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Introduction

Welcome to our June edition of the Health Legal Update.

This edition comes hot on the heels of NHS Confederation. It was great to catch up with friends (old and new). For those of you who we didn’t see at Confed you may be interested in reading our bulletin Six key issues for NHS Confed 2014.

The general consensus was that there was a real buzz at Confed this year. We heard, among other things, Simon Stevens setting out his vision on how to future proof the NHS for the years ahead through improving the sophistication of our commissioning system, accelerating the redesign of care delivery and actively exploiting the fundamental transformations now occurring in modern western medicine. Rob Webster made a plea for a ten year NHS funding settlement, the “decade deal”. And who will forget the thoroughly enjoyable session with the four former Secretaries of State for Health, free to share what they really think …

So it is back to the day job and the bulging inbox.

We have set out in this month’s edition some interesting features. The Care Bill has now received Royal Assent and we have outlined some of the key sections of the Act. The courts have been busy and we set out decisions relating to whistleblowing, funding and best interests that ought to be on your horizon. As usual, we hope there is something for everyone.

Mills & Reeve health briefings this month include What does Rose v Thanet CCG tell us about the status of NICE guidance in the context of priority settings?

Those of you with an interest in information governance the latest NHS England Information Governance newsletter has been published.

We will continue to keep you abreast of key developments but, in the meantime, please also feel free to browse the new content on our Healthcare Resource Centre, Health Commissioning Portal, Procurement Portal, Health Broadcast Centre and our seminar programme.

You can also follow us on Twitter and LinkedIn.

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NHS commercial: commissioning

CCGs to have a primary commissioning role

England’s 211 CCGs will be able to co-commission primary care in partnership with NHS England under new powers announced by NHS England chief executive, Simon Stevens on 1 May.

NHS England has written to all CCGs with details of how to submit expressions of interest for taking on enhanced powers and responsibilities to co-commission primary care.
CCGs will need to describe the additional powers and responsibilities they would like to assume. NHS England has said that applicants will be required to meet a number of criteria, including showing they will help advance care integration, raise standards and cut health inequalities in primary care. CCGs will also need to demonstrate “how they will ensure transparent and fair governance – with a continuing oversight role for NHS England to safeguard against conflicts of interest”.

Applications need to be submitted by 20 June, the same date that CCGs will complete their initial five year plan for local NHS services. Each applicant CCG will then discuss its proposal with the local area team of NHS England, which will then make a recommendation to the board of NHS England.

This new initiative has been welcomed by NHS Clinical Commissioners who highlight in their manifesto the need for “a more co-ordinated approach at all levels so involving local commissioners in local primary care decisions”. However, reaction from commissioners and other healthcare leaders is mixed according to a recent Health Service Journal report.

Labour has raised similar concerns about NHS England’s bid to share primary care commissioning with CCGs saying that it would create conflicts of interest.

A version of this article first appeared on our Health Commissioning Portal blog.

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

**NHS commercial: Monitor**

Monitor updates its approach to competition and advises Competition and Markets Authority to clear Berkshire merger

Monitor has changed the way it receives advice on competition issues. It will replace the stand-alone co-operation and competition panel (CCP) with two experts to provide the advice as part of Monitor’s routine decision-making processes. Two members drawn from the CCP – John Swift QC and John Wotton – will attend meetings of the co-operation and competition executive – the internal group, chaired by Monitor chief executive Dr David Bennett, that oversees the regulator’s competition work.

Dr David Bennett, said “we would like to thank all of the CCP members for their hard work and invaluable advice over recent years. Special thanks go to Lord Carter of Coles who chaired the panel since it was established in 2008. The new arrangements mean that we will have the right expertise around the executive table when we make our decisions on competition matters.”

Following the advice of Monitor, the Competition and Markets Authority (CMA) has cleared the proposed merger of Heatherwood and Wexham Park NHS Foundation Trust and the neighbouring Frimley Park NHS Foundation Trust.

Heatherwood and Wexham Park was put in special measures after the Care Quality Commission found care was inadequate and the trust was not well-led. Monitor advised the CMA that the proposed acquisition was the best available solution to the problems faced by Heatherwood and Wexham Park, and the most likely way to achieve improvements in services for patients. It also advised the merger was likely to deliver a quicker and more sustainable solution to the issues faced by the trust than further regulatory intervention.

Monitor will now undertake a detailed review of the merger proposals to ensure that the risks around sustainability of the enlarged organisation are identified and managed appropriately.
A version of this article first appeared on our Health Commissioning Portal blog.

For further information or advice please contact Simon Elsegood on 01603 693449.

NHS legislation: Care Act 2014

The Care Bill gained Royal Assent on 14 May 2014.

It is not yet in force but we have set out below a summary of the key provisions specifically relating to health. There is, in addition, a large part of the Care Act 2014 which specifically covers local authorities - the aim having been to pull together the myriad of legislation dating back to 1948 into one single modern framework.

Care Act 2014: Safeguarding Adults

The Government was concerned that although local authorities have been responsible for safeguarding for many years there has never been a clear set of laws and regulations behind it. The Care Act 2014 aims to put this right by creating a legal framework so key organisations and individuals with responsibilities for adult safeguarding agree on how they must work together/what roles they must play to keep adults at risk safe.

Sections 42 – 45 and schedule 2 of the Act cover this in detail.

Local authorities are required to set up safeguarding adults boards (SAB). The SAB must:

- Include the local authority, the relevant CCG and the police who should meet regularly to discuss and act upon local safeguarding issues
- Develop shared plans
- Publish the plan and report to the public annually on its progress

Local authorities are required to make enquiries when they have reasonable cause to suspect that an adult may be or is at risk of abuse or neglect in their area whether or not they are actually providing any care or support.

The Act does not give local authorities new powers to enter a person’s property. Readers may recall some of the debate around this. As opinions were split, the Government decided that there was not a strong enough case in favour of a new law.

If an SAB requests information from an organisation or individual who is likely to have information relevant to the SAB’s functions, they must share what they know with the SAB.

Care Act 2014: Section 117 Mental Health Act 1983

Section 75 Care Act 2014 amends section 117 Mental Health Act to:

- Assist in determining which local authority is responsible for aftercare
- Define aftercare
- Deal with preferences for accommodation
Include amendments to direct payments

Aftercare is now defined as services which have both of the following purposes:

- Meeting a need arising from or related to the person’s mental disorder
- 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 a mental disorder)

**Care Act 2014: Chief Inspectors**

Section 89 amends Schedule 1 of the Health and Social Care Act 2008 to provide for the appointment of three Chief Inspectors covering hospitals, adult social care and general practice.

A formality to regularise the current position given that the three inspectors have already been in post for some time now!

**Care Act 2014: Duty of Candour**

The contractual duty of candour has been included in the NHS Standard Contract since 2013.

Now, by virtue of section 81 of the Care Act 2014, there is also a statutory duty of candour too. It will be part of the new set of registration requirements for all healthcare organisations regulated by the Care Quality Commission.

It will not apply to individuals.

It is proposed that the duty will apply when there is a notifiable safety incident that has led to the death of a patient or to them suffering “severe” or “moderate harm” or “prolonged psychological harm”.

This would include providing information and support to the patient or another, issuing an apology and agreeing what further inquiries are needed.

Non-compliance would be a criminal offence.

The changes will take effect in October 2014 in the Health and Social Care Act 2008 (Duty of Candour) Regulations 2014 (the regulations can be found at Annex A of the consultation document). The consultation in respect of those regulations closed in April.

Detailed guidance is also expected.

**False or misleading information**

This has given us yet another health acronym – FOMI!

Another new criminal offence has been created by the Care Act 2014.

It is an offence where a care provider supplies, publishes or otherwise makes available information which is required under an enactment or other legal obligation and the information is false or misleading in a material respect.

It is a strict liability offence which means that it does not need to be proved that a provider knew it had supplied false or misleading information.
The offence will apply to the whole organisation but it could also apply to senior staff. Regulations are awaited but we understand they will initially limit the offence to providers of NHS secondary care.

The regulations will set out the type of information covered by the offence eg mortality rates.

Punishments may include:

- Unlimited fine
- Imprisonment for not more than two years following conviction on indictment or a fine (or both)
- Remedial order – steps to put things right
- Publication order – to publish details of offence

Providers will need to assure themselves of the accuracy of the information they publish and ensure that they have an audit trail.

There will be a defence if the provider proves that they took all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information.

For further information or advice please contact Jill Mason on 0121 456 8367.

Regulatory: information governance

Care.data timetable: a programme will only rollout nationally once the process ‘is right’

The Care.data patient records project timetable has been scrapped by NHS England. NHS England, not surprisingly, has said the project will only rollout nationally once the process is right.

Tim Kelsey, National Director for Patients and Information, said the programme is currently in the middle of a six month pause. NHS England had hoped a national rollout would be possible following the pause but will only now commit to a pilot by autumn.

Mr Kelsey is quoted as saying the project will not be subjected to “artificial deadlines”. The decision to scrap the timetable was taken after consultation with GPs, patients, researchers and privacy campaigners. Mr Kelsey stated: “in light of all of these conversations we are now proposing to phase the implementation of Care.data work with 100 to 500 GP practices in the autumn to test, evaluate and refine the data collection process ahead of a national rollout.”

Simon Stevens, NHS England's new Chief Executive, told MPs at his appearance at the commons health committee recently, that the NHS should not be tied to “an artificial start date”.

Health bodies need to watch this space and await future updates on the roll out of Care.data.

For more information please contact Stuart Knowles on 0121 456 8461 or Lorna Shastri-Hurst on 0121 456 8400.
Whistleblowing: dismissal is only automatically unfair if there is a causal link between disclosure and dismissal

Whilst not an NHS case, the recent decision of the Court of Appeal in Co-Operative Group Ltd v Baddeley emphasises that there must be a causal link between disclosure and dismissal for the dismissal to be automatically unfair.

In particular, the court emphasised that when making a finding that an employee has been automatically unfairly dismissed because of a protected disclosure, the employment tribunal must satisfactorily explain how the protected disclosure operated on the mind of the dismissing officer. On the facts of this case, the Court of Appeal was not satisfied that the employment tribunal had explained its findings as to the causal connection between the protected disclosure and dismissal.

Mr Baddeley was found to have made a protected disclosure to his line manager that he believed the company did not have the necessary approvals for storing old stock. The employment tribunal found that his line manager had decided as a consequence of this disclosure that Mr Baddeley "had to go" (ie leave the company), and the tribunal therefore found that there was a link between Mr Baddeley's protected disclosure to his subsequent dismissal (ie the former had caused the latter to occur).

The Court of Appeal were critical of the tribunal's approach, saying that the tribunal had made very serious findings about Mr Baddeley's line manager (that he wanted Mr Baddeley "to go") as well as the disciplinary and appeal officers, yet they had not explained how the disciplinary and appeal officers became aware of the line manager's "agenda" to "get rid" of Mr Baddeley.

The company's appeal was successful and the case has been remitted to a new tribunal for a fresh decision.

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

Employment Appeal Tribunal (EAT) guidance on managing whistleblowing claims

Two recent decisions have come from the EAT regarding whistleblowing cases which raise some interesting and relevant issues for NHS employers.

The first of these is AJ Panayiotou v (1)Chief Constable Paul Kernaghan (2) Police and Crime Commissioner for Hampshire. This case involved a policeman, Mr Panayiotou (C) who made a series of disclosures to his employer (R). His disclosures were investigated by Hampshire Police and C was found to be largely correct in his concerns. However, C was not satisfied with the outcome of the investigation and continued to raise numerous complaints to the point where the employer was having to devote a great deal of management time to responding to C's correspondence and complaints. C became completely unmanageable and was dismissed.

C brought a claim in the employment tribunal alleging that he had been unfairly dismissed because the protected disclosures he had made were the principal reason for his dismissal. The tribunal concluded that the employer acted as it did in dismissing C because of his long term sickness absence together with the manner in which he had pursued his complaints, not because of the protected disclosures.

C appealed the decision. The EAT held that the tribunal was entitled to treat the sickness absence and the manner in which C brought the complaints as distinct from the fact of the claimant having made protected disclosures, and that these other factors were the actual reason for the dismissal. C's appeal was dismissed on the grounds that
there was ample evidence for the tribunal to conclude that the making of the protected disclosures was not the reason for the dismissal.

This is a helpful case as it shows that it is possible to tackle a whistleblower who, whilst raising legitimate concerns, does so in an unmanageable way and behaves in an unacceptable manner. This case suggests that in these circumstances, as long as the dismissal is clearly attributable to the way in which the whistleblower conducts itself, rather than the disclosures themselves, it is possible to dismiss without a finding of automatic unfair dismissal.

The second case of relevance is Blackbay Ventures t/a Chemistree Ltd v Gahir. Ms Gahir (C) was employed by Blackbay (R) as a responsible pharmacist. Part of her role was to monitor compliance with the various statutory requirements and guidance laid upon R. During her first week of employment, C identified a large number of health and safety concerns, most of which she set out in an email to R dated 31 August 2010. R dismissed C on 3 September 2010. C brought a claim in the employment tribunal for automatic unfair dismissal and unlawful detriment on the basis that the health and safety concerns she raised were protected disclosures. C's claim was upheld by the tribunal who held that C had been dismissed because R resented the fact that C had questioned its practices and procedures and that the "principal reason" for her dismissal was the making of the protected disclosures. R appealed to the EAT.

The EAT was critical of the tribunal's approach to this case and concluded that the tribunal should have identified and considered each disclosure separately, using a systematic approach, rather than rolling them all up together. It went on to set out helpful guidance as to how employment tribunals should approach such claims. Key points included the need to:

- Identify each disclosure separately, along with the basis on which each disclosure is said to be protected and qualified
- Identify the alleged failure or likely failure to comply with a legal obligation and the source of the legal obligation
- Identify each detriment and where relevant the date of the act/deliberate failure to act
- Determine whether each disclosure was made in the public interest

The EAT concluded that C had not suffered detriment, as due to her short period of employment they found it difficult to see how she could have suffered such detriment between her dismissal and the submission of her email of complaint. Further, and more importantly, the EAT found that there had been no deliberate action or failure to act by R, and mere inaction was not enough to show a detriment.

The EAT did however uphold C's unfair dismissal claim, as it found that whilst it was more likely that C was dismissed for her confrontation with management and her aggressive attitude following the protected disclosures, the reason for dismissal was a question of fact for the tribunal and there was some factual evidence to support the tribunal's finding.

These cases are helpful for NHS employers as a reminder of how to deal with whistleblowers and potential claims, and the need to carefully identify the reason for subjecting an employee to a detriment or deciding to dismiss.

For further information or advice please contact Laura O’Donnell on 0121 456 8447.
Affirmation of contract by extension of a notice period

In the recent case of Cockram v Air Products Plc, Mr Cockram (C) was employed by Air Products Plc (R). His contract of employment provided for a three month notice period. In May 2013, C raised a grievance about comments made by his line manager. He was unhappy with the procedure and outcome, and appealed. The decision was upheld and the outcome of the appeal was sent to him in July 2013. C then resigned by letter some weeks later in response to what he considered to be a fundamental breach by R of the implied term of trust and confidence. He set his notice to expire on 28 February 2013, meaning that his notice period was some seven months in length, rather than the three months provided for in his contract. He then issued proceedings for constructive unfair dismissal, detriment from protected disclosures and age discrimination.

The employment tribunal struck out C’s claim at a preliminary hearing as having no reasonable prospect of success on the basis that C had affirmed the contract by virtue of the length of notice he was prepared to work and the fact that notice was given for personal, financial reasons and not for altruistic purposes.

C appealed the judgment, but the Employment Appeal Tribunal (EAT) upheld the decision of the employment tribunal. In the EAT judgment it was noted that it is common ground that the Employment Rights Act varies the common law contractual principles by giving an employee the right to resign on notice without being treated as having affirmed the contract. However, the EAT concluded that this variation is limited "to allow only for the giving of notice". It held that the employment tribunal had been entitled to consider the issue of post-resignation affirmation and concluded that C had in fact affirmed the contract by providing services to R and receiving payment during the seven month period after giving notice.

This is an interesting case on the issue of post-resignation conduct, where any conduct by an employee, whether prolonged delay before resigning or by conduct such as an election to extend a notice period can be seen as affirmation of a contract and consistent with the continued existence of a contract, thus meaning any claim for constructive unfair dismissal must fail.

For further information or advice please contact Laura O’Donnell on 0121 456 8447.

Patient matters: abortion

New guidance on abortions published

Following a decision by the Crown Prosecution Service (CPS) in August 2013 not to prosecute two doctors investigated for certifying abortions based on the gender of the foetus, the CPS highlighted the lack of guidance for doctors about abortion law. In particular, the statement made by the CPS in relation to those cases highlighted that "there is no guidance on how a doctor should go about assessing the risk to physical or mental health, no guidance on where the threshold of risk lies and no guidance on a proper process for recording the assessment carried out".

In response, the DH agreed to produce guidance on these issues. The intention is to provide support for doctors by setting out how the law is interpreted by the DH.

The new guidance was published on 23 May 2014. It clarifies:

- That 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
That it is good practice for at least one of the doctors to have seen the pregnant woman before reaching a decision about the termination.

That pre-signing of statutory abortion certificates prior to consideration of a woman’s circumstances is not compliant with the Act.

That doctors have a legal duty to report all abortions to the Chief Medical Officer.

The Government has also issued *Procedures for the approval of independent sector places for the termination of pregnancy* which highlights the procedures that independent sector abortion clinics must follow in order to be approved to provide services: independent sector places will have until 23 June 2014 to reapply for approval to continue practising.

For further information or advice please contact Helen Burnell on 020 7648 9237 or Jane Williams on 0121 456 8421.

Patient matters: children

Court overrules refusal of 17-year-old to accept life sustaining treatment

In the case of *P (a child) an NHS Foundation Hospital v P*, heard in very urgent circumstances by Mr J Baker, an NHS trust applied for an order to force treatment on P.

The case is of interest for various reasons. Firstly, it illustrates how the court can and will make orders in urgent situations, 24 hours a day. Secondly, it required the court to consider both the *Mental Capacity Act 2005* (MCA 2005), (which governs the issue of consent in respect of those aged 16 and over who lack capacity) and the inherent jurisdiction of the court (which applies to people of any age who meet particular tests in relation to their vulnerability including those aged 18 and under). The court in this case did not feel able to declare that P lacked capacity but was willing to make a declaration for treatment under its inherent jurisdiction.

P was 17½ years old and she had overdosed on paracetamol. Normal treatment in these circumstances is the administration of an antedote within eight hours which needs to be continued for several hours thereafter in order to be effective. P had refused this and the matter reached a crisis point at around 10 o’clock at night. The court dealt with the matter by phone but did not hear from P.

P had been assessed on the ward by the trust’s adolescent psychiatrist. They had assessed that she did have capacity to consent to/refuse treatment. The clinician treating her had some doubts about this but it does not appear from the judgment that they were indicating that they disagreed with the psychiatrist on this point. The court noted that the evidence it had was extremely limited and it had not had the opportunity of hearing from P herself.

The trust applied to the court for an order incorporating a declaration that it was lawful, and in the girl’s best interests, for the medical practitioners having responsibility for her care and treatment to treat her for the overdose “notwithstanding the fact that she was refusing treatment”.

The first question for the judge was whether or not P had capacity. He was not satisfied that she lacked capacity. This meant that the provisions of the MCA 2005 could not be used.

The second question was whether he should make a declaration authorising the treatment, to which she was refusing to give her consent, under the court’s inherent jurisdiction. This jurisdiction applies to certain categories of
people who appear able to make decisions for themselves, including the *Gillick* competent aged under 18. The judge acknowledged that the MCA 2005 applied to those aged 16 or over but as he was unable to make a declaration that she lacked capacity under the MCA, he turned to the inherent jurisdiction to see if he should make a declaration.

Although the judge acknowledged that the wishes and feelings of the child are an important factor in considering her welfare, he made it clear that those feelings are not decisive. In this case it seemed likely that if she did not receive treatment she would probably die. The judge concluded that in order for the court’s inherent jurisdiction to be meaningful it must be able to override a child’s wishes. In delivering his judgment he made it clear he had no hesitation in reaching the conclusion that P’s wishes could be overridden and treatment could be given against her wishes, because the court is under what he described as a “heavy duty” to take what steps it can to preserve P’s life. He therefore made a declaration that it was lawful for her to be treated against her will, even if that required her to be sedated or restrained notwithstanding that such actions amount to a deprivation of liberty.

The judgment illustrates the need to consider whether or not a young person aged under 16 is *Gillick* competent or, for those aged 16 or over, have capacity to make their own decisions. Where those treating a young person aged 16 or over are faced with a decision which constitutes life sustaining treatment and that treatment needs to be given urgently, there is scope for a court application to be made on a 24/7 basis.

The judge did not address when it might be that a capacitous 17-year-old would be permitted to make a decision that allowed them to die, owing to the fact they had capacity under the MCA 2005 test. Although, as explained above, he did outline that, in exercising its inherent jurisdiction, the court must have the child’s welfare as its paramount consideration and that there is a strong presumption in favour of taking all steps which would prolong life. We suspect that this argument could not be developed further given that this application was made on an urgent basis out of usual court hours.

We will keep readers updated in relation to how this area of law develops as we expect that cases will be brought where the argument is that treatment should not be forced, on the basis that a young person has capacity under the MCA 2005.

We recommend that if you are dealing with such an issue, you seek legal advice to support your clinicians.

For further information or advice please contact Helen Burnell on 020 7648 9237.

**Court confirms the approach to decisions relating to children under the age of 16**

The recent case of *An NHS Foundation Trust v A (1) M (2) P (3)* related to a girl (A) who was 15-years-old and weighted five and a half stone at the time of the application. She had been in hospital for ten months. She vomited up to 30 times a day (but not at night). Three experts had concluded that there was no gastroenterological cause for the vomiting. Both A and her mother disagreed. There was a concern that A may suffer from fabricated and induced illness. The need for treatment was considered very urgent. The matter was heard by Mr Justice Hayden.

Mr Justice Hayden said: “I have grave concerns that A is suffering under a form of fabricated and induced illness (the extent to which A is colluding with the mother remains to be seen). I would suggest that this goes beyond exaggerated illness behaviour…. by removing the child from a potentially harmful parent it would then be possible to see to what extent the child would benefit from less invasive care”.
The NHS trust treating her applied for various declarations under the inherent jurisdiction in relation to her treatment, including permission to insert a nasojejunal tube and to administer fluids, food and medication via the tube.

The judge made the orders. Contact between A and her mother was suspended for the first two weeks of her treatment. A was also made a ward of court to allow the court to oversee independent decisions in relation to her treatment. The judge also considered a table of benefits/disadvantages to assist in weighing-up what would be an appropriate decision for A. This method has been in use for a number of years and those faced with similar decisions should undertake this exercise when making decisions about children and young people. The judge has suggested that the template be used in future cases and we would be happy to provide a copy of this to readers.

The court outlined the key points for the court to consider in making this type of decision (as taken from the case of Wyatt, in which Mills & Reeve acted for the NHS trust). They serve as a useful reminder for readers and are as follows:

- The judge must identify what is in the best interests of the child
- The child's welfare is the paramount consideration
- The judge must look at it from the assumed point of view of the patient
- There is a strong presumption in favour of the course of action which would prolong life but, that presumption is not irrebuttable
- The term “best interests” encompasses medical, emotional and all other welfare issues

Readers familiar with this age group of patient will be aware that the issue of “competency” arises in relation to the decision making ability of children under the age of 16. This test derives from the case of Gillick. For those aged 16 and over, the test is whether or not someone has “capacity” to make decisions in accordance with the Mental Capacity Act 2005 (MCA 2005). The judge held that A was not competent to make decisions as to the appropriate course of medical treatment. Two psychiatrists had provided evidence to this effect. Of interest is the comment from the court that if A were an adult, it would conclude that she lacked capacity under the MCA 2005 to make decisions about her treatment.

For further information or advice please contact Helen Burnell on 020 7648 9237 or Laura Jolley on 01223 222448.

**Patient matters: funding of treatment and care**

What happens to a CHC domiciliary care package when the recipient has to go into hospital?

The recent case of R (on the application of JF) v NHS Sheffield Clinical Commissioning Group examined the question of who is responsible for the provision of necessary services when a person in receipt of NHS continuing healthcare (CHC) is admitted to hospital.

Prior to hospital admission, JF (who had an acquired brain injury, learning difficulties and bipolar affective disorder) was in receipt of a CCG-commissioned CHC package, which provided her with one-to-one supervision 24/7 to manage her challenging behaviour to enable her to live at home. The hospital initially assessed JF as not requiring this supervision in the acute setting, given the supervision and monitoring available to her there, while JF’s
solicitors issued proceedings challenging the CCG’s decision to suspend funding for the community care package upon admission, after relatives complained about a number of “incidents” which they alleged would not have happened had JF been supervised as she was at home.

Although the National Framework states that eligibility for CHC places no limits on the setting in which the package of support can be offered, Mr Justice Stuart-Smith observed that CHC will “generally be geared to the provision of care other than in an acute hospital context”. The CCG argued that it had assessed JF as needing one-to-one care 24/7 when in the community, not in any other setting, and that it was for the hospital to assess JF’s needs and provide for them on admission. CHC, the CCG argued, was by definition not care in a hospital setting and it had discharge its duty under section 3 NHS Act 2006 by commissioning acute care for the patient.

The contract between the CCG and the acute hospital incorporated the NHS standard conditions, including a provision that “if the provider believes that a service user … may have an unmet health or social care need, it must notify the responsible commissioner accordingly. The responsible commissioner will be responsible for making an assessment to determine any steps required to be taken to meet those needs”. In other words, if the provider, through assessment of the patient on or post admission, identifies a need which it is unable to meet, it must notify the commissioner, who is then responsible for assessing the patient to determine any steps required to be taken to ensure those needs are met. In the absence of such communication, however, the commissioner is entitled to assume that the hospital has sufficient expertise and capacity to identify the patient’s needs and decide how best they should be met in the acute setting.

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

New case on the responsible commissioner for section 117 aftercare: and a reminder that this case will only be relevant for local authorities after the change in the regulations

On 22 May, the Court of Appeal gave judgment in the case of R(on the application of Wiltshire Council) v Hertfordshire County Council and SQ.

SQ was resident in Wiltshire until 1995 when he was made the subject of a hospital order with restrictions. He remained in hospital until 2009 when he was conditionally discharged. One of the conditions was that he would reside at a hostel in Hertfordshire that was staffed 24 hours a day.

In 2011, SQ was recalled to hospital. In 2014 he was conditionally discharged back to the hostel in Hertfordshire. At this point Wiltshire Council asked Hertfordshire County Council to take over funding for the section 117 aftercare. Hertfordshire County Council refused and Wiltshire Council sought judicial review of their decision.

In an interesting turn, and perhaps as an indication that the Administrative Court is frustrated with proceedings being brought by public bodies against other public bodies, the court refused the application on the papers and at the oral hearing. The matter was referred to the Court of Appeal which heard the case in full.

The Court of Appeal confirmed that the responsible local authority was Wiltshire. SQ did not establish residence in Hertfordshire between 2009 and 2011 because he was compelled to be there as a condition of his discharge and therefore he could not be seen to reside there voluntarily.

For CCGs (but not local authorities) the test for the responsible commissioner of aftercare services was simplified by regulation 14 National Health Service Commissioning Board and Clinical Commissioning Groups.
(Responsibilities and Standing Rules) Regulations 2012 which provided that the responsible CCG will be the CCG responsible for the area the patient moves to on discharge.

A version of this article first appeared on our Health Commissioning Portal blog.

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

National Health Service (Right to Treatment) Bill resurrected

Readers, cast your minds back if you will, to a time just before Christmas 2011 and you may recall a Private Member’s Bill being introduced into the House of Commons by Hugh Bayley MP. Come the following year however, the National Health Service (Right to Treatment) Bill 2011 disappeared without trace.

Introducing the Bill, Mr Bayley observed that the NHS was becoming a postcode lottery, where resource allocation decisions were taken locally, leading to differential availability, and not by Ministers accountable to Parliament. The Bill, he said, would “restore equity by giving patients a legal right to treatment recommended by their doctor”.

Indeed the Bill made provision:

- To ensure that medical treatment, prescribed as necessary by a doctor or other medical professional, was made available unless it was not approved by the Secretary of State for Health or NICE
- To establish a national register of cases where such prescribed treatment was refused
- To introduce an appeal mechanism for such decisions

It is therefore interesting that, a year or so on from the advent of CCGs and thereby yet more localised decision making, the Bill appears to have been recalled to life, enjoying its first reading on 8 April this year and scheduled for its second in early June.

As every health media headline draws our attention to the plight of cash-strapped commissioning bodies, we watch with interest to see whether the Bill demonstrates more stamina this time around.

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

Patient matters: best interests

Court of Protection considers the rights of the media in best interest case

The case of G (London Borough of Redbridge) v G (by the official solicitor as her litigation friend) and Associated Newspapers Limited related to personal welfare proceedings in the Court of Protection in respect of a 94-year-old lady, G. In previous proceedings it had been found on the balance of probability that G lacked capacity under sections 2 and 3 Mental Capacity Act and therefore the case fell to be dealt with under the jurisdiction of the Court of Protection. During the course of proceedings a High Court judge had made a reporting restriction order preventing the identification of G and her two carers. An order was sought forbidding one of the carers from taking G to meet with the press relating to an aspect of proceedings. In essence, the issues for current consideration was whether it was in G’s best interests that she should in fact engaged with the press.
Associated Newspapers Limited (ANL) decided to make an application seeking to be joined as a party to the proceedings arguing that it had a legitimate interest in them because the issue of whether G had capacity to communicate with the media will affect the ability of ANL to receive information about the proceedings and to report upon them. They further argued that there is a strong public interest in allowing G to exercise her Article 10 and Article 8 rights to communicate with third parties.

ANL took the view that its ability to report on the proceedings was restricted and therefore its rights under Article 10 were therefore engaged, they argued that the restriction on their rights was particularly important in this case given the strong public interest in reporting on the work of the Court of Protection. By the time the case came to court, the issues had been refined and ANL were seeking, amongst other things, an order that:

ANL be joined as an interested party to the proceedings on the issue of

(a) G’s capacity to communicate with third parties including the media
(b) If G does lack capacity whether it would be in her best interest to communicate with third parties including the media
(c) The reporting restriction order already in place

The application was opposed by the official solicitor on behalf of G and also by the local authority. It was broadly supported by G’s carers.

With regard to the issue of Article 8 rights, the judge stressed that the state has a positive obligation under Article 8 to ensure that X’s right to respect of a private life is not violated as a result of press intrusion or harassment and that if X does not wish to have anything to do with Y then Y cannot impose himself on X by praying in aid his own Article 8 rights and that applies even if X lacks capacity. In the event of dispute it is for the Court of Protection, on behalf of X, to determine what X’s best interests require. However that does not give rise to any justiciable issue between Y and X. Article 8 protects two distinct rights, the right to receive and the right to impart information and ideas. The court held that if a competent adult declines to disclose information to a third party then that right is protected by Article 8 and the press cannot require that person speaks to them. If on the other hand the person in question lacks capacity the next question is whether or not their best interests lie in passing the information to the third party. In this case, the Court of Protection held that the identification of G’s best interest did not give rise to any justiciable issue between G and ANL.

It was held that:

1. ANL’s application to be joined as a party is misconceived
2. Even if ANL’s rights under article 10 were to be engaged, that would not give ANL a sufficient interest in the proceedings
3. ANL had argued that it should be joined as a party in relation to the issues of G’s capacity and best interests because otherwise relevant arguments may not be adequately put before the court. The court held that there is no basis for this and this cannot be a ground for being allowed to participate in proceedings.

The application was dismissed.

For further information or advice please contact Jacqueline Haines on 0121 456 8453.
Court criticises trust for inaction in Court of Protection case

This case is based on two recent judgments of the High Court in the matter of LW, one heard by the Family Division and relating to the welfare of an unborn (and then newly born) baby of LW. The second was a Court of Protection application (heard simultaneously with the first application) in relation to whether or not a caesarean section should be performed on L, on the basis that, at the time the application was made, it was believed she lacked capacity to consent to or refuse treatment.

The court was highly critical of the conduct of the acute trust who was overseeing the care of a vulnerable woman, LW, and her unborn child and in an unusual step, ordered the trust to pay costs.

The cases are reported as North Somerset Council v LW and others and North Somerset Council v LW and others.

Key lessons in this matter

- Care must be taken to consider who is a decision maker for the purpose of the Mental Capacity Act 2005 where there is concern a person may lack capacity to consent to/refuse treatment. Where the treatment in issue is a surgical intervention, it is for the acute team to take decisions and lead on the matter.

- Where there is an unresolved issue in relation to capacity, decision makers must be mindful of the time frames involved and ensure that the necessary arrangements are undertaken and decisions made which allow for the delivery of safe care and, where other agencies are involved, that there is sufficient time to discuss matters with inter-agency partners.

- Where a court order has been made that cannot be complied with or a trust wishes to take issue with, the correct procedure is to apply to vary the order and this should be done as soon as possible, even where the court proceedings do not appear to be central to the issues relevant to the trust.

Background

LW suffered from hebephrenic schizophrenia. She had a difficult childhood. Her global IQ was assessed at 63. She was under the care of a psychiatrist. Her compliance with medication was variable.

She was pregnant, with a due date in late April 2014. The local authority had started to plan to have her child removed from her care immediately after birth. Her psychiatrist assessed in February 2014 that she would likely pose a significant risk of harm to herself, her child and professionals if she knew of the local authority's plan. The local authority agreed. There was real concern held by the social work and health care teams that the mother would not be aware when she was going into labour and might not understand what was happening when she did so. In addition, the foetus was in the breech position and it was likely that the baby would have to be delivered by caesarean section. She had been abusive to staff at an appointment on 9 April relating to her pregnancy. It is understood that it had been arranged for LW to undergo a capacity assessment on 17 April, on the basis of her presentation.

The local authority made an application under the inherent jurisdiction of the High Court for an order that it be permitted not to tell LW about the plan to remove her baby at birth. There was discussion as to whether or not a Court of Protection application in relation to LW's medical treatment for her pregnancy/birth should be brought, given the concern she may lack capacity.

At a directions hearing on 11 April the court ordered that University Hospital Bristol NHS Foundation Trust (UHBT) should attend the next hearing on 15 April to provide assistance, as they were going to be delivering the care to LW and her child after the birth. UHBT declined to attend and in correspondence to the applicant local authority,
indicated that it was for the trust and not the local authority to make an application to the court and requested that the hearing be vacated. It did not seek to vary the order.

At the hearing on 15 April the court granted an order allowing the local authority to withhold the information from LW about its plans to remove the baby at birth on the basis that it was justified by the overriding necessity of the interests of the child and was essential to secure the child’s safety. It was made clear that it is only in an extreme case that such a draconian and highly exceptional course of conduct would be permitted by the court.

At the hearing on 15 April 2014, the judge hearing the matter made the point of calling UHBT’s legal team and outlined that he planned to call the chief executive, in open court, to ask for an explanation for the failure to comply with the order dated 11 April. Counsel was then instructed.

The court directed UHBT to undertake an urgent assessment of LW's capacity to consent to medical treatment around the elective cervical inversion and caesarean section and make that available the next day. It did not do so or give a reason as to why this had not been undertaken. Evidence was heard from LW's treating team. The risks associated with treatment were outlined. There appeared to be a lack of clarity however in relation to the assessments of capacity undertaken by her obstetrician.

On 16 April, UHBT agreed to issue an immediate application to the Court of Protection to seek permission for the trust to undertake a caesarean section for LW.

On 17 April, LW was assessed as having capacity to consent to/refuse treatment in relation to her pregnancy and the birth. She agreed to a caesarean section and the baby was subsequently born and removed from her care on 1 May 2014. As LW had consented to undergo the caesarean section no court order was required in relation to permission to undertake a caesarean section.

However, the issue of costs was raised. The court was critical of the role of UHBT. The judge said that it fell well short in meeting their duties to LW and her unborn child for the following principle reasons:

- There was no comprehensive plan or contingency plan devised until after the court had been seized of the matter.
- There was an unacceptable delay in arranging and/or undertaking a capacity assessment of LW to consent to medical treatment.
- The unborn child was at serious risk of death or very serious harm.
- In light of this, the court did not understand why an urgent capacity assessment was not undertaken on 9, 10 or 11 April and if the assessment found LW lacked capacity, why it did not make an application to the Court of Protection immediately.
- Until the first court application was made, no psychiatrist familiar with LW had been invited to attend the capacity assessment.
- The response of UHBT to the order of 11 April was wholly inappropriate and unacceptable.
- There appears to have been little or no planning or communication between component parts of UHBT responsible for LW's medical care and/or between the clinical staff and its legal department. Certainly none which reflected the complexity, seriousness and urgency in this matter.
On this basis, the court awarded costs against UHBT in relation to both the Official Solicitor and the local authority. This is a very unusual step for the court to have taken and illustrates the displeasure of the court in relation to the stance taken by UHBT.

For further information or advice please contact Helen Burnell on 020 7648 9237 or Jill Weston on 0121 456 8450.

Patient matters: Mental Health Act

Court considers the procedure to be followed when a person is recalled to be detained in hospital under section 42(3) Mental Health Act 1983

In the recent case of *R (on the application of Dale Lee-Hirons) v The Secretary of State for Justice and another*, the appellant contended that his recall to hospital under the power conferred by section 42(3) *Mental Health Act 1983* was effected unlawfully and therefore his subsequent detention was also unlawful. He claimed damages for false imprisonment pursuant to the *Human Rights Act 1998*.

Background

The appellant had 61 convictions for offences including theft, fraud and offences against property together with two convictions for arson. In December 2003, he had been informally admitted to hospital and discharged with a diagnosis of mania with possible schizophrenic features. In March 2004, he was admitted to hospital again and subsequently discharged with chronic paranoid delusional disorder, a sociopathic personality disorder and drug misuse.

In 2006 he was convicted of arson and burglary. When he was sentenced by the Crown Court, a hospital order and a restriction order were made pursuant to the Mental Health Act.

The appellant applied to the First Tier Tribunal for discharge from hospital.

The First Tier Tribunal decided that he was suffering from a mental disorder which made it appropriate for him to be liable to be detained in hospital for medical treatment, that it was necessary that he should receive the treatment and it was also satisfied that medical treatment was available and that it was also appropriate for the him to remain liable to be recalled. Having heard the evidence, the tribunal noted a conflict of evidence between experts and concluded that it was not satisfied that he had a mental illness, although it decided that he was suffering from anti-social personality disorder.

Subsequently the Upper Tribunal set aside the judgment of the First Tier Tribunal on the basis that the First Tier Tribunal’s decision, in which it held that he would benefit from continued treatment, was not sufficiently reasoned and it was remitted back to the First Tier Tribunal for determination.

When the First Tier Tribunal gave judgment, it held that notwithstanding the earlier diagnosis, they were not satisfied that he had paranoid schizophrenia although it did hold that he had an anti-social personality disorder. The tribunal was satisfied that the treatment could be provided but that it may also be possible for him to be treated in the community under conditional discharge but remain subject to recall to hospital if it was considered necessary to do so.

Following what was believed to be a deterioration in his mental health, he was recalled to hospital. He was verbally informed that he was being recalled because his mental health had deteriorated although this information was not included in the formal signed recall warrant. Two weeks after his recall, he met with his new responsible clinician who read him a copy of the professional report on which the decision to recall him had been made.
The appellant contended that his recall to hospital under the power conferred by section 42(3) Mental Health Act 1983 was effected unlawfully and therefore his subsequent detention was also unlawful. He claimed damages for false imprisonment pursuant to the Human Rights Act 1998.

The judge at first instance held that the reasons for the recall of a patient had to be given to them when recalled, although it was sufficient for them to be given orally, and that the reason given to the patient when the warrant was executed was adequate.

On appeal the court noted that the modern practice is to include brief reasons for the individual’s recall in the warrant. If that had been in place in July 2012 when the appellant was recalled, the warrant in this case would have included brief reasons for his recall and the present problems would have been avoided. In those circumstances it was felt that the court was not prepared to accept that the absence of written reasons made the detention of the appellant unlawful.

The other main issue related to the adequacy of the reason given to the appellant for his recall, namely that his mental health had deteriorated. This was not backed up as it should have been by fuller written reasons within two hours, although on balance the court found that they did not render the appellant’s detention unlawful. However at least one of the judges made it clear that the case was close to the line and the conclusion had only been reached after some hesitation.

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

Court of Appeal considers duty to consult ‘nearest relative’ under the Mental health Act

In the recent case of TW v Enfield Borough Council an approved social worker (ASW) made an application for TW’s compulsory admission to hospital pursuant to section 13(1) Mental Health Act 1983. Under the version of the Mental Health Act then in force, the ASW (subsequently replaced by approved mental health professionals) was obliged to consult the person appearing to be the “nearest relative” of the patient before making the application, namely TW’s father. TW’s father was not in fact consulted before the application because the ASW had decided that the consultation was not reasonably practical or would involve unreasonable delay.

TW, who suffered from obsessive compulsive disorder did not wish to be admitted, did not wish her family to be consulted and there was evidence that if TW learned that her family had been given details of her condition, that would have caused her great distress and might damage her health.

Subsequently the police broke into her flat and she was forcibly removed to hospital for treatment and detained for 77 days until released by order of the Mental Health Review Tribunal following an application by her father.

TW sought subsequent leave of the High Court to bring a claim for damages for unlawful detention and psychiatric injury against Enfield.

Leave was refused on the ground that it had not been reasonable practical to consult TW’s father (being her nearest relative) before applying for her admission for treatment because to do so would have constituted an action by a public body that would have infringed TW’s right to her private life pursuant to Article 8(1) European Convention on Human Rights. Therefore the ASW had been entitled to make the application to have TW voluntarily admitted to hospital without consulting TW’s nearest relative. Thus any claim against Enfield for unlawful detention and subsequently psychiatric injury was bound to fail.
TW appealed against that decision to the Court of Appeal. The main issue in the appeal proceedings was whether the court had correctly determined the ambit of the words “… not reasonably practicable” contained within section 11(4) Mental Health Act 1983.

It was argued on appeal that the judge had wrongly concluded that the fact that TW demanded complete patient confidentiality was sufficient to permit the ASW to conclude that it was therefore “impracticable” to consult TW’s father as her “nearest relative”. It was accepted that it would have physically possible to consult TW’s father before the application was made and there were three reasons why he was not consulted. Firstly because of the allegation of abuse of TW by him and TW’s brother, secondly because of TW’s insistence that the details of her case be kept confidential and not disclosed to her family, and thirdly because of the ASW’s view that she could not effectively consult TW’s nearest relative without disclosing that confidential information, which disclosure could have been detrimental to TW’s health.

On appeal the court held that as a matter of construction of section 11(4) the assertion, even if founded on fact and even if reasonable, that consultation would lead to an infringement of her Article 8(1) rights cannot, as a matter of law, lead automatically to the conclusion that it is “not reasonably practicable” to consult the “nearest relative”. Nor is an ASW’s conclusion that such consultation would lead to an infringement of the patient's Article 8(1) rights enough, in law, to lead to the decision that there should be no such consultation under section 11(4).

The obligation to consult the “nearest relative” may result in a conflict between two of the patient's convention rights, because section 11(4) in general and the words “not reasonably practicable” have to be construed in a way that is compatible not only with the patient's Article 5 right not to be deprived of her liberty but also in a way that is compatible with the patient's Article 8 right of respect for her private life and her "correspondence". A mental patient's right to maintain the confidentiality of her medical history and file and all the circumstances of her medical case must be a part of her Article 8 right to a private life.

The ASW had to make her decision on whether or not to consult TW’s “nearest relative” upon the proper construction of section 11(4), taking into account the patient's two convention rights. In the judge’s view, on what is known of the reason for the ASW's decision not to consult, there is obviously an arguable case that the decision was not made on the right basis. Whether the decision not to consult was correct, must depend upon a careful analysis of the facts and therefore leave to bring the claim should have been given. The appeal was therefore allowed.

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

Patient matters: inquests

Coroner statistics 2013 published by the Ministry of Justice

The Ministry of Justice have published its annual bulletin setting out statistics of deaths reported to coroners in 2013.

The statistics have not changed dramatically from the 2012 figures. In summary, the headline figures are as follows:

- The number of deaths reported to coroners in 2013 increased by less than one per cent from the 2012 figures.
Of deaths registered in 2013, 45 per cent were reported to coroners which is slightly less than the 46 per cent reported in 2012.

Of those cases reported to coroners in 2013, 41 per cent resulted in post mortem examinations, this percentage has dropped from 53 per cent to 41 per cent over the last ten years.

Of those deaths reported to coroners in 2013 inquests were held in 13 per cent of them, which represents a small decrease from the previous year.

The most common conclusion (formerly known as verdicts) in 2013 were deaths from natural causes (28 per cent) and deaths by accident or misadventure (26 per cent). Unclassified conclusions, which includes narrative conclusions, represented 17 per cent of the total in 2013 and conclusions of suicide comprised 12 per cent. The bulletin concludes that the increase in unclassified conclusions is partly due to the increase of “narrative conclusions” where the coroner records a factual account of how the patient died and the circumstances of their death. However, the unclassified conclusions category also includes conclusions of alcohol/drug related and “road traffic collision” deaths.

There appears to be four main points regarding the proportion of conclusions recorded by coroners over the last ten years:

- Natural causes conclusions have risen from 20 per cent in 2003 to 28 per cent in 2013
- Unclassified conclusions have risen from 4 per cent in 2003 to 17 per cent in 2013
- Conclusions of death by misadventure or accident have declined from 40 per cent in 2003 to 26 per cent in 2013
- Open conclusions have been declining, accounting for just over 6 per cent of the total in 2013 compared with 11 per cent in 2003

It is also interesting that male deaths accounted for about 67 per cent of all conclusions reach in 2003 although they accounted for 54 per cent of deaths reported which clearly indicates that males are more likely to die in circumstances resulting in an inquest!

Also interesting to note is that of the suicide conclusions, 80 per cent were in respect of males and only 20 per cent were in respect of females.

In 2013, the average time taken to process an inquest, defined as being from the date the death was reported until the conclusion of the inquest, was 28 weeks which is an increase from the 2012 average of 26 weeks.

For further information on individual coroner’s statistics is also available here or by using the coroners statistical tool 2013.

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