health law newsletter

September 2015

Birmingham I Exeter I London I Manchester I Nottingham
0370 270 6000
www.bjhealthlawyers.com

brownejacobson
health lawyers

health law newsletter - September 2015

index

talk to us...

Simon Tait | 0115 976 6559 | simon.tait@brownejacobson.com
Oliver Pritchard | 0115 976 6292 | oliver.pritchard@brownejacobson.com

...but no right to be killed

The European Court of Human Rights has again upheld the English Law on assisted dying, in Nicklinson and Lamb v the United Kingdom.

Summary

The European Court of Human Rights (ECtHR) has confirmed that the UK's ban on assisted suicide is compatible with the right to a private life under Article 8 of the European Convention on Human Rights. Article 8 is a qualified right affording member states a "margin of appreciation" within which it can determine its own laws on socially and morally sensitive matters. Whilst the Assisted Dying Bill proceeds slowly through parliament, future prosecutions for assisting suicide, under s2(1) of the Suicide Act 1961, will continue subject to guidance published by the Director of Public Prosecutions ('DPP') although many grey areas remain.

Proceedings

Committing suicide used to be a crime until the Suicide Act 1961 ('the Act'), but s2(1) of the Act still prohibits the aiding, abetting, counseling or procurement of the suicide (or an attempt to commit suicide) by another person, and carries a maximum penalty of fourteen years imprisonment.

There has been a string of high profile, tragic cases in which individuals who needed assistance from loved ones to end their own lives fought to guarantee they would not face prosecution.

In 2002, the ECtHR concluded that Diane Pretty did not have a 'right to die' and the Act's ban on assisting suicide was lawful as such a matter fell within the margin of appreciation granted to member states to deal with social and ethically sensitive matters.

In 2009, following an application by Debbie Purdy, the House of Lords ruled that the Director of Public Prosecutions ('DPP') should give clearer guidance on the circumstances in which a prosecution for assisting suicide would be brought. The DPP published its policy in 2010 (revised in October 2014) setting out those factors it will consider when determining whether to pursue a prosecution under the Act or not.

In November 2011, Tony Nicklinson, who suffered locked in syndrome after a stroke, started proceedings arguing that his own consent should be available as a defence to the Act. Tragically, when he lost in the High Court in 2012 he refused all nutrition, fluids and medical treatment and died from pneumonia on 22 August 2012. Since then, his wife has continued to challenge s2(1) of the Suicide Act as, she says, incompatible with human rights and Article 8 in particular.

Though she lost the case in the Court of Appeal, there was some encouragement in the Supreme Court in June 2014 the Supreme Court, who ruled unanimously that it had jurisdiction to determine whether s2(1) of the Suicide Act 1961 was incompatible with the Article 8, even though it should be much better if this issue were tackled by Parliament. The majority of the Supreme Court indicated the incompatibility of the Act with Article 8 and called on Parliament to consider whether the ban is necessary and proportionate in cases such as Mr Nicklinson, and the associated case of Mr Paul Lamb.

In December 2014, Mrs Nicklinson took the case on to the ECtHR, as her very last legal resort, complaining that despite the UK courts recognizing their jurisdiction to examine the compatibility of the Act with Article 8, they had failed to do so. Mr Lamb also complained to the ECtHR on similar grounds. Both cases were rejected by the ECtHR:

1. The margin of appreciation meant the UK Parliament was entitled to consider the risks and likelihood of abuse should the defence of voluntary euthanasia be available;
2. Article 8 did not impose a procedural obligation on domestic courts to examine the merits of a challenge to primary legislation; and
3. In any event, Mrs Nicklinson's complaint has been appropriately addressed by the Supreme Court previously in the matter of Pretty. There had been no relevant developments since Pretty and an appropriate balancing exercise had been undertaken by the Supreme Court, which was entitled to heavily weigh in the balance the views of Parliament regarding the risks and likelihood of abuse should such a defence be available.

The compatibility of the Act with Article 8 may yet be reconsidered by the Supreme Court in another case, and no doubt the pressure to do so will increase over time, the longer that Parliament does not address the issue, but for now this is the end of the road for this legal challenge.

So where does this leave us?

Assisting suicide remains illegal in the UK and is expressly reflected within the regulatory framework of healthcare professionals – see for example the GMC guidance.

Though prosecution will have to be considered on a case by case basis, the DPP's policy offers some guidance, identifying factors to be taken into account, including:

- The age of the deceased (over 18 years old), their mental capacity and whether they had made a voluntary, clear, settled and informed decision to commit suicide;
- Whether the person could undertake the act themselves;

- The relationship between the deceased and the suspect, and whether they had provided assistance to more than one person who were not known to each other;
- Whether assistance was motivated entirely by compassion (and not, for example, in return for payment or by someone with a history of violence), and provided reluctantly in the face of the determined wish of the deceased to commit suicide;
- Whether the assistance was minor and provided by a person who had sought to dissuade the deceased from their intended course of action;
- Assistance was provided by the management or an employee of an organisation or group, the purpose of which is to provide an environment in which suicide may take place; and
- The person providing assistance reports the death to the police and fully co-operates with their investigation, including the role they played in the deceased's death.

In October 2014, the DPP confirmed that where a healthcare professional is facing prosecution, it will consider whether they acted in their professional capacity and whether there was an existing relationship of care between them such that there is a risk that undue influence was exerted over the deceased to commit suicide. This means prosecutors may distinguish circumstances where a clinician is assisting as a friend (rather than in their professional capacity) or where they do not have a pre-existing relationship with the deceased.

Some grey areas remain, however. For example, what counts as 'assistance'? How proximate must the assistance be to the death? Must the "assistant" have reasonably known for what purpose assistance was being given?

No doubt the DPP's guidance will continue to evolve over time. But as the Supreme Court noted, it would be much better to get clear legislation from Parliament, though it seems optimistic.

In the meantime, the clear advice for any clinician concerned about getting involved in such a situation is to immediately raise their concerns and seek legal advice.

talk to us...
Claire Morris | 0161 300 8034 | claire.morris@brownejacobson.com
Ben Troke | 0115 976 6263 | ben.troke@brownejacobson.com

Do the Agency Workers Regulations 2010 (the Regulations) and Articles 5 and 6 of the Temporary Agency Worker Directive (2008/14/EC) (the Directive) require agency workers to be given the same opportunities to apply for vacancies as existing 'at risk' permanent employees placed within a redeployment pool?

A recent Employment Appeal Tribunal case has examined the rights granted by both the regulations and the directive and concluded that they do not.

Mr Coles -v- Ministry of Defence UKEAT/0403/14/RN

The claimant was an agency worker engaged to provide services relating to estates management for RAF service personnel and service families' domestic accommodation for the Defence Housing Executive (in effect, the Ministry of Defence). In 2013, the DHE undertook a substantial restructure and 530 employees were placed into a redeployment pool as a result. Those employees were to be given priority consideration for vacancies in the Ministry of Defence at their existing grade (under what is known as Stage 1 of the National Vacancy Filling Scheme).

A post of Service Family Accommodation Estate Manager was advertised. This was, in effect, the post that the claimant had been filling. This advertisement would have been visible to any internal candidate, including the claimant, had he chosen to look for it.

The claimant did not apply. Another employee from the redeployment pool did apply and was appointed under Stage 1. A consequence of her appointment was that DHE no longer had need for the claimant's services and he was given notice.

The claimant brought a claim under both the regulations and the directive, arguing that the Ministry had failed to allow him access to details of the vacancy of his position and had denied him the opportunity to apply for his position.

What rights are protected?

The EAT considered the extent to which agency workers were entitled to equal treatment. It concluded that, under the directive, this was limited to working hours and pay; there was no general right for a temporary agency worker to be treated no less favourably than a direct employee.

The parties in this case sought to compare the directive to the directive concerning fixed term work. However, the EAT held that rights conveyed by the directive relating to fixed term work (and hence the Fixed-Term Employees (Prevention of Less Favourable Treatment) Regulations 2002) were of an entirely different character – they conferred a general right not to be treated in a less favourable manner simply because the person concerned is a fixed-term worker and therefore included a much broader concept of equal treatment than under the directive or regulations.

The claimant argued that the right to have information about vacancies required corresponding rights to apply for those vacancies and to have any such applications considered on an equal footing with those of permanent employees. The EAT disagreed. Equal provision of information was what was stressed by the Directive and Regulations, rather than equality in the job application process. The right to information was a meaningful right in itself but this was limited to ensuring that information was provided to agency workers in as useful a form and at as convenient a time as it was to employees within the organisation.

"The purpose of the Directive is to give temporary agency workers the same chance as other workers in the undertaking of the end user to find permanent employment with that end user. It has nothing to say about the terms upon which there should be recruitment for any post. If an employer wishes to give preference to those being redeployed, perhaps to satisfy his obligations to them as his permanent employees, he is entitled to do so, and will not in doing so break any duty imposed by the Regulations or the Directive."

(The Honourable Mr Justice Langstaff)

Is a comparator required?

The Regulations provide that agency workers must be given the same opportunity as a 'comparable worker' to find permanent employment with the organisation. The test for assessing comparability is whether the individuals are engaged in the 'same or broadly similar work' (and not whether they have the same or broadly similar qualifications and skills). However, it is worth noting that under the Directive, there is not so clearly a requirement for a comparison – the Directive refers to agency workers being informed of any vacant posts to give them the same opportunity as 'other workers'.

As the Directive is directly effective against emanations of the state, public authorities should ensure that equal information is given to all employees and workers, including agency workers.

talk to us...

Sarah Hooton | 0115 976 6033 | sarah.hooton@brownejacobson.com

The Chief Coroner published his annual report to the Lord Chancellor on 16 July 2015. The report reflects upon the Coroners and Justice Act 2009 Act which came into force on 25 July 2013 and the Coroner (Investigations) Regulations 2013, the Coroners (Inquests) Rules 2013 and the Coroners Allowances, Fees and Expenses Regulations 2013.

We have provided a summary of this report below:

1 The aims of the coronial reforms

- place the family at the heart of the coronial process
- achieve consistency between coroners and coroner's areas by implementing national standards across a local service
- reduce the delay in hearing Inquests and reduce the backlog of historical cases
- implement an open, fair and transparent method of appointing coroners.

2 Key changes to the coronial system

- the Coroners Guidance No. 16 has confirmed that those individuals who are subject to a Deprivation of Liberty Safeguards (DoLS) authorisation should be treated as having died 'in state detention' and must be investigated by an Inquest. DoLS applications within the Coroner's court have increased from 11,300 for the year 2013-2014, to 83,100, for the first three quarters of 2014-2015
- Rule 8 requires Coroners to complete inquests within six months of the date on which the coroner is made aware of the death 'or as soon as reasonably practicable after that date'. The Chief Coroner must be notified of older cases which have not been completed within 12 months, the reason for the delay and any remedial action which is being taken
- investigative powers have successfully reduced the requirement to hold an inquest, as investigations can be discontinued where the cause of death has been revealed by a post-mortem examination
- it is no longer mandatory to hold an inquest with a jury when there has been a death in prison. This predominantly includes cases of natural causes, but is not exclusive
- now under the 2009 Act all coroners are appointed by the local authority. Previously coroners were appointed with freehold tenure for life. Now newly appointed coroners must now retire at the age of 70. No appointment may be made by a local authority without the consent of the Chief Coroner (and Lord Chancellor) (section 23, Schedule 3).

3 Successes of the Coronial Reforms

- the number of cases which have not been completed within 12 months has fallen by 45%
- implementation of compulsory training for all coroners

- issuing national guidance to achieve consistency
- 97 coronial areas have been reduced to around 75 jurisdictions upon merging.

4 Recommendations for change

- Section 13 of the Coroners Act 1988 currently allows the High Court, on an application brought with the permission of the Attorney General, to quash an inquest and order a fresh one, where it is necessary or desirable in the interests of justice to do so (irregularity of proceedings, insufficiency of inquiry or submission of fresh evidence). As some cases only require a change to the record of the inquest and do not call for a fresh inquest, an amendment to this section is proposed
- To allow the investigation of deaths at sea by the coroner, in the absence of a body, even if the death may not have occurred 'in or near the Coroner's area'. The amendment will allow a coroner to investigate if the death, or suspected death, occurred outside the State where there is 'a close connection to the coroner's area'.
- At present section 4 of the 2009 Act limits discontinuance of a coroner investigation to cases where the cause of death has been revealed by a post-mortem examination. This provision could be extended to 'material' which reveals the cause of death without a post-mortem examination and there is no other good reason to continue the investigation. 'Material other than from a post-mortem examination' may come to light and persuade the coroner of the cause of death. For example, medical records not previously available or not known about, for example, could lead a coroner to discontinue an investigation.

talk to us...

Imogen Hamblin | 0115 934 2031 | imogen.hamblin@brownejacobson.com

Summary Care Records (SCRs) containing patients' sensitive personal data will be sent to all pharmacies this autumn.

Health minister, Alistair Blunt announced a national rollout of the scheme, following an evaluation of pilots in 140 pharmacies. Pharmacists involved in the pilots gave it their backing.

SCRs are an electronic patient summary held on all patients by the NHS, unless they specifically opt-out. Current data shows SCRs are held by the Health & Social Care Information Centre on 96% of patients in England. Information within SCRs includes medication prescribed over the last 6-12 months, personal information, patient diagnoses and patients' preferences. Information is added by the patient's GP.

Pharmacists will have to ask patients for 'permission to view' from the patient the SCR before any encounter.

The Health and Social Care Information Centre (HSCIC), the national provider of information, data and IT systems for health and social care has been commissioned by NHS England to lead on the implementation of SCRs into community pharmacies.

HSCIC confirm the pilot showed using SCRs in pharmacies very beneficial. It allowed patients to be treated more efficiently and effectively by reducing the need to contact their GP and providing information normally unobtainable after work hours. Other benefits include:

- improving patient safety by ensuring the patient gets the right medicines
- improving efficiency by reducing the number of phone calls and reducing the time spent waiting on a call
- improving effectiveness by supporting clinically appropriate calls to GPs
- improving the patients experience by reducing patient waiting time for queries to be resolved, and resolving them at the point where they are presenting for care.

Privacy campaigners are concerned the scheme could leave the public exposed to heavy marketing tactics from firms with inside knowledge about their health. Whilst the law is unlikely to permit this, this is a fear privacy campaigners have. To counter the criticism, NHS England released a press statement confirming "If a pharmacy professional shared confidential patient information for any purpose other than direct care, they can be held liable in law and held to account by the General Pharmaceutical Council, which has the legal

authority to apply sanctions, up to including withdrawal of their licence to practice." Breaches of the Data Protection Act 1998 (which regulates the processing of personal data) can result in enforcement action including the levying of a fine (these are called Civil Monetary Penalties) of up to £500,000 and civil claims for compensation. This in itself should act as a strong deterrent to using information for alternative purposes.

Importantly, technical safeguards have been put in place to ensure appropriate accessing of patients' sensitive personal data. In order to access information pharmacists need a smartcard, along with the specific SCR role assigned to it. Further they need to be on the N3 network and able to access the NHS spine web-portal. Further information can be found on the Health & Social Care Information Centre website.

Additional controls are in place to monitor and audit access. Pharmacies must have clear robust Standard Operating Procedures in place as part of their approach to Information Governance. Patients can request to see who has accessed their SCR at any time. Any inappropriate access will be investigated and escalated accordingly.

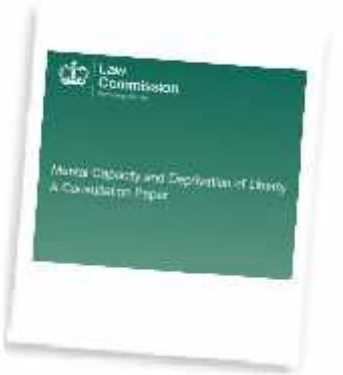
The project's completion date is expected to be autumn 2017. Whilst there remains some concerns regarding the use of patient sensitive information for marketing this appears to mitigated, and is far outweighed by the potential benefits to patient care and community services.

talk to us...

Lorna Shastri-Hurst | 0121 237 4588 | lorna.shastri-hurst@brownejacobson.com
Ros Foster | 020 7337 1015 | ros.foster@brownejacobson.com
Helena Wootton | 0115 976 6108| helena.wootton@brownejacobson.com

the Law Commission proposals for deprivation of liberty

The issue of deprivation of liberty ("DOL") has risked bringing the law into disrepute over the last few years, as a result of its complexity, ambiguity and, some would say (post Cheshire West), impracticality.



The Law Commission has been asked by the Government to review the whole issue, including both the Deprivation of Liberty Safeguards and DOL in the community, which can currently only be authorised by an application to the Court of Protection. Their consultation paper, published on 7 July 2015, is open for response to 2 November 2015.

At more than 200 pages, the consultation is a wide ranging and ambitious document, and its scope goes far beyond the narrow issues of Article 5 (the right to liberty) of the ECHR, and into rights to family life (Article 8), as well as supported decision making / care planning much more widely.

Headlines

- **The Law Commission will not attempt to redefine a DOL**, deferring instead to the Supreme Court. The *Cheshire West* "acid test" ("continuous supervision and control and not free to leave") will hold sway for the foreseeable future. This means that those who are currently regarded as DOL will remain so under the Law Commission proposals, and a proper legal process / authorisation is still required for each patient / service user to meet their Article 5 rights.
- But the Law Commission deliberately takes **a broader view**, and proposes a system which is **as much concerned with Article 8 rights** to family life. It feels that the line between "DOL" and "not DOL" has acquired too much significance, and carries more weight than it can bear, blurry as it sometimes is, if it makes the difference (in theory at least) between enormous levels of scrutiny (through DOLS or the Court of Protection) on one side of the line and, on the other, nothing. The Law Commission seems to intend to level off that disparity, by identifying a much wider pool of people who should be of concern and require some level of safeguards, though they may fall short of being DOL, even with the line drawn in *Cheshire West*.
- As such, **a tiered system is proposed, with proportionate safeguards** according to the extent of the restrictions, and **tailored to the particular setting**. The apparent complexity of the system (which will no doubt provoke much debate) is inevitable with any move away from the "one size fits all" of the Deprivation of Liberty Safeguards to a more nuanced approach.

- The overall system will be known as "**Protective Care**" – reflecting an acceptance that the terminology of "deprivation of liberty" has not been helpful – and contains a number of different, self contained schemes, set out in a little more detail below, but in outline:-

    - "**Supportive Care**" – a "protective outer layer" to the system (para 5.9), drawn much more widely than "DOL", and intended to extend some additional protection (mainly by way of additional advocacy and emphasis on care planning) for those in care homes, supported living or shared lives (not a family home) who lack capacity to decide on care / accommodation. It is especially aimed to ensure that care plans do not progress to become a DOL unless absolutely unavoidable (chapter 6).
    - "**Restrictive Care and Treatment**" – is the closest equivalent to the current DOLS scheme, and is intended to be Article 5 compliant, but is deliberately defined more widely than the *Cheshire West* acid test (see below) to ensure that it covers more people, across care homes, supported living and shared lives (and, in some circumstances, a family home). Again, the safeguards mainly consist of increased access to advocacy, and independent scrutiny of the care planning, which will be the responsibility of a BIA (rather than the local authority), with their role beefed up and rebadged as "Approved Mental Capacity Professionals" ("AMCP"), bringing them into line with AMHPs under the MHA (chapter 7).
    - A separate "**Hospital Scheme**" will apply for a DOL in Hospital (and, where appropriate, in palliative care) with a doctor able to authorise a DOL of up to 28 days, with certain safeguards, before referral to an AMCP, in line with the wider Restrictive Care and Treatment scheme (chapter 8).
    - Overall, huge emphasis is put on the value of **advocacy** (chapter 9), and the role of the **BIA (now "AMCP")**, though it will be the responsibility of the local authority to ensure that these are fully available to P. With DOLs across all settings authorised, effectively, by an AMCP, there will be a right of appeal / review to a (new) **Tribunal** and then, ultimately, to the Court of Protection. Routine cases of DOL in the community would no longer always need Court applications, therefore, but to make the appeals "meaningful", the Law Commission propose that a local authority should be required to refer Restrictive Care and Treatment cases to the Tribunal automatically, if there has been no appeal within a particular period (chapter 11).

Supportive Care – the "protective outer layer"

- Applies to everywhere except Hospitals and the family home (ie care homes, supported living and shared lives).
- Is "intended to provide suitable protection for those people who are in a vulnerable position, but not yet subject to restrictive forms of care and treatment (including DOL), in other words… a preventative set of safeguards…" (par 6.2)
- Would apply to a person who lacks capacity and is moving into the relevant accommodation or someone in such accommodation who subsequently loses capacity.

- The safeguards would be (para 6.46):-

    - The local authority must "keep under review the person's health and care arrangements, and whether a referral to the restrictive care and treatment scheme is required"
    - Care plans must include a record of capacity and best interests and any restrictions imposed (including confirmation that they are in P's best interests)
    - The local authority would have discretion to appoint an AMCP to oversee the case
    - An advocate or an appropriate person must be appointed, who would be responsible for ensuring that P has access to the reviews or appeals process (to the Tribunal or the Court).

- Where pressure is brought to bear on resource allocation, as a result of the advocacy on P's behalf for less restrictive care, the Law Commission recognises that "best interests" cannot secure preferential treatment as against someone who has capacity, but expects that "the division between care planning (which is not, broadly speaking a best interests process) and decisions taken on behalf of an adult in the context of care delivery (which is a best interests process) will need to be more carefully delineated" (para 6.60).

Restrictive Care and Treatment – the new (wider) DOLS

- Should apply to those who lack decision making capacity as a result of a disturbance or impairment in the functioning of the mind or brain (ie in line with the MCA, rather than the MHA, as DOLS was).
- Should include (but not be limited to) cases where ANY of the following apply (para 7.31):

    - P is under continuous or complete control OR P is not free to leave
    - P is not allowed to leave the premises unaccompanied, or is not physically able to without assistance
    - Barriers are used to limit P's access to parts of the premises
    - P's actions are controlled by physical force, restraint or medication, other than in emergencies
    - P objects to care or treatment (verbally or physically)
    - Significant restrictions are in place on P's diet, clothing, access to the community or contact with relatives, carers or friends (other than generally applicable rules eg about visiting hours).

- In addition to the protection of the Supportive Care scheme, meeting the criteria for Restrictive Care and Treatment will mean that an AMCP should have overall responsibility for the case, arranging assessments, whether independently or by those already involved in P's care. The AMCP will have direct responsibility for the decision whether to authorise the Restrictive Care and Treatment, including a DOL where this is explicitly justified by the care plan (para 6.168), with objective medical expertise, for up to 12 months, as well as power to make recommendations or impose conditions.
- After authorisation, a different AMCP would be allocated to keep the case under ongoing review.

- The local authority's role as supervisory body under DOLS is effectively taken over by the AMCP decision making, but the local authority does still have responsibility to ensure that the AMCP, and appropriate advocacy support, is properly appointed.
- P has a right to appeal to a First Tier Tribunal, and then to an Upper Tribunal or to the Court of Protection, with the local authority required to make automatic referrals to the Tribunal periodically in any event.
- In urgent cases, the AMCP can authorise Restrictive Care and Treatment (including a DOL) for up to 7 days, which can be extended one for up to another 7 days (para 6.202). The Law Commission felt that the enabling of care providers to self-authorise is "one of the least satisfactory elements of the DOLS", so while Hospitals still effectively have this power for 28 days (see below) it appears that care homes etc will be wholly dependent on an AMCP.

Deprivation of Liberty in a family home

- The Law Commission recognise the possibility of a DOL in a family home, and so some form of scheme is required to scrutinise and authorise this, controversial as this may be.
- The Law Commission propose the same safeguards as under Restrictive Care and Treatment above – ie with the onus very much on the AMCP appointed by the local authority – but this should only be triggered in a domestic setting by the existence of a DOL, rather than the deliberately wider non exhaustive list of factors for other settings set out above.
- For this reason, the case law and disputes over where to draw the line to define a DOL and how to apply this in a family home will not disappear under the Law Commission proposals.

Hospital Scheme

- In hospitals (and in palliative care) shorter admissions, typically, justify a proportionate approach to the authorisation of any DOL – though the Law Commission is loud and clear that the Cheshire West acid test applies equally there (including in Intensive Care) as anywhere else (para 8.11-8.12).
- The Law Commission endorses the advice in the recent Law Society Guidance that immediate provision of life sustaining treatment in an emergency will not be considered a DOL, but following the initial emergency the risk of a DOL increases (para 8.19).
- Where there is "an immediate need for a DOL" to provide care or treatment, and this is proportionate and in P's best interests, a doctor can authorise a DOL for up to 28 days (para 8.24).
- With strong echoes of the MHA system, hospital managers would then appoint a person as the "Responsible Clinician" (RC) and notify the local authority, to put them on notice of the possible need for an AMCP after 28 days.
- The RC would ensure that an appropriate, written care plan was in place, after appropriate consultation with P / others, that an advocate or appropriate person is appointed for P, and would continue to review whether P still meets the criteria throughout the period authorised.

- After the initial 28 days, further DOL (for up to 12 months) can only be authorised by an AMCP, during which time responsibility continues to rest with the RC while P is an in patient.
- An application to the Court of Protection can be made to review the case.

Other Issues

The Law Commission also proposes that:

- All the "Protective Care" schemes would extend to **16-18 year olds**, extinguishing the anomaly in age between DOLS and the MCA (para 15.11).
- Greater investment should be made in "**supported decision-making**" – including appointment of a "supporter" in appropriate cases, as well as an advocate (chapter 12), alongside much more use where possible of **advanced decision making** (chapter 13).
- The "**best interests" checklist** under MCA s4 should be amended to ensure that P's wishes and feelings are given priority and respected wherever possible (para 12.47).
- The uncertain interface between **DOLS and the Mental Health Act** is to be addressed by proposed amendments to the MHA to provide for care to patients who lack capacity but do not necessarily fall within the compulsory detention powers (chapter 10).
- The CQC would continue to have responsibility for monitoring the use of the laws on DOL, as they currently have for DOLS (but with the potential for restrictive Care and Treatment to be authorised in a family home by an AMCP, this will extend the CQC's remit to a domestic setting, and may be controversial) (chapter 14).
- The law should be changed so that the vast majority of deaths under a "Restrictive Care and Treatment" authorisation would be excluded from the need for an **Inquest** (para 15.63).
- It "seems unfair", they say, that someone who lacks capacity who is being deprived of liberty by the state is also charged for that accommodation, particularly where the decision to place them in that accommodation is made by the state, but the Law Commission stops short of a concrete proposal to make all such care free of charge, given the resource implications! (para 15.71).

Funding and Resources

This raises one of the obvious questions about the proposals – funding and resources. BIAs are already a fairly scarce and precious resource in the Post Cheshire world and their enhanced role (as AMCP) is absolutely central to the much wider schemes under the banner of Protective Care. With the law of supply and demand, it seems likely to be a good time to be in business as a BIA / AMCP (or a supplier of BIA / AMCP training).

There is a similar point about the huge weight put on vastly extending advocacy support to P, which is already sometimes difficult to secure under the current system.

As well, there will be the need to establish and maintain the new Tribunal system envisaged, though the extent to which this might have a costs benefit for the Court of Protection is unclear.
In the big picture, of course, implementation of any reforms with significant resource implications is going to depend on support from the Treasury, as much as from other parts of government or the consultees across the health and social care system. The Impact Assessment, published some time later on 11 August 2015, puts the cost of implementation of the Law Commission's proposals at around £1.8 billion over 10 years (but needs to be seen in context, as it calculates the cost of fully funding the current system to do what is now required of it at £11.8 billion!)"

What next?

Following Government intervention, the timeline for publication of draft legislation has been brought forward to "the end of 2016", but even with full and prompt support from the powers that be it is unlikely to be implemented until 2018.

Even then, it is clear that the Law Commission will not make the "post Cheshire" problems go away – the definition of DOL will not be curtailed, and if anything the schemes they propose to ensure lawful authorisation of DOL go far beyond the current approach and aim to offer supportive intervention to a much wider group of people.

The details are a little sketchy at the moment on the process and evidence that will be required for authorisation of a DOL under the Restrictive Care and Treatment Scheme (or the Hospital Scheme after the initial 28 days). But there is no reason to think that the obviously relevant evidence (lack of relevant capacity, the care plan being a DOL, imputable to the state, no less restrictive options and being in P's interests, assessed after proper consultation with P and others) is going to change.

Of course, much of this is about good practice and appropriate care planning, and should be happening regardless of the new proposals for independent scrutiny.

What now?

The Law Commission consultation is open until **2 November 2015**.

We will be preparing a response to the Consultation based on what our clients and contacts all over the country are telling us, and if you would like to tell us what you think, or share your Consultation response, we would be delighted to hear from you.

In the meantime, there is **no basis whatsoever to await reform of the law as a reason for inaction on the cases of people who are currently DOL**. In care homes and hospitals those cases must be referred to the

DOLS system, and in all other settings, applications must be made promptly to the Court of Protection. We would be pleased to discuss how we can help with this.

talk to us...

Ben Troke | 0115 976 6263 | ben.troke@brownejacobson.com

what happens when findings of fact are disputed?

The Chief Coroner's Guidance (No. 17) now encourages coroners to sum up their findings of fact, in open court, before reaching their conclusions. In two recent cases, **Dr S v HM Coroner North Yorkshire East (Admin Court) Judgment 21 July 2015** and ***MRH Solicitor v Manchester County Court* EWHC [2015] 1795** the situation arose where the claimants sought to challenge the factual findings, although the inquest conclusion and final judgment were not under review.

In Dr S v HM Coroner North Yorkshire East (Admin Court) Judgment 21 July 2015, the claimant brought a successful judicial review challenge against the coroner for making unlawful comments about his integrity during evidence. In the findings, the coroner stated that the deceased's fracture had, on the balance of probabilities, occurred when the claimant had taken a blood sample. The coroner went on to say that the claimant had been "economical with the truth". Where a doctor's probity is called into question, he has a professional duty to self-refer to the General Medical Council, who will investigate the matter further. The claimant therefore challenged the specific comments made about him although the inquest conclusion was not disputed.

Following issue of the judicial review proceedings, the coroner agreed that his comments regarding the claimant had been unlawful and should be struck from the record. In light of the coroner's admissions, permission to bring the judicial review was granted and the agreed order to quash was made on the papers.

In ***MRH Solicitor v Manchester County Court* EWHC [2015] 1795**, judicial review proceedings were brought by a claimant solicitor to quash a County Court judgment, where the judge had made ill-considered findings of fraud against the solicitor. The claimant had not been notified of the allegations and was not given the opportunity to respond. The Administrative Court overturned the findings of fraud and considered an alternative way of achieving the same remedy without quashing the judgment by way of judicial review proceedings. The court stated that when the judge makes an extempore judgment, it is usual practice for a judge to refine their comments when approving the final transcript. Therefore, there is an opportunity for the judge to amend or change those comments which are subject to challenge, without the need for judicial review proceedings or a re-hearing.

This case may mean that there is an alternative remedy available to properly interested parties who seek to challenge the findings of fact made by a coroner, without the need to resort to judicial review proceedings, and an application to quash.

talk to us...

Imogen Hamblin | 0115 934 2031 | imogen.hamblin@brownejacobson.com

London sexual health clinic facing security breach

Whilst patients' summary care records are being sent to pharmacies this autumn, with appropriate safeguards and systems in place, a leading sexual health clinic in London has mistakenly revealed the HIV positive status of nearly 800 patients.

On 1 September 2015, the London clinic inadvertently sent a newsletter that disclosed the names and email addresses of about 780 HIV patients. Chelsea and Westminster NHS Trust, the responsible Trust, have apologised for the breach and pledge to investigate. It is highly likely the Information Commissioner will launch major investigation into the breach of highly sensitive and personal data. The breach is thought to be one of the biggest of its kind. One recipient indicated the email contained the names of friends who had never disclosed their HIV status to him before. In today's era of social media, it would not be difficult to put names into Facebook and bring up profiles and personal details.

The leaked information contained patients' full names and email addresses.

Dr Allen McOwan, Chelsea and Westminster Hospitals NHS Trust Director of Sexual Health, issued an email apology within hours of the breach and the clinic set up a helpline. In the email, he asked patients to delete the email immediately.

The Trust are urgently investigating how this breach could possibly have happened and it pledges to ensure it never happens again. Patients will be informed of the outcome of the investigation. A spokesman from the clinic indicated the breach was down to a "human mistake" and the employee responsible was distraught. Apparently, not all recipients of the email were necessarily HIV positive.

The clinic is likely to face a hefty fine from the privacy watchdog, the information commissioner's office, which can levy fines of up to £500,000 for significant data breaches.

This is a timely reminder of the potential risks and liabilities that can come with control of large volumes of sensitive personal data. Organisations should ensure they have good systems, procedures and policies in place to avoid inadvertent disclosure of information which lead to not only financial but also reputational implications.

talk to us...

Lorna Shastri-Hurst | 0121 237 4588 | lorna.shastri-hurst@brownejacobson.com
Ben Troke | 0115 976 6263 | ben.troke@brownejacobson.com