides services, not being employment, in return for payment or other consideration from the other

contract of service a contract for employment

coroner a person appointed to hold an inquiry (inquest) into a death that occurred in unexpected or unusual circumstances

counter-offer a response to an offer that suggests different terms and is therefore counted as an offer, not an ***acceptance***

criminal wrong an act or omission which can be pursued in the criminal courts

cross-examination questions asked of a witness by the lawyer for the opposing side: leading questions may be asked

damages a sum of money awarded by a court as compensation for a ***tort*** or breach of contract

declaration a ruling by the court setting out the legal situation

disclosure documents made available to the other party

dissenting judge a judge who disagrees with the decision of the majority of judges

distinguished (of cases) rules of precedent require judges to follow decisions of judges in previous cases, where these are binding on them. However, in some circumstances, it is possible to come to a different decision, because the facts of the earlier case are not comparable to the case now being heard and therefore the earlier decision can be 'distinguished'

examination in chief witness is asked questions in court by the lawyer of the party that has asked the witness to attend. Leading questions may not be asked

ex gratia as a matter of favour, e.g. without admission of ***liability***, of payment offered to a claimant

expert witness evidence given by a person whose general opinion, based on training or experience, is relevant to some of the issues in dispute (contrast with ***witness of fact***)

guardian *ad litem* a person with a social work and childcare background who is appointed to ensure that the court is fully informed of the relevant facts which relate to a child and that the wishes and feelings of the child are clearly established. The appointment is made from a panel set up by the local authority

guilty a finding in a criminal court of responsibility for a criminal offence

hearsay evidence that has been learnt from another person

hierarchy recognised status of courts that results in lower courts following the decisions of higher courts (*see* ***precedent***). Thus decisions of the Supreme Court must be followed by all lower courts unless they can be ***distinguished***

indictment a written accusation against a person, charging him with a serious crime, triable by jury

informal of a patient who has entered hospital without any statutory requirements

injunction an order of the court restraining a person

inquisitorial a system of justice whereby the truth is revealed by an inquiry into the facts conducted by the judge, e.g. coroner's court

invitation to treat early stages in negotiating a ***contract***, e.g. an advertisement or letter expressing interest. An invitation to treat will often precede an ***offer*** that, when accepted, leads to the formation of an agreement that, if there is consideration and an intention to create legal relations, will be binding

judicial review an application to the High Court for a judicial or administrative decision to be reviewed and an appropriate order made, e.g. ***declaration***

justice of the peace (JP) a lay ***magistrate***, i.e. not legally qualified, who hears ***summary*** (minor) ***offences*** and sometimes indictable (serious) offences in the magistrates' court in a group of three (*see* ***bench magistrates***)

liable/liability responsible for the wrongdoing or harm in civil proceedings

litigation civil proceedings

magistrate a person (*see* ***justice of the peace*** and ***stipendiary magistrate***) who hears summary (minor) offences or indictable offences that can be heard in the magistrates' court

mandamus (we command) an order of the court requiring the defendant to take specified action

mens rea mental element in a crime (contrast with ***actus reus***)

negligence a civil ***action*** for compensation, also a failure to follow a reasonable standard of care

offer a proposal made by a party that, if accepted, can lead to a ***contract***. It often follows an ***invitation to treat***

Ombudsman a commissioner (e.g. health, local government) appointed by the government to hear complaints

payment into court an offer to settle a dispute at a particular sum, which is paid into court. The claimant's failure to accept the offer means that the claimant is liable to pay costs, if the final award is the same or less than the payment made

plaintiff term formerly used to describe one who brings an action in the civil courts. Now the term ***claimant*** is used

plea in mitigation a formal statement to the court aimed at reducing the sentence to be pronounced by the judge

practice direction guidance issued by the head of the court to which they relate on the procedure to be followed

pre-action protocol rules of the Supreme Court that provide guidance on action to be taken before legal proceedings commence

precedent a decision that may have to be followed in a subsequent court hearing (*see* ***hierarchy***)

prima facie at first sight; sufficient evidence brought by one party to require the other party to provide a defence

privilege in relation to evidence, being able to refuse to disclose it to the court

privity relationship that exists between parties as the result of a legal agreement

professional misconduct conduct of a registered health practitioner that could lead to conduct and competence proceedings by the registration body

proof evidence that secures the establishment of a claimant's, prosecution's or defendant's case

prosecution pursuing of criminal offences in court

quantum amount of compensation, or the monetary value of a claim

Queen's Counsel (QC) a senior barrister, also known as a 'silk'

reasonable doubt to secure a conviction in criminal proceedings the prosecution must establish 'beyond reasonable doubt' the guilt of the accused

Re F* ruling** a professional who acts in the best interests of an incompetent person who is incapable of giving consent does not act unlawfully if he follows the accepted standard of care according to the ***Bolam Test

solicitor a lawyer who is qualified on the register held by the Law Society

specialist community public health nurse replaces the health visitor as a registered practitioner under the Nursing and Midwifery Council

statute law (statutory) law made by Acts of Parliament

strict liability liability for a criminal act where the mental element does not have to be proved; in civil proceedings liability without establishing ***negligence***

subpoena an order of the court requiring a person to appear as a witness (*subpoena ad testificandum*) or to bring records/documents (*subpoena duces tecum*)

summary judgment a procedure whereby the claimant can obtain judgment without the defendant being permitted to defend the action

summary offence a lesser offence that may only be heard by ***magistrates***

tort a civil wrong, excluding breach of contract. It includes: ***negligence***, ***trespass*** (***to the person***, goods or land), nuisance, breach of statutory duty and defamation

trespass to the person a wrongful direct interference with another person. Harm does not have to be proved

trial a court hearing before a judge

vicarious liability liability of an employer for the wrongful acts of an employee committed while in the course of employment

volenti non fit injuria to the willing there is no wrong; voluntary assumption of risk

ward of court a minor placed under the protection of the High Court, which assumes responsibility for him or her and all decisions relating to his or her care must be made in accordance with the directions of the court

Wednesbury principle court will intervene to prevent or remedy abuses of power by public authorities if there is evidence of unreasonableness or perversity. Principle laid down by the Court of Appeal in the case of *Associated Provincial Picture House Ltd* v. *Wednesbury Corporation* [1948] 1 KB 233

without prejudice without detracting from or without disadvantage to. The use of the phrase prevents the other party using the information to the prejudice of the one providing it

witness of fact a person who gives evidence of what they saw, heard, did or failed to do (contrast with ***expert witness***)

writ a form of written command, e.g. the document that used to commence civil proceedings. Now a claim form is served

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Relatives and Residents Association	**www.relres.org/**
RESCARE (The Society for Children and Adults with Learning Disabilities and their Families)	**www.rescare.org.uk**
Respond	**www.respond.org.uk**
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Royal College of Nursing	**www.rcn.org.uk**
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Index

abortion
  abnormality, failure to detect, 422
  best interests, 428–9, 478
  challenge by husband, 423
  challenge by putative father, 423
  confidentiality of illegal, 426–7
  conscientious objection, 419–20
  consent under 16 years, 427–8
  future reforms, 429
  general principles, 417–19
  illegal, 421
  live birth, 421–2
  notification, 427
  nurses participation in, 420–1
  offences, related, 425–6
  right refused, 424–5
  termination of one in multiple pregnancy, 426
accident and emergency
  aggression and violence in, 569
  ambulance services, 565
  clinical nurse specialist, 568
  confidential information, disclosure of, 568–9
  duty of care, joint with GP, 567–8
  information giving to patients, 566
  legislation for emergency workers, 565
  local initiatives, 564
  managing the workload, 562–3
  National Audit Office Report 2013, 564
  NHS 111 service, 564–5
  scope of professional practice, 660
  units, strategy for, 362
accountability
  civil, 8–9
  in criminal law,
  to employer, 9–10
  professional, 7–8
Adams, Dr Bodkin, 33, 755
adolescents *see* children
Adomako, Dr 33–34
advance decision *see* living wills
agency nurses, 663
AIDS/HIV
  confidentiality, 194, 200, 572, 699–700
  contaminated blood, 448, 699
  and the midwife, 407, 693–4
  nurse training in, 572–3
  pre-birth injury, 399
  teenage sexual health, 374
  testing for, 693–5
Allitt, Beverley, 35, 123–4, 179, 488
  see also Clothier Report
alternative therapies *see* complementary therapies
approved mental health professional, 539–40, 637

babies *see* midwives
best interests
  and abortion, 428–9
  of a child, 352, 354–8, 350
  decision making by adult, 462–5, 766–7
  deprivation of liberty (DOLS), 463–70, 514, 757
  dispute about lack of capacity, 373
  information giving, 173–4, 176, 178, 179, 434
  of mentally incapacitated person, 167–8, 351, 389
  of older person, 510
  statutory, 169–71
  sterilisation, 430
  treatment in, 171, 462–3
  of unconscious patient, 160
  see also learning disabilities, mental capacity
Bolam Test, 50–3, 72, 544, 657

Caldicott Guardians, 206–7, 569
carers, for learning disabilities, 468–70, 474, 629–30
care homes
  feeding tubes, 515
  human rights, 15, 625–7
  and property, 675
  and specialist dementia care, 516
  standards in, 639–40
  see also community and primary care, older people
Care Quality Commission, 98, 116–19, 299–300, 393, 554–5, 688–9, 692, 719
causation, in negligence case, 56–60
civil proceedings
  case management, 134–7
  defences in, 142–50
  the hearing, 137–9
  mediation, 134
  reforms, 152
  see also compensation, NHS
children
  adolescents, 373
  child protection
    Baby P, 363–5
    Daniel Pelka, 365
    liability of local authority, 194, 245, 367
    non-accidental injury, 204, 358–60, 497
    Working Together to Safeguard Children, 360–3
  consent to treatment
    best interests of, 352, 354–8
    by child, 352–4
    DNA and parental consent, 356–8
    emergencies, 350
    Gillick competence, 352–3, 373, 427, 644
    letting die, 358
    by non-parents, 352
    overruling the parent, 354–6
    parallel consent, 350–1
    and refusal, 349–50
    and research, 348–9
    16 and 17 year old, 348
    sterilisation, 354–5
    under 16 years, 351–7
  court proceedings and, 374–5
  criminal responsibility, 37
  and discipline, 370
  educating in hospital, 370–1
  foster placement negligent, 48–9
  health information disclosure, 205
  health and safety, liability for, 309–10
  National Service Frameworks, 371–3
  parental care and the nurse, 367–8
  and sexual abuse
    errors in identifying, 366–7
    liability of local authorities, 366
    mandatory reporting, 365–6
  teenage sexuality, 373–4
  as transplant recipients, 451–2
  Trusts, 371
claim form, civil action, 136
Clinical Negligence Scheme for Trusts, 151, 220, 222
clinical nurse specialist, 568, 656–7
clinical supervision, 662–3
clinic nurse, 643–4
Clothier Report, 123–4, 200, 488
Cobb, Kevin, 35
compensation
  brain damage at birth, 329
  contaminated transfusion, 448
  criminal injuries, 40–2, 45–6
  for harm, 61–4
  health and safety duty, breach, 333
  negligence, civil proceedings, 139–42
  quantum, 134, 142
  unplanned birth, disabilities, 432–3
  see also civil proceedings, negligence

complaints
detained patients, relating to, 719
handling, 707–8
Health Service Ombudsman, 714–15
Healthwatch England, 716
House of Commons Select Committee, 715
Independent Complaints Liaison Service (ICAS), 717
legal, 13
Local Healthwatch, 716–17
methods of, 705–7
NHS Constitution, 720
NICE and CQC, 718–19
Patient Advice and Liaison Services (PALS), 717–18
procedure, 709–14
review, 720–1
Secretary of State inquiries, 719
Wilson Report, 708–9, 718
complementary therapies
Complementary and Natural Healthcare Council, 795–8
definitions of, 790
House of Lords Select Committee, 794
liability for using at work, 791–2
NMC practitioner, 790–1
patients receiving, 792–4
regulation of, 794–5
community and primary care nurse
advice, giving, 632
Care Act 2014, 615–25
carers, 468–70, 474, 629–30
clinic nurse, 643–4
community matrons, 640
community professional, safety of, 633–5
compulsory removal, 637–8
consent to treatment, mental capacity, 636
criminal suspicion, 638–9
deferred payments, 624
delayed discharges, 509, 613, 627–9
developments in technology, 646–7
disclosure of information, 638
duty and instructions, clash, 631–2
equipment in, 624–5
funding of long-term care, 612–15
independent advocate, 624
NHS and social services provision, 608–12
patient, underage, 644
practice nurse, 645–6
protection of property, 637–8
scope of professional practice, 658–9, 738
school nurse, 641–3
specialist community public health nurse, 641
standard of care, 630–1
and violence, HSC guidance, 635
see also care homes, learning disability, mental capacity, mentally disordered
confidentiality
Caldicott Guardians, 206–7
disclosure and exceptions to duty of
access to health records, 197
consent of the patient, 192–4
under the Data Protection Act, 205
human rights, 18, 205
of information relating to a mentally incapacitated adult, 205
in the interests of the patient, 194
to parents, 205
in personal injury cases, 196
to the police, 201–4, 568–9
by police to employers, 204
to the press, 194, 568–9
in the public interest, 197–200, 326, 426–7, 568–9, 600, 699–70
to a registration body, 200–1
statutory duty to disclose, 197
and the terminally ill, 179
before trial, 196
duty of, 189–91
and genetics, 600
in genito-urinary medicine, 571–2
HIV/AIDS, 695–6
Human Fertilisation and Embryology Authority, 579–80, 591
legal professional privilege, 195–6
public interest immunity, 195
regulations on disclosure, 191–2
in research, 497
subpoena, 194–5
consent
after pre-medication, 446–7
basic principles, 157
in the community, 636–8
and covert administration of medicines, 737
no decision about me, without me, 179–80
discharging oneself, 164
implied, 160
information giving, prior to, 173–9
and the older person, 510–11, 513
refusal, mental capacity, 161–4, 446–7, 513, 636, 771
to research, 497–9
retrieval, storage and use of human gametes, 589–90
by transplant recipients, 451–2
valid, 157–8
by word of mouth, 159–60
in writing, 158–9, 447
see also abortion, children, death, mental capacity, mentally disordered, midwives, trespass to the person
coroner, 6, 775–6
Court of Protection, 172, 351, 373, 389, 470–3, 478, 545–6, 675, 678–9, 771
Cox, Dr Nigel, 33
crime and criminal acts
corporate manslaughter and corporate homicide, 34–5
defences to, 37–40
elements of, 32–3
medical practitioners, 35
offence of ill-treatment or wilful neglect, 36
wrongful administration of drug, 36
Criminal Injuries Compensation Authority, 40–2, 45–6, 323–5, 390, 569
criminal proceedings
arrest and prosecution of nurse, 6, 24–6
crown court, 6, 29–32
magistrates court, 6, 27–8
critical care services, review, 456–7

data protection
Access to Medical Reports Act 1988, 213
access to personal health records, 211–13
disclosure under, 205–6
DNA databases, 210–11
Freedom of Information Act 2000, 208–10
Health and Social Care Information Centre, 207
human rights, 187
manual files, 185
principles, 187–9
terminology, 186
see also confidentiality, health records
death and end of life care
assisted suicide, 18, 767–70
certification and registration of, 772–4
coroner, reporting to, 6, 775–6
Coroners and Justice Act overview, 782
cot death, 405
definition of, 757–8
disposal of the body, 775
end of life care, 755–7
exact time of death, 759–60
inquests, 776–9
letting die, 401–5, 453, 761
life-support, switching off, 162, 758, 760–2
living wills/advance decisions, 771–2
not for resuscitation, 763–4
post mortems, 775
property of the deceased, 782–3
relatives and patient close to death, 766–70
Shipman Inquiry, recommendations, 779–82
treatment, refused, 764–66, 764–66
wills, 783–4
delegation, 368, 654–5
Deprivation of Liberty Safeguards (DOLS)
application for, 465–6
persons covered by, 465, 512–14, 626, 636, 757
review and monitoring, 466–8, 557, 627, 719
Disclosure and Banning Service, 246
discrimination
age, 506–7
disability, 262, 267
Equality and Human Rights Commission, 261
equality legislation, 261, 264–7
harassment, 267–8
male midwives, 270
in the NHS, 270
positive, 268–9
race, 262–3
religion, 263
sex, 263–4, 329, 334
sexual orientation, 18, 262, 264
victimisation, 268
dismissal, unfair *see* employee

duty of care
breach of, 8, 51–6, 173–7
owed, 8, 46–7

educator, nurse
employment law, 491–2
good character, good health, 488
liability for instructing others, 490
post-registration education and practice, 289–90, 653
record-keeping by, 489
standards for, 288–9, 488
unsound practices and confidentiality, 490–91
embryo *see* human fertilisation, midwives
employee
in the course of employment, 78–82, 791
dismissal
constructive, 244, 256–7
professional conduct and competence, 254
unfair, 10, 248–9, 255–9
at fault, indemnity, 84–5
gagged to prevent disclosure, 91–3
injured, 320–2
part-time, 253–4
when pregnant, 248–51
public and private, 260–1
statutory rights, 247
see also discrimination
employer
accountability to, 9–10
direct liability, 83–4
duty of care for health and safety, 318–20, 333
health and safety duty to non-employees, 300–2
and inadequate resources, 87–9
surveillance by, 254
vicarious liability, 8, 77–8
employment, contract of
breach of, 244
changing, 243–4
content of, 241–2
formation of, 239
implied terms, 9–10, 84, 241–2, 318
interview terms binding, 240–1
pre-employment checks, 240
privity of, 244
statutory right to see, 243
employment law
Disclosure and Barring Service, 246
national minimum wage, 253
and the nurse educator, 491–2
protection of
children, 245
sex offenders, 245
vulnerable adults, 245–6
redundancy, 252
statutory sick pay, 252
trade union rights, 259–60
Working Time Directive, 252–3
see also discrimination
euthanasia, 358
evidence in court
by children, 375
cross-examination, 231–2
defamation, 233–4
expert witness, 231
fears of giving, 230
internet, 234
liability for references, 234
preparation for giving, 230
witness of fact, 231
see also record keeping, statements

Francis Report, 64, 77, 93, 124–6, 179, 339, 491, 801
female circumcision, 435–7

genetics
cloning, 600–1
and confidentiality, 600
gene therapy and diagnosis, 596–7
genetic tests and insurance cover, 599–600
gender selection, 597–8
identification and testing, 595
medication, personalised, 601, 746–7
screening and selection, 598–600
tissue typing for benefit of sibling, 596–7
genito-urinary medicine
confidentiality, 571–2
day surgery, 573–4
sexual health, 572–3
tracing, 572
Gillick-competence *see* children

harm, in negligence cases, 61–4
harassment
bullying, 335–6
legislation, 267–8
sexual, 334–5
of whistleblower, 92
health and safety
bullying, 335–6
children, liability for, 309–10
of the community professional, 633–5
consumer protection legislation, 311–14
Control of Substances Hazardous to Health, 317–18
corporate manslaughter and corporate homicide, 318
defective equipment, 320
duty of employer for, 318–20
the future, 338–9
general principles, 289–302
harassment, 334–5
injured employee, remedies in, 320–2
management of, 303
manual handling, 329–34
Medicines and Healthcare Products Regulatory Agency, 315–17
National Patient Safety Agency, 254, 305–7, 444, 731, 734
nurse in the community, 311
occupier's liability, 307–11
privatisation of cleaning and catering services, 309
prosecution of nurse, 300
regulations, 302–3
repetitive strain injury, 336–7
Reporting of Injuries, Diseases and Dangerous Occurrences, 305
risk assessment, 303–5, 325–6, 330, 333
single-use items, 317
smoking, 337
stress, 327–9
trespassers, 310–11
whistleblowers, 307
see also violence
Health Education England, 501–2
Health and Social Care Information Centre, 207, 224–5, 522, 722
health records
access to, 205, 210, 211
at common law, 213
correction of, 212
of deceased persons, 212–13
withholding information, 212
see also confidentiality, data protection
hepatitis C, 448–9, 693
hospital-acquired infection (HAI) *see* public health
human fertilisation
artificial insemination, 579–80
confidentiality, 591
conscientious objection to, 594–5
counselling and consent, 590
donors, anonymity of, 580–1
embryos, 587–9
human gametes, consent provisions, 589–90
in vitro fertilisation (IVF), 585–7
legislation, 577–8, 581–2
surrogacy, 591–4
tissue and cells, safety of, 581–4
see also genetics, midwives
Human Fertilisation and Embryology Authority
legislation, 587–91
selection of embryo, 356–7, 585
use and definition of embryo, 587
Human Rights Act 1998, 14–19, 238–9
see also Table of Statutes
Human Tissue Authority, 406

infectious diseases *see* public health
independent mental capacity advocate, 171, 463, 469, 546, 557
information
giving
in accident and emergency, 566
consent, prior to, 173–7
for non-therapeutic procedures, 177–8
patient and relatives' rights, 178–9
to patient, of negligence by colleague, 179–80
to the police, 201–4
to terminally ill, 178–9

Information Commission, 185–6
insurance
  car, in the course of employment, 642–3
  employer's liability for, 319
  genetic testing, 599–600
  professional indemnity, 49, 85–6, 290, 411

Jehovah's Witness, 163, 350, 351–2, 354, 357, 446
judicial review, 12–13

Kennedy Report, 93–4, 158–9

lasting power of attorney, 171–2, 525–6
law
  civil and criminal, 11–12
  family courts, 13
  judicial review, 12–13, 103
  language, 14
  legal personnel and legal complaints, 13–14
  sources, 10–11
  see also civil proceedings, criminal proceedings
learning disabilities
  abortion, 478
  the Bournewood case, 464–5
  care of adults at risk, 462–3
  carers, 468–70, 474, 629–30
  community homes, registration and inspection, 482
  Court of Protection, 351, 373, 389, 470–3, 478, 545–6, 675, 678–9, 771
  Deprivation of Liberty Safeguards (DOLS), 172–3, 465–8, 512–14
  direct payments, 478–81
  health care payments, 481–2
  legislation, 463
  premature deaths, 475
  property, 478
  restraint, 463–4
  safeguarding vulnerable adults policy, 475–6
  service provisions, crossing boundaries, 475
  sexual relations, 476
  sterilisation, 17, 160, 167–8, 355, 428, 430–1, 477–8
  White paper Valuing People, 473–4
  see also community and primary care nurse
Ledward, Dr Rodney, 124
legal aid, 150
letting die *see* death
liability
  direct, of employer, 83–4, 322
  for instructing others, 490
  no-fault, 8, 151
  professional, 441–2
  team, 71–3, 630
  vicarious, 8, 77–8
  see also negligence
living wills, 510, 546, 761, 771–2

magistrates court, 27–8
manual handling
  compensation, remedies for, 333
  enforcement of regulations, 331–2
  hoists, 331–2
  regulations, 330–3
  training in, 333–4
mediation, 134
medicines
  administration of, checklist, 727
  antibiotics, misprescribing, 736
  calculation errors, 730–1
  controlled drugs, 727–9
  in the community, refusal of, 634–6
  disguised in food and drink, 737
  general principles, 725–7
  group protocols, 739–40
  infusion therapy, 734
  injecting wrong site, 36
  liability, shared, 732–3
  management of errors or incidents, 731–6
  Medicines and Healthcare Products Regulatory Agency, 315–17, 513, 744, 795
  and the midwife, 396–7
  misuse of, 745–6
  in the NHS, availability, 747–8
  and older confused patient, 514
  and operating department practitioner, 737–8
  pharmacist, role, 743
  personalised, the future, 601, 746–7
  prescribing
    conflict, 729
    implications for scope of professional practice, 743
    by independent nurse, 741–2
    by nurse, 73, 397, 657, 738–9
    NMC guidance on, 742
    remote, 735
    supplementary, 742
  PNR, 733–4
  product liability of, 744
  safety of, 743–4
  self-administration by patient, 736–7
  sources of information, 729–30
  writing, illegible, 730
mental capacity
  amputation of healthy limbs, 167
  code of practice, 171
  and consent to treatment, 161–4, 498–9, 510
  Court of Protection and deputies, 172
  definition of, 164–6, 168–9
  Deprivation of Liberty Safeguards (DOLS), 172–3, 465–8, 512–14
  hunger strikes, 166
  independent mental capacity advocate, 171, 463, 469, 546, 557
  lasting power of attorney, 171–2, 525–6
  legislation, 463
  see also best interests, learning disabilities, trespass to the person
mentally disordered
  admission, compulsory, 535–9
  aftercare services, section 117, 548
  approved mental health professional, role of, 539–40
  Care Quality Commission, 554–5
  community treatment order, 548–52
  consent to treatment
    challenges to compulsory treatment, 544
    electroconvulsive therapy (ECT), 543
    for long-term detained patients, 542–3
    nurse, role, 544
    for physical illness, 545–6
    provisions, 542
    seclusion, 544–5
    short-term patients, 546
  definition of nearest relative, 539
  detention of an informal patient, compulsory, 535
  disclosure of confidential information, 205
  European Convention on Human Rights, 555
  failures in the community, 552
  guardianship, 547
  holding power of the nurse, 533–5
  informing the patient and relatives, 541–2
  leave, section 17, 547–8
  mental health strategy and priorities, 556–7
  National Service Frameworks, 555–6
  offence of ill-treatment or wilful neglect, 36
  patients, informal and detained, 531–3
  police powers, section 135(1), 136, 552–3
  role of managers, 553–4
  time limits for mental health review tribunals, 553
  treatment, refusal, 161–4, 446–7, 513, 636, 771
  see also best interests community and primary care, learning disabilities, mental capacity
midwives
  and AIDS, 407, 693–4
  breastfeeding, 395–6
  care, taking newly born into, 391–2
  in the community, 395
  consent
    to caesarean section, 161–2, 387–9
    criminal offence, 385
    home birth, 385–7
    mentally incapacitated woman, 389
    opposition to the midwife, 384–5
  cord blood collection, 396, 597
  cot deaths, 405
  and the doctor, 392–4, 422
  fetal tissue and the placenta, use of, 406
  human rights and birth, 411
  independent, 411
  male, 270
  management of, 409–10
  medicines, 396–7
  midwives rules and code of practice, 382–4
  Morecambe Bay Inquiry, 384, 411
  mother's liability for harm, 389–90
  national guidelines, 407–9
  nurseries in midwifery departments, 400

midwives (*continued*)
pre-birth injuries, 41, 390, 397–400, 432–3
record keeping, 406–7
registration of births and stillbirths, 405–6
special care baby units
care of grossly handicapped, 358, 401–3
withdrawal of care, disputes, 403–5
teenage mother, planning for the baby, 390
see also human fertilisation
misconduct, by nurse
in communication between practitioners, 393
criminal, 6–10, 13, 36, 283–4
and drugs, 24, 729, 733
false qualifications and records, 278, 383, 384, 733
information disclosure, 193–4, 290
in primary care, 659
sleeping on duty, 291
in theatre, lost swab, 441–2
under pressure, 456, 565–7
as volunteer, 49–50, 81
see also employee, negligence, NMC
MMR, dispute, 698–9
MRSA, 688

National Clinical Assessment Service, 254
National Health Service (NHS)
Care Quality Commission, 98, 116–19, 299–300, 393, 554–5, 688–9, 692, 719
charges, 289
Clinical Commissioning Groups, 108–10
clinical governance, 114–15
duty of quality, 115–6
Health and Social Care Act 2012, 99–102
Healthy NHS Board, 128
history of, 98–9
the mandate, 110
Monitor, 111–14, 719
NHS Commissioning Board, 98, 106–10
NHS Constitution, 126–7, 152, 181, 570, 720
NHS England, 306, 563–4
NHS Foundation Trusts, 111
NHS Improving Quality, 292–3
NHS inquiries, 123–6
NHS Litigation Authority, 85, 151, 220, 254, 306, 392
NHS 111 and walk-in clinics, 122–3, 562, 564–5, 660–1
NHS Redress Scheme, 8, 64, 151–2, 718
NHS Trust Development Authority, 114
nursing initiatives, 128
and the private sector, 128
statutory duties, enforcement of, 102–6
see also complaints
National Institute for Health and Care Excellence (NICE), 53, 119–21, 508, 519, 747
National Patient Safety Agency, 45, 254, 305–7, 444, 520, 731, 734
National Quality Board, 122–3
National Service Frameworks (NSF), 121–2
negligence
breach of duty of care, 8, 51–6
causation, 8, 56–60
in communication, 69, 173–7
contributory, 143–4
duty of care owed, 8, 46–7
foster child, placement, 48–9
harm, 8, 61–4
and inadequate resources, 87–9, 455–6, 502, 565, 732
by independent contractors, 82–3, 309
through inexperience, 69–71
misuse of medication, 731–2
nurse as manager, 75–7
standard of care, 50–6, 630
taking instructions: refusal to obey, 73–5
team liability, 71–3
in theatre, 441–3
in volunteering help, 49–50, 82
see also children, employee, liability
nurse
in the community, 311, 326
consultant, 655–6
as manager, 75–7
prescribing, 73, 397, 645, 657, 741–3, 738–9
and product liability, 312–14, 657
Nursing and Midwifery Council (NMC)
Conduct and Competence Committee, 7, 74, 254, 278, 281–8, 290, 519
constitution, 276–7
education and training, 288–9
establishment of, 267
fitness to practice, 290–1
Health Committee, 284–5, 290
Investigating Committee, 281–7, 290
Post-registration education and practice, 289–90, 493
professional standards and codes of practice, 288, 652–3
public involvement, 292
registration and removal, 278–9
restoration to the register, 287–8
screeners and practice committees, 280
no win, no fee, 150

Office of Public Guardian, 172
older people
abuse of, 522–5
bad practice, examples, 512
consent to treatment, 510–11
continuing care of, 520–1
control at night, 513
daily care, 513–14
decision making for, 525
dementia, 515–18
force, restraint and assault, 511–14
intermediate care, 509
lasting powers of attorney, 525–6
medication and the confused, 514–15
National Service Framework for, 507–9
pressure ulcers, 520
restless patients, 512–13
rights to care, 506–7
risk management, 521–2
standard of care, 519–21
winter crises, 520
see also Court of Protection, Deprivation of Liberty Safeguards
organ transplantation
and children, 356–7, 451–2
donors, encouraging, 453–4
legislation, 455
liability arising from, 453
from living donors, 450–1
from mentally incapacitated persons, 452
retention of organs, 454–5
ventilating the patient, 450
outpatient department
patient identification, 570–1
waiting, excessive, 569–70

palliative care nurse, 755–7
see also death
persistent vegetative state (PVS), 15, 162–3, 761–2
post-traumatic stress, 60–4
practice nurse, 645–6
Professional Standards Authority for Health and Social Care, 288, 291–2
property
in the community, protection of, 638
Court of Protection, 678–9
of the deceased, 782–3
direct payments, 478–81
exclusion of liability, 673–4
gifts, 681–2
of the mentally incompetent, 674–5
and money, care of, 676–7
patients, returning, 679–80
power of attorney, 677–8
principles of liability, 672–3
relatives, grasping, 679
staff, 680–1
public health
AIDS/HIV, 693–6
blood donors, 699
confidentiality, 699–700
cross-infection control, 688–9
hepatitis, 693
legislation, 685–6
legislative powers, 690–1
notifiable diseases, 686–8
Public Health England, 691–2
tuberculosis (TB), 692–3
vaccination, 696–9

record keeping
audit, 222
common errors in, 221–2
computerised records, 223–4
and court, use in, 223

record keeping (*continued*)
and dismissal, unfair, 256
essence of care, DOH, 220
general principles, 219–20
Health and Social Care Information Centre, 224–5
maintaining high standards in, 223
mistakes, 222
NMC guidance, 220
by teachers, 489
registration, professional *see* NMC
repetitive strain injury (RSI), 336–7
research
confidentiality, 497
consent to, 497–9
control of, 494–5
ethics committees, 495–6, 596
fraud in, 500
health and safety in, 500
Health Education England, 501–2
legal aspects of, 492–4
liability for volunteers in, 499–500
local education and training boards, 502
publication and libel, 500–1
resources, inadequate, 86–9, 455–6, 502, 565, 732
restraint, 465–8, 511–14
risk assessment and management
principles, 303–5
training in, 333–4

school nurse, 641–3
scope of professional practice
agency nurses, 663
basic principles, 662
clinical nurse specialists, 656–7
clinical supervision, 662–3
consultants, nurse, 655–6
delegation and supervision, 654–5
in emergency nursing, 660
healthcare support workers, 663–4
modern matrons, 661–2
NHS 111 and walk-in clinics, 660–1
practitioner's concerns, 657–8
in primary care, 658–9
professional guidelines, 652–4
in theatre nursing, 659
see also medicine
self-defence, 325
Shipman Inquiry, 6, 35, 124, 179, 779–82
smoking, 337
specialist community public health nurse, 641
staffing *see* resources
standard of care
approved practice, 50–2, 288
balancing the risks, 56
keeping up to date, 55–6
and older people, 519–21
policies, guidelines and benchmarks, 52–5, 292–3
Professional Standards Authority of Health Care Professionals, 291–2
reasonable foreseeability, 55
see also negligence
statements
criminal implications, 225–6
as evidence, 226–7
principles, 227–30
purpose and guidance, 227
see also evidence in court
sterilisation
and best interests of child, 355
of mentally incapacitated adult, 17, 160, 167–8, 428–9
of minor with learning disabilities, 430–1, 477–8
private health care, 434
rights of the spouse, 434–5
risk of pregnancy, failure to warn, 433–4
unplanned baby with disabilities, 432–3
unsuccessful, 177–8, 431–3
stress, 327–9
subpoena, 194–5, 232
suicide, assisted, 18, 767–70
surrogacy *see* human fertilisation

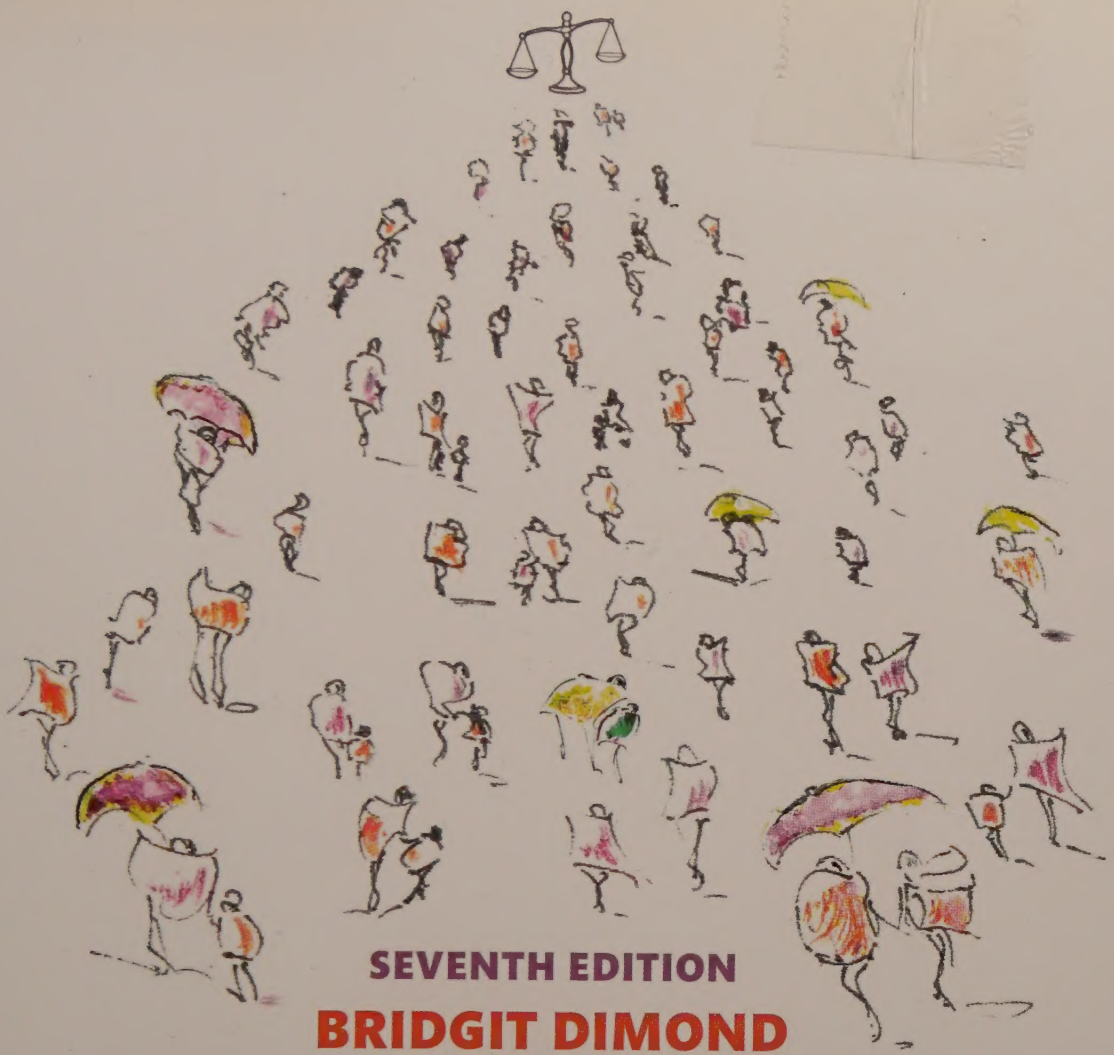
theatre nurse
accidents in theatre, 444–5
consent, after pre-medication, 446–7
inquest, witness at, 779
policies and practice, 442–3
professional liability, 441–2
in recovery room, 447
scope of professional practice, 443–4, 659–60
transfusions and blood contamination, 448–9
therapeutic privilege, 173–4, 178–9
trespass to the person
consent, 157
defences to action for
Jehovah's witness, 446–7
patient lacking mental capacity, 167, 513
unconscious patient, 167–8
see also mental capacity, mentally disordered
tuberculosis (TB), 692–3

unconscious patient, 160, 167–8, 171, 350, 672, 680

violence
in A and E, 569
domestic, 326
health and safety, 322–7
HSC guidance, 635
remedies following, 323
self-defence, 325
suing the employer, 324–7
zero tolerance of, 323
voluntary assumption of risk, 145–6, 308, 324, 500
volunteer
negligence by, 49–50, 82
nurse, 4
vulnerable adults, protection of, 245–6

waiting, excessive, 569–70, 562–4
whistleblowing
gagging of employee, 91–3
by nurse lecturer, 490–1
public interest disclosure, 90–1, 307
unfair dismissal, 256–7
witness
expert, 137, 230, 231, 359
of fact, 30–1, 137, 230, 231
nurse as, 138
see also evidence in court
writ *see* claim form

x-ray, 660



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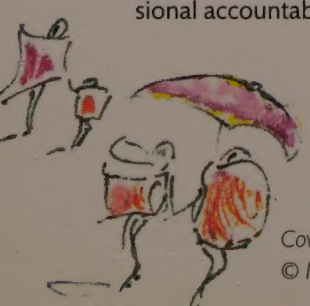
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