

Health protection regulations

A consultation

HEALTH PROTECTION REGULATIONS

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Contact Details	Health Protection Regulations Health Protection Division Health Protection Regulations Consultation, Room 514 133-155 Waterloo Road, London SE1 8UG healthprotectionregulations@dh.gsi.gov.uk
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Executive summary

1. This consultation paper sets out proposals for regulations to be made under the amended Public Health (Control of Disease) Act 1984. The regulations take forward the process started by the Health and Social Care Act 2008, which replaces outdated measures in the 1984 Act with a new, modernised framework for health protection. The 2008 Act introduced an “all hazards” approach with more flexible powers and improved safeguards for people who might be affected by them.

2. Much of the detail of the new legislation is to be in the form of regulations, allowing scope for amendment in the future in the light of advancing science or better health protection measures. We propose three sets of regulations to complement the primary legislation and so complete the legal infrastructure for health protection within England. Further regulations to update measures applying at borders (“port health regulations”) are planned to follow in due course. It is hoped to implement all the new measures during 2010.

3. This consultation is on three sets of draft regulations:

- **The Health Protection (Notification) Regulations**

These regulations replace the existing system of notification of infectious disease with updated requirements. Notification enables prompt investigation and response to protect public health. Doctors (registered medical practitioners) will continue to be required to notify cases of specified infectious disease, as well as cases of contamination with chemicals or radiation that present or could present significant harm to human health. Diagnostic laboratories that test human samples will also be required to notify identification of specified microorganisms that cause infectious disease. The proposed lists of notifiable infectious diseases and microorganisms take account of expert advice from the Health Protection Agency.

- **The Health Protection (Part 2A Orders) Regulations**

These regulations provide extra safeguards to protect people who might be subject to a Justice of the Peace (JP) order imposing restrictions or requirements to protect public health. They cover the evidence to be available to a JP before he or she can make an order; the parties who must be notified of an application for an order and who can apply for variation or revocation; duties on local authorities to protect the interests of vulnerable people; and a requirement for applications for orders to be reported to the Health Protection Agency.

- **The Health Protection (Local Authority Powers) Regulations**

These regulations replace the current set of outdated local authority powers to protect human health. They provide powers for local authorities to carry out certain health protection functions including keeping a child with infectious disease or contamination off school; powers to formally request cooperation to protect public health; and powers to limit contact with a body of a person who has died from infectious disease or contamination.

4. We invite comments on these regulations, and, in particular, responses to the questions set out in this consultation paper.

1: Background

5. Globally, infections cause a quarter of all deaths¹. They account for approximately 1 in 15 deaths in the UK². New infectious diseases are emerging at an historically unprecedented rate³. In addition, the world faces greater than ever risk of chemical or radiological contamination, whether by accident, or by malign act.

6. The overall aim of health protection legislation is to prevent or minimise the spread of infectious diseases and contamination by requiring the timely notification of infection, or radiological or chemical contamination, and enabling restrictions or requirements to be imposed on people or things where necessary to protect public health.

7. The behaviour of a person with an infectious disease can in some circumstances put the health of others at risk. In the vast majority of cases, such problems can be tackled by advising and/or supporting the person concerned. For example:

- Schools often explain to parents that children who have experienced diarrhoea and vomiting should not return to school until they have been clear of symptoms for two days, to avoid the risk of passing infection to others;
- Effective treatment of tuberculosis (TB) involves a course of medication lasting six months or more. If a patient does not complete their course of treatment, they may remain infectious and develop (and infect others with) a drug-resistant, harder to treat, form of the disease. To help patients complete their course of treatment, TB clinics offer directly observed therapy, with patients taking their medication under staff supervision.

8. However, there may be cases where a person with an infectious disease refuses to act on the best advice, and continues to behave in ways that put others at risk. Legislation is necessary to deal with these situations. Part 2 of the Public Health (Control of Disease) Act 1984 contains this legislation in its current form. It also includes other provisions aimed at preventing or controlling the spread of infectious disease - for example, there are duties on doctors to notify cases of specified infectious diseases to allow prompt investigation and response.

¹ WHO Infectious Diseases Report 1999, available [here](#).

² OECD Health Data 2008, available [here](#).

³ WHO, The World Health Report 2007- 'A Safer Future', available [here](#).

Newly emerging infections and health threats

“Communicable diseases also deliver surprises, whether in the form of new diseases or well-known diseases behaving in new ways.”

Dr David Heymann, Chairman, Health Protection Agency and former Assistant Director-General for Health Security and Environment Health Security and Environment, World Health Organisation

American Public Health Association (2004). Control of communicable diseases manual (18th edition). Heymann, D L (Ed).

Different public health threats have to be dealt with in different ways. The Department of Health has been planning for the possibility of a pandemic of influenza for a number of years. This year's outbreak of swine flu has now been classified by the World Health Organisation as a pandemic. We are continuing to work with other government departments, health protection officers and other healthcare professionals to contain the spread of the virus. These measures have helped us secure valuable time to gather more information about the virus, and prepare the NHS and other public services should the outbreak become more serious. We are unlikely to prevent a widespread outbreak indefinitely and at some stage will need to move our focus towards mitigating the effects of a widespread virus.

The Health Protection Regulations consulted on here have been drafted to complete the process of updating legislative health protection powers begun by the Health and Social Care Act 2008. They ensure there is a sound legislative framework in place to protect human health, available for use in the appropriate circumstances. These regulations are not framed to provide any particular powers in respect of swine flu, and we do not currently envisage them having any application to people who have swine flu. However, the legislation could be used if this was considered suitable and necessary.

Review of the 1984 Act and introduction of new primary legislation

9. The Department of Health published a consultation paper in March 2007, which set out proposals for changes to key parts of the 1984 Act. The proposals were broadly supported. The report of the consultation response is available on the Department of Health website ([Review of Parts II, V and VI of the Public Health \(Control of Disease\) Act 1984: report on consultation](#)). The first step in the implementation of the proposals from the March 2007 consultation was the introduction of new primary legislation in Part 3 of the Health and Social Care Act 2008. Part 3 amends the Public Health (Control of Disease) Act 1984 by repealing Part 2 of that Act and replacing it with a new Part 2A. Some other parts of the 1984 Act are also amended.

10. The updates introduced by Part 3 of the Health and Social Care Act 2008 mean that the Public Health (Control of Disease) Act 1984:

- takes an “all hazards approach” to health protection, (rather than focusing only on specified infectious diseases), and can therefore be used to help protect against any infection or chemical or radiological contamination that could present significant harm to human health.

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This enables a quick response to new or unknown diseases or threats (for example SARS or polonium 210).

- protects the needs and rights of people who might be affected by legislative measures.

The need for an ‘all-hazards’ approach....

“Infectious diseases are only one of the threats to health from the external environment – they represent the main biological threat. However, there are threats to health that arise regularly from the physical environment – for example, chemical and radiation incidents.”

Sir Liam Donaldson, Chief Medical Officer

Department of Health (2002). Getting ahead of the curve: a strategy for combating infectious disease (including other aspects of health protection) - a report by the Chief Medical Officer.

In 2006 and 2007, up to 27,970 people were estimated to have been exposed to chemicals in England and Wales with 6,220 reporting symptoms. More than 1000 people were exposed in each of six separate events (five of which involved contamination of water). 20% of chemical incidents resulted in evacuation of nearby populations and there were 9 fatalities as a result of these incidents.

Health Protection Agency (2008). Chemical Incidents Surveillance Review: January 2006 - December 2007, available [here](#).

What regulations are we consulting upon?

11. The new Part 2A of the 1984 Act specifies that the detailed powers and duties for responding to a public health threat must be set out in regulations. These regulations will apply to England only. We are consulting on the following sets of regulations:

- **Health Protection (Notification) Regulations:** requirements for doctors (registered medical practitioners) and laboratories testing human samples to report cases of infectious disease or contamination which present, or could present, significant harm to human health, to allow prompt investigation and response;
- **Health Protection (Part 2A Orders) Regulations:** safeguards to apply when a Justice of the Peace (JP) makes an order imposing restrictions or requirements on someone to protect public health, and reporting of applications for orders;
- **Health Protection (Local Authority Powers) Regulations:** standing powers and duties of local authorities relating to their health protection role, where the judicial oversight of a JP is not necessary.

12. The new Part 2A also gives powers to make other sets of regulations, not consulted upon here:

- We will consult on international “port health” regulations in the coming months. These regulations will include provisions to prevent the import or export of infection or contamination that could be a risk to public health internationally.

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- Regulations may also be made imposing controls to deal with specific contingencies. We do not propose at this stage to make any regulations using these powers.

13. It is appropriate that the detail of modern health protection legislation is set out in these regulations. If necessary, regulations, a form of secondary legislation, can be quickly amended and updated to reflect new or urgent risks, advances in science and technology or better health protection measures. This is important in making sure we are able to respond quickly to public health threats. Although there is no statutory duty to do so, the Government has committed to consult on these framework regulations. This consultation paper meets this commitment.

14. When the new Part 2A of the Public Health Act 1984 comes fully into force, along with the proposed regulations described here, these pieces of legislation will form a coherent set of powers and duties for the protection of human health (as shown in the diagram on the following page).

The Justice of the Peace (JP) order-making powers

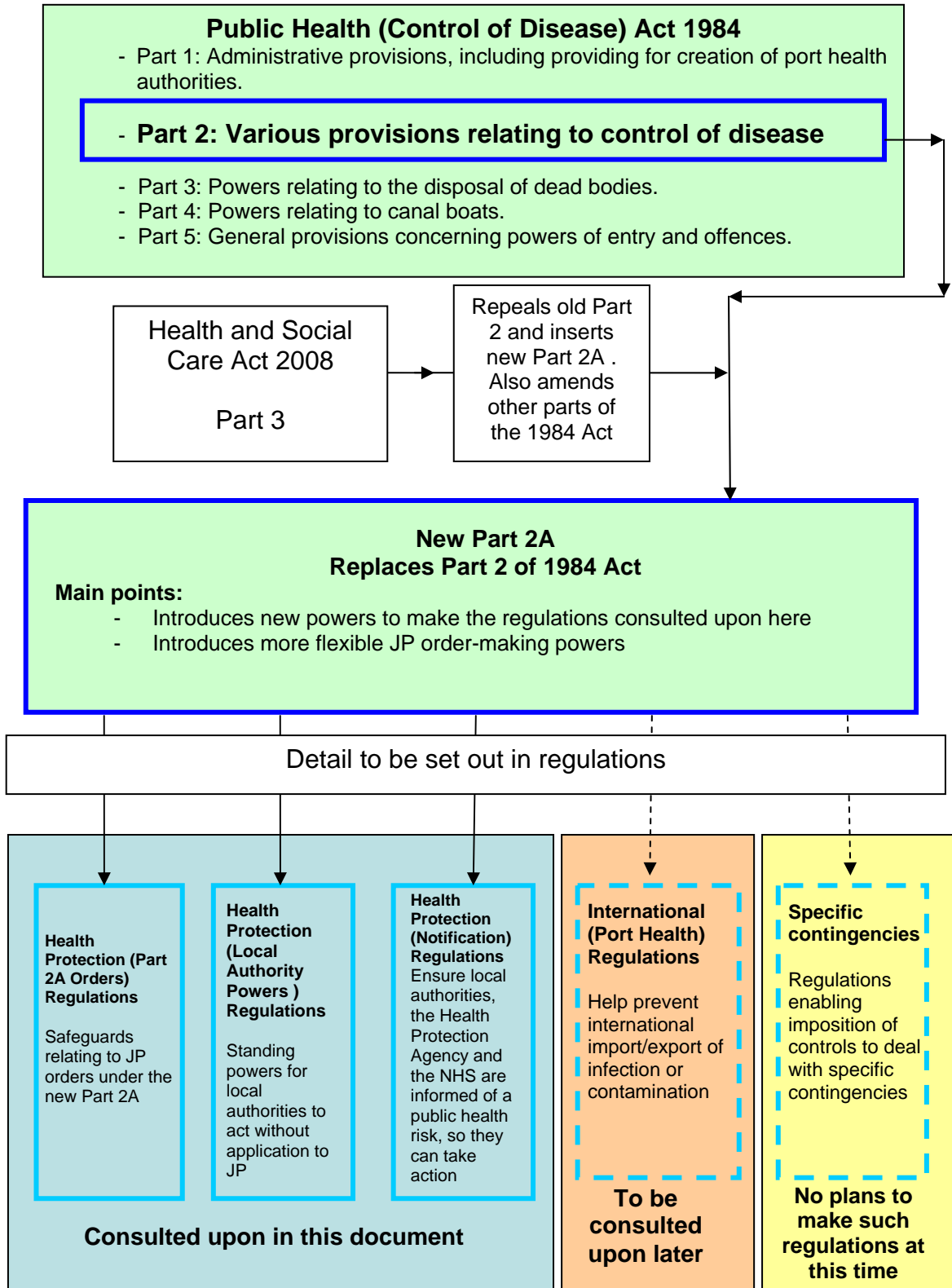
Under the law currently in force, a JP may order the medical examination, removal to a hospital, or detention in hospital of a person with a 'notifiable disease' (30 infectious diseases specified in the current law). When the new Part 2A of the Act is implemented, the JP's powers will focus on risk from any infection or contamination (chemical or radiological) which presents, or could present, significant harm to human health.

The new powers are therefore more appropriate to deal with the threats of today's world. They are also more flexible than the current arrangements. For example, it may be sufficient to make an order requiring a person to stay at home, with monitoring from the community nursing service, rather than to order them to be detained in hospital.

A JP may also make an order imposing requirements relating to premises or "things" if a risk to public health from infection or contamination arises.

For further details, see the Impact Assessments for the Health and Social Care Bill: public health protection measures, available [here](#) on the DH website.

Public Health Protection Legislation: A Summary of the Recent Updates



Producing the draft regulations

15. We aimed to capture a wide range of expert input before drafting the new regulations. In particular, a meeting held in early 2009 with a range of stakeholder organisations directly contributed to the content of the current draft regulations.

16. The following chapters discuss the draft regulations in detail. The draft regulations are available from the health protection regulations consultation website alongside this consultation document. The website also contains a comprehensive set of draft impact assessments, which assess the economic, equality, health and legal costs and benefits of these proposed regulations. The production of these impact assessments helped us to formulate the policy underlying the draft regulations.

17. This consultation document seeks formal views on the draft regulations. 'Questions for consultation' are presented throughout the consultation document. A complete list of these questions is presented at **Annex 1**. A version of this form which can be filled out in Microsoft Word is available on the health protection regulations consultation website, alongside this consultation document. Electronic submission to the e-mail address indicated on the response form is preferred.

The continuing health protection role of local authorities

Public health legislation has always given significant powers and functions for public health protection to local authorities. Local authorities can discharge specific responsibilities by appointing "proper officers" to carry out those functions on their behalf. A proper officer for the purpose of implementation of public health legislation is usually a public health or environmental health professional: for example, a consultant in communicable disease control/health protection who is typically employed by the Health Protection Agency's local Health Protection Unit. The updated legislation does not in any way propose a change to this practice - the appropriate officers will continue to discharge their local authority's health protection functions.

What are the next stages of the process?

18. The Department will publish a response to this consultation, which will summarise the views we have received and outline how they have been acted upon. This will inform the production of final draft regulations, which must also meet the commitments made in Parliament during the passage of the primary legislation. These commitments are highlighted in the relevant chapters of this consultation document.

19. The draft regulations will be laid before Parliament. The Health Protection (Part 2A Orders) Regulations and the Health Protection (Local Authority Powers) Regulations will be debated in both Houses before they become law. Parliament will also have the opportunity to debate the Health Protection (Notification) Regulations if it chooses to do so.

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20. If Parliament is satisfied with the content of the regulations, they will become law and will come into force, along with the relevant parts of the new Part 2A, on a specified date in 2010. Guidance will be published which will help health protection professionals use the updated legislation.

2: Draft Health Protection (Notification) Regulations

Summary

New notification regulations will modernise the current system for notification of infectious diseases by:

- Updating the current list of notifiable infectious diseases to be reported by registered medical practitioners to reflect up to date epidemiological evidence, and to provide for notification of diseases that may be caused by emerging or new infections, or by chemical or radiological contamination;
- Placing a new obligation on diagnostic laboratories testing human samples to notify identification of specified microorganisms that cause infectious disease;
- Providing clear time limits for notification by registered medical practitioners and diagnostic laboratories, including provision for urgent reporting.

This will help ensure that there is prompt investigation of and response to risks to public health from infection or contamination.

The draft Notification Regulations can be found alongside this consultation document on the health protection regulations consultation website.

21. Statutory notification of infectious diseases has been a crucial health protection measure in England since the late 19th century. Notification enables prompt investigation, risk assessment and response to cases of infectious disease that pose a significant risk to public health.

22. Many countries across the world have statutory notification systems in place with notification made by doctors, laboratories or hospitals (e.g. France, Germany, the Netherlands, Sweden, USA, Canada, Australia and New Zealand). Scotland have recently updated their notification system in the Public Health etc. (Scotland) Act 2008⁴.

23. It is worth noting that the domestic notification system outlined in these draft regulations is different from the requirement for member states to notify the World Health Organisation of a potential Public Health Emergency of International Concern under the International Health Regulations 2005. More information concerning the International Health Regulations notification system is available on the Health Protection Agency website, [here](#).

⁴ Public Health (Scotland) Act 2008 - <http://openscotland.gov.uk/Topics/Health/NHS-Scotland/publicact>

Why clinical notification of certain infectious diseases is important in protecting public health – example: meningitis

Neisseria meningitidis bacteria are found naturally in the back of the throat or nose (nasopharynx). However, these bacteria occasionally cause invasive meningococcal disease, which is associated with a case fatality rate of approximately 10%. Close household contacts are at increased risk of acquiring the same infection through nasopharyngeal spread. Therefore, it is important to be able to identify them promptly.

Administering antibiotics reduces the risk of invasive meningococcal disease by eradicating carriage of these bacteria in close contacts at highest risk.

Requiring clinicians to report cases or suspected cases ensures timely clinical investigation and management of the case (appropriate antibiotic treatment) and reduction in the risk of additional cases occurring through antibiotic administration to contacts as necessary.

Current provisions for notification of infectious diseases in England

24. The current provisions for notification of cases of specified infectious diseases by registered medical practitioners to the proper officer of the local authority are contained in the Part 2 of the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Diseases) Regulations 1988.

Current list of notifiable diseases

Infection	When made notifiable
Under the Public Health (Control of Disease) Act 1984	
Cholera	1889
Food poisoning	1949
Plague	1900
Relapsing fever	1889
Smallpox	1889
Typhus	1889
Under the Public Health (Infectious Diseases) Regulations 1988	
Acute encephalitis	1918
Acute poliomyelitis	1912
Anthrax	1960
Diphtheria	1889
Dysentery (amoebic or bacillary)	1919
Leprosy	1951
Leptospirosis	1968
Malaria	1919
Measles	1940
Meningitis	1968
Meningococcal septicaemia (without meningitis)	1988
Mumps	1988
Ophthalmia neonatorum	1914
Paratyphoid fever	1889
Rabies	1976
Rubella	1988
Scarlet fever	1889
Tetanus	1968
Tuberculosis	1912
Typhoid fever	1889
Viral haemorrhagic fever	1976
Viral hepatitis	1968
Whooping cough	1940
Yellow fever	1968

Source: McCormick A. The notification of infectious diseases in England and Wales. Commun Dis Rep CDR Rev. 1993 Jan 29;3(2):R19-25

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25. The main features of the current notification system are:

- The notification of cases or suspected cases of specified diseases by the attending doctor to the proper officer of the local authority.
- The onward notification by the local authority to the relevant primary care trust(s) and local or port health authority, as appropriate.
- Aggregated data on notifications are sent weekly and quarterly by local authorities to the Health Protection Agency.
- A nominal fee (£3.36) is payable to the reporting doctor by the relevant primary care trust for each notification.
- An offence is committed and a level 1 fine⁵ is payable for failure by a registered medical practitioner to inform the proper officer of the local authority of a case or suspected case of a notifiable disease.
- Certain cases of infectious diseases must be specially reported by the proper officer of the local or port health authority to the Chief Medical Officer.
- The local authority may direct that other diseases are notifiable in their area (subject to approval of the Secretary of State, except in emergency).

Proposed provisions for notification of infectious diseases and disease caused by contamination in England

26. It is proposed that the draft regulations made under Part 2A of the Public Health (Control of Disease) Act 1984 will replace existing provisions in the 1984 Act and the 1988 Regulations. The main changes in the proposed new provisions are set out in the following paragraphs.

Updated list of notifiable diseases

27. The current list of notifiable diseases to be reported by registered medical practitioners includes some diseases originally made notifiable 120 years ago. It needs to be updated to reflect current epidemiology and public health concerns, taking account of expert advice from the Health Protection Agency.

28. Notification by registered medical practitioners also needs to take account of emerging or new infectious diseases and disease caused by chemicals or radiation that may pose a

⁵ See box on p35 for further information on fines.

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wider risk to public health, reflecting the “all hazards” approach to health protection taken by the revised 1984 Act.

29. The current list of infectious diseases to be notified by registered medical practitioners has therefore been updated. There is also provision for notification of diseases that may be caused by new or emerging infectious diseases, or by chemical or radiological contamination. Schedule 1 to the notification regulations contains the full list of proposed notifiable diseases. This is attached at the end of this chapter.

30. Having the complete list in regulations - a form of secondary legislation - rather than split between primary and secondary legislation as now, will make it easier to update the list in the future. It also makes the legislation easier to use.

31. While the recently updated list of statutorily notifiable diseases in Scotland⁶ includes healthcare associated infections (HCAIs) such as MRSA, we are not currently proposing this addition in England. There is already an effective mandatory HCAI surveillance system in place for MRSA and vancomycin-resistant enterococcal bloodstream infections, *C. difficile* infection and surgical site infections following orthopaedic surgery. Furthermore, HCAIs represent a variety of clinical conditions of differing severity that would require complicated definition for notification under these regulations to be useful. However, it would be possible to make HCAIs notifiable in future should this be appropriate.

32. The regulations also clarify that if a registered medical practitioner suspects that a person has died with (but not necessarily because of) a notifiable disease, or other infection or contamination that presents or could present significant harm to human health, then that should be reported to the proper officer of the local authority - unless such notification has already been made.

⁶ Public Health (Scotland) Act 2008 - <http://openscotland.gov.uk/Topics/Health/NHS-Scotland/publicact>

Information to be notified, as far as it is known, by a registered medical practitioner (RMP) to the proper officer of the local authority

- The patient's name, date of birth and sex;
- The patient's home address including postcode;*
- The patient's current residence (if not home address);
- The patient's NHS number;*
- The patient's occupation (if the RMP considers it relevant);*
- The name, address and postcode of the patient's place of work or education (if the RMP considers it relevant);*
- The patient's ethnicity;*
- The disease or infection which the patient has or is suspected of having, or the nature of the patient's contamination or suspected contamination;
- The date of onset of the patient's symptoms;
- The date of the RMP's diagnosis;* and
- The RMP's name, address and telephone number.

* Additional items of information compared to current statutory reporting requirements. Similar information will be required in relation to patients who have died with (but not necessarily because of) a notifiable disease, or other infection or contamination that presents or could present significant harm to human health.

Questions for consultation

A- Is the list of notifiable diseases for clinical reporting at Schedule 1 (attached at the end of this chapter) to the draft notification regulations appropriate? If you answered that it is not appropriate, what changes would you make and why?

B- Is there any health protection benefit in Primary Care Trusts receiving from the proper officer of the local authority copies of individual notifications from registered medical practitioners?

C- Is the information to be reported by registered medical practitioners, as far as it is known to them, appropriate? If you answered that it is not appropriate, what changes would you make and why?

Statutory notification by laboratories

33. The draft regulations introduce the statutory notification of specified microorganisms that cause infectious disease to the Health Protection Agency by all diagnostic laboratories testing human samples (see Schedule 2 to the notification regulations, attached at the end of this chapter, which lists the specified microorganisms to be notified). Although voluntary laboratory notification of a wide range of microorganisms to the Health Protection Agency already takes place, statutory laboratory notification is necessary:

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- to ensure that notification of laboratory diagnoses of infectious diseases requiring prompt investigation and response takes place, improving completeness and timeliness of reporting;
- to confirm clinical diagnoses and assist with investigation and response;
- to deal with diseases that can only be diagnosed in the laboratory;
- to help identify geographically dispersed outbreaks.

Why laboratory notification of certain infectious diseases is important in protecting public health – example: Legionnaires' Disease

Cases of Legionnaires' Disease (due to infection with *Legionella pneumophila* bacteria) often present with non-specific symptoms of pneumonia such as cough, shortness of breath and weight loss.

There are several documented Legionnaires' Disease outbreaks resulting in fatalities where a cooling tower contaminated with *Legionella pneumophila* has been identified as the source.

Since laboratory testing is required to confirm the diagnosis of Legionnaires' Disease, laboratory reporting of Legionnaires' Disease cases would ensure timely public health investigation of potential point sources of *legionella pneumophila* and the implementation of appropriate control measures, thus minimising the possibility of further cases of Legionnaires' Disease occurring through exposure to the same source.

Timeframe and mechanism for notification

34. We propose clear time limits for notification by registered medical practitioners and laboratories, and provision for urgent oral reporting. This is because there may only be a limited window of opportunity for health protection interventions that can prevent further spread of infection or contamination.

35. Electronic communication of notifications will be allowed, in order to make the notification requirement as convenient as possible within the specified timescales.

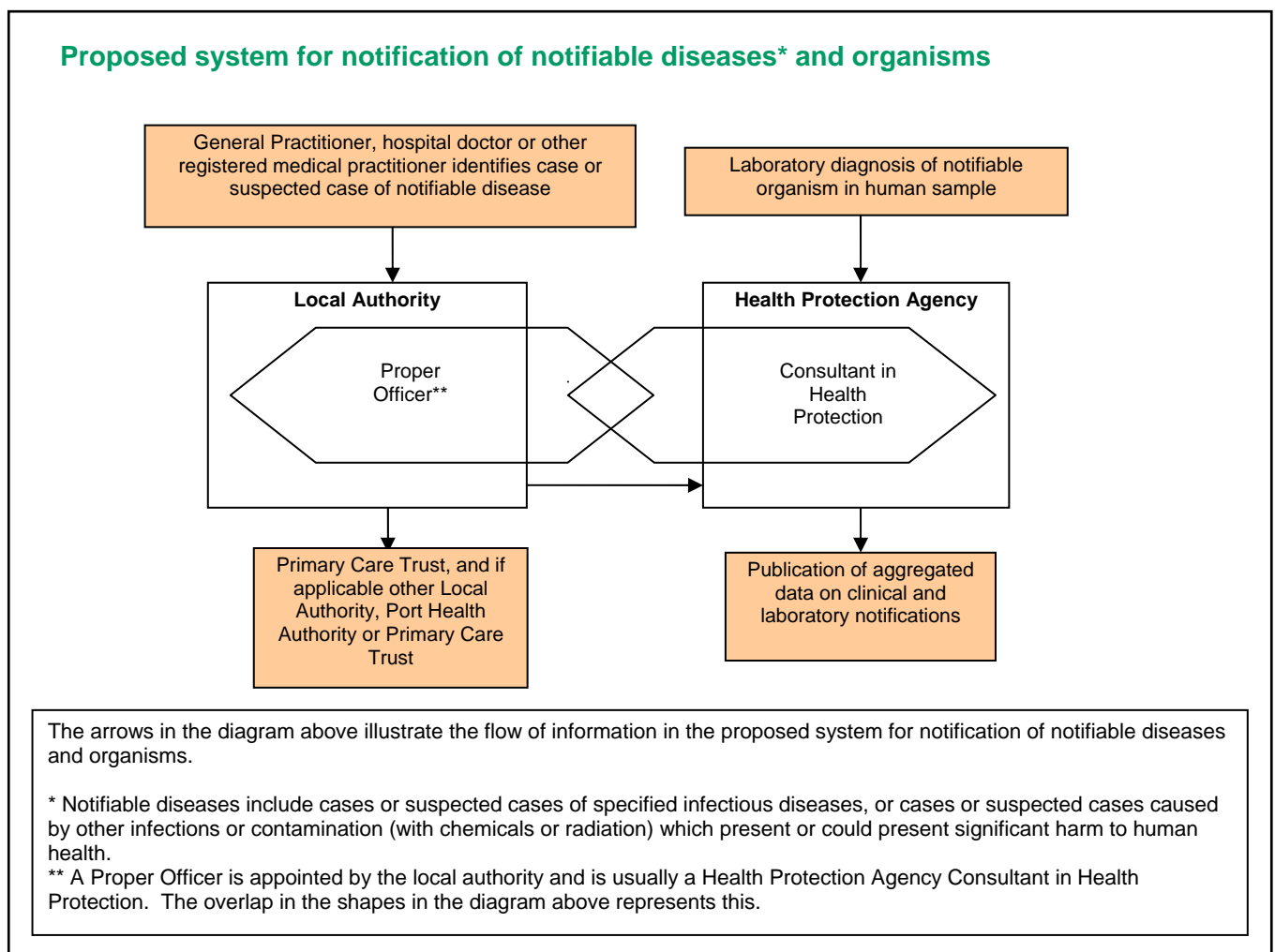
Information to be notified, as far as it is known, by a diagnostic laboratory to the Health Protection Agency

- The name and address of the diagnostic laboratory;
- The details of the causative agent identified;
- The date of sample;
- The nature of sample;
- The name of the patient from whom sample was taken;
- The patient's date of birth and sex;
- The patient's current home address including postcode;
- The patient's current residence (if not home address);
- The patient's ethnicity;
- The patient's NHS number; and
- The name, address and organisation of the person who solicited the test or tests which identified the causative agent.

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36. The draft regulations require, as now, that registered medical practitioners make their notification to the proper officer of the local authority, who informs the relevant primary care trust(s), local authority or port health authority. In addition, the proper officer will also be required to inform the Health Protection Agency. This will ensure that the Health Protection Agency is in a position to take prompt action as appropriate. It will also allow streamlining of current arrangements for collation and publication of anonymised aggregated data.

37. We propose to remove the current requirement for cases of infectious disease to be specially reported to Department of Health and Chief Medical Officer (CMO). The Health Protection Agency already routinely informs the Department of Health of any cases/outbreaks that may pose a significant risk to human health.



Questions for consultation

D- Is the list of specified microorganisms (“causative agents”) for laboratory reporting at Schedule 2 (attached at the end of this chapter) to the draft regulations appropriate? If you answered that it is not appropriate, what changes would you make and why?

E- Is the information to be reported by laboratories, as far as it is known to them, appropriate? If you answered that it is not appropriate, what changes would you make and why?

Ensuring notification takes place

38. We propose to remove the nominal payment of £3.36 per notification for notifications by registered medical practitioners. This is on the basis that such information needed to protect public health should be provided without payment, as part of professional responsibility of medical practitioners and in accordance with good medical practice.

39. The draft regulations no longer provide for an offence for non-notification by registered medical practitioners. This is because the arrangements for clinical governance, the contracts for general medical services and personal medical services, and oversight by the General Medical Council, all act to promote adherence by registered medical practitioners to legislative requirements about the disclosure of information, including specifically in relation to notifiable diseases.

40. However, we propose to introduce an offence for non-notification by laboratories as there are no arrangements similar to those for registered medical practitioners, to promote compliance with the notification requirements. The offence will apply to the corporate body that operates the laboratory.⁷ The proposed penalty will be a fine not exceeding level 5 (£5,000) on the standard scale.⁸ An offence is only committed where there has been a failure to notify without “reasonable excuse”.

⁷ If the laboratory does not have a corporate body, the offence will apply to the director of the laboratory or the person nominated by the director to make notifications.

⁸ See box on p35 for further information on fines.

Notification Regulations Schedule 1 Notifiable Diseases

Acute encephalitis
Acute poliomyelitis
Acute viral hepatitis
Anthrax
Botulism
Brucellosis
Cholera
Diphtheria
Enteric fever (typhoid or paratyphoid fever)
Food poisoning
Haemolytic uraemic syndrome (HUS)
Human influenza virus caused by a new subtype of influenza virus
Infectious bloody diarrhoea
Invasive group A streptococcal disease and scarlet fever
Invasive meningococcal disease (meningococcal meningitis, meningococcal septicaemia and other forms of invasive disease)
Legionnaires' Disease
Leprosy
Leptospirosis
Malaria
Measles
Mumps
Plague
Rabies
Rubella
SARS
Smallpox
Tetanus
Tuberculosis
Typhus
Viral haemorrhagic fever (VHF)
Whooping cough
Yellow fever

The regulations also make provision for registered medical practitioners to notify cases of other infections or contamination that present or could present a significant risk to human health.

**Notification Regulations Schedule 2
Causative Agents**

Bacillus anthracis
Bacillus cereus
Bordetella pertussis
Borrelia spp
Brucella spp
Campylobacter spp
Chikungunya virus
Chlamydia psittaci
Clostridium botulinum
Clostridium perfringens
Clostridium tetani
Corynebacterium diphtheriae
Corynebacterium ulcerans
Coxiella burnetii
Crimean-Congo haemorrhagic fever virus
Cryptosporidium
Dengue virus
Ebola virus
Entamoeba histolytica
Francisella tularensis
Giardia lamblia
Guanarito virus
Haemophilus influenzae (invasive)
Hanta virus
Hepatitis A, B, C, delta, and E viruses
Influenza virus
Junin virus
Kyasanur Forest disease virus
Lassa virus
Legionella spp
Leptospira interrogans spp
Listeria monocytogenes
Machupo virus
Marburg virus
Measles virus
Mumps virus
Mycobacterium bovis
Mycobacterium tuberculosis complex
Neisseria meningitidis
Omsk haemorrhagic fever virus
Plasmodium falciparum, vivax, ovale, malariae
Polio virus wild or vaccine types
Rabies virus (classical rabies) and rabies-related lyssaviruses
Rickettsia spp

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Rift Valley fever virus
Rubella virus
Sabia virus
Salmonella enterica serovar Paratyphi
Salmonella enterica serovar Typhi
Salmonella spp
SARS coronavirus
Shigella spp
Streptococcus pneumoniae (invasive)
Streptococcus pyogenes (invasive)
Varicella zoster virus
Variola virus
Verocytotoxigenic *Escherichia coli*
Vibrio cholerae
West Nile Virus
Yellow fever virus
Yersinia pestis

3: Draft Health Protection (Part 2A Orders) Regulations

Summary

Regulations will provide more safeguards for people who might be subject to a Part 2A Justice of the Peace (JP) order by:

- setting out the evidence a JP must have available before he or she can make an order about a person;
- providing that the next of kin of the deceased is an “affected person” if an order involves a dead body - giving them the right to apply to have the order varied or revoked;
- setting out who the local authority must notify about an application for an order;
- introducing local authority duties to:
 - provide information to people subject to an order so that they understand what the order does, the reasons for it, and their right to apply for variation or revocation;
 - report applications for orders to the Health Protection Agency so that the use of orders can be monitored at the national level;
 - have regard to the welfare of anyone whose liberty is restricted by an order with the result that they cannot care for themselves or any dependants.

The draft Part 2A Orders Regulations can be found alongside this consultation document on the health protection regulations consultation website.

41. Part 2A of the 1984 Act gives powers to a Justice of the Peace (JP) to make orders, on application by a local authority, imposing restrictions or requirements on people, or about things or premises, to protect against an infection or contamination that presents or could present significant harm to human health. The draft regulations consulted upon here complete the new arrangements for JP orders, safeguarding the interests of individuals who may be the subject of an application for an order. They also provide for scrutiny of the use made of the powers, through the proposed requirement for local authorities to report all applications for orders to the Health Protection Agency.

The evidence that a JP must have before he or she can make an order about a person

42. Under the new Part 2A, a JP must be satisfied that certain criteria are met before making an order. For an order about a person, the criteria are:

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- the person is or may be infected or contaminated;
- the infection or contamination presents or could present significant harm to human health;
- there is a risk that the person (or, for an order requiring information about a related party, the related party) might infect or contaminate others;
- it is necessary to make the order to remove or reduce that risk.

43. Part 2A requires the Government to make regulations about the evidence the JP must have available to support an application for an order about a person, before the JP can decide if these criteria are met. These draft regulations set out our proposals for what the minimum evidence requirements should be. The JP is free to ask for further evidence if he or she wishes.

44. The evidence must be given to the JP by one or more people who the local authority judge to be suitably qualified. Those people must provide a written or oral report covering at least one of the points set out below. If any of these points are not covered, the report must explain the reasons why. The points are:

- the person's symptoms;
- the diagnosis;
- the outcome of any clinical or laboratory tests;
- the person's recent contacts with, or proximity to, a source of infection or contamination.

45. The report must also include a summary of the characteristics of the infection or contamination which the person has, or may have, covering how it spreads, how easily it spreads, and its impact in terms of pain, disability and likelihood of death.

46. In some cases, the infection or contamination giving rise to concern may not yet have been identified. In such a case, the information to be given must relate to the observed characteristics of the infection or contamination in question.

47. In addition, the evidence must include a written or oral assessment of:

- the risk that the person, or related party, presents to others - including anything which the person is either doing or not doing to affect that risk, and;
- the options available to deal with that risk.

48. This latter requirement is intended to help the JP to decide if an order is necessary - if there are other viable options available to deal with the threat, that criterion will not be met.

Who is the right person to give evidence?

We considered carefully the question of who can give the best evidence to support an application for an order which would have the effect of restricting a person's liberty. The views of a medically qualified person may be crucial to the evidence, for example if a person has a serious infectious disease. However this would not always be the case, if, say, the person had been exposed to certain forms of contamination, when a specialist scientist might be in a better position to provide evidence. Who can provide the best evidence will depend on the particular circumstances of each case. We believe that the JP is in a position to judge whether the evidence produced is the best available. No detention (or other restriction on liberty) can take place without judicial oversight at the outset.

49. Overall, we have aimed to require enough evidence about each aspect of the criteria to be helpful to the JP in making his or her decision. At the same time, we do not want to impose burdensome processes which hinder appropriate action to protect public health. We think the regulations as drafted achieve this balance.

Evidence requirements for a JP order in an emergency situation: example

A situation might arise where a person has been exposed to a dangerous infection or contamination, but has no symptoms, no diagnosis is available at the time and no test results are yet available. It becomes an emergency because the person is behaving in a way which puts others at risk from spread of the infection or contamination, and the person cannot be dissuaded from this behaviour. An application for a JP order could be the only way to deal with the risk to others from the person's actions. The evidence brought to the JP would explain that the symptoms, diagnosis and test results were not available, and why. In that scenario, the focus would be on the person's exposure to infection or contamination and the behaviour which puts others at risk. It should always be possible to give evidence about the characteristics and effects of the infection or contamination in question, and the assessment of risk and options will be an essential component of the evidence in all cases.

Questions for consultation

F- Will the proposed requirements for evidence to be given to a JP be helpful to the JP? If you consider that the evidence requirements will be unhelpful, what evidence should be required, in addition to, or instead of, the requirements identified?

G- Are the proposed requirements for evidence sufficiently flexible to allow action to protect public health in all circumstances? If you do not think they are flexible enough, what changes would you make? Please give your reasons.

Who has the right to apply to the JP for an order to be revoked or varied

50. The new Part 2A allows "affected persons" to apply to the JP for an order to be varied or revoked. It sets out who affected persons are in the case of orders relating to people, things

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and premises respectively, and allows regulations to be made setting out who else, apart from those people, can be an “affected person”.

Affected persons as set out in Part 2A

Part 2A sets out that affected persons are:

- For orders about a person:
 - the person;
 - anyone who has parental responsibility for that person;
 - a husband, wife or civil partner;
 - anyone living with the person as such.
- For orders about things:
 - the owner;
 - anyone with custody or control.
- For orders about premises:
 - the owner;
 - any occupier.

51. The Government made two commitments in Parliament about affected persons. The first was to “look again at how the regulation-making power...could be used to add to the list of affected persons, or persons nominated to act on their behalf”. We have considered the scope for adding to the list of affected persons, and have concluded that this would not be the right thing to do, except in the specific circumstances of an order involving a dead body or human remains. We must take “affected person” to mean what it says: someone personally affected by the order. We do not think we should stretch this meaning to include others who might, for example, wish to apply for variation of an order on the person’s behalf, as has been suggested. This would go beyond the remit of the legislation and is not necessary, because the new Part 2A and regulations, taken together, will provide adequate safeguards and support for vulnerable people who might be affected by an order. Anyone legally entitled to act on the affected person’s behalf in this context may of course do so.

Question for consultation

H- Does the list of “affected persons” in the Act cover everyone who might be personally affected by a JP order? If not, who else should be included?

52. The second commitment regarding affected persons is that “next of kin” would be added to the list of affected persons where an order involves a dead body. For such orders, we propose that the regulations should state that the next of kin of the deceased person is an affected person (and so able to apply for the order to be varied or revoked). There is no generic definition of next of kin in law, so we have considered how best to interpret the phrase. We have broadly followed the model of the Human Tissue Act 2004, and propose that next of kin should be the first occurring in the following hierarchical list:

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- anyone with parental responsibility for the deceased (this would apply if the deceased were a child under 18);
- the deceased's husband, wife or civil partner;
- anyone who had been living with the person up to the time of their death as husband, wife or civil partner;
- the deceased person's child or children aged 18 or over;
- the deceased person's parent;
- brother(s) or sister(s) of the person (if aged 18 or over).

53. This short list focuses on the main family relationships. Our intention is to meet the commitment that a JP should not be able to make an order affecting a body or human remains, including for burial or cremation, without a close family member being able to apply for the order to be varied or revoked. That argument is less strong in the case of more distant relationships. We must also consider the potential burden on a local authority arising from the linked duty to notify the next of kin (see below).

54. We recognise that in some cases a deceased person will not have any next of kin as set out in this list. It has been argued that for this reason, others, such as friends, should be included in the hierarchical list. It is also the case that a friend may have been closer to the deceased person than a relative who is on the list. We have considered how the regulations might deal with these issues, and have concluded that it is not practicable to cover every eventuality. We do not want the JP or local authority to be required to make detailed enquiries into the nature of the deceased's relationships and friendships before a person's status as affected person can be determined. We propose the list above as meeting the vast majority of circumstances in what will certainly be a very rare use of powers. Again, this is also relevant to the local authority duty to notify the next of kin, set out below.

Question for consultation

I- Is the proposed list of next of kin who are to have the right to apply for variation or revocation of any JP order applying to a body adequate for this purpose? If not, have you suggestions as to what the regulations should require here?

Who the local authority must notify if they make an application for an order

55. The new Part 2A requires us to make regulations about who must be notified whenever the local authority applies to a JP for an order to be made to protect public health.

56. There are potential problems in simply saying that all affected persons must be notified. For example, a wife, husband or civil partner is an affected person under the new Part 2A. They retain this status even if they are estranged from the person concerned. We do not want the local authority to have a legal obligation to notify an estranged spouse or partner of a matter which could be regarded as a breach of that person's confidentiality. It seems

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reasonable to assume that if the person remains on good terms with their spouse or partner, then that person would know about the application for an order and so be in a position to exercise their right to apply for variation or revocation.

57. We propose therefore to confine the scope of the regulation to the person concerned (or their parent, in the case of a child), and any representative of the person appointed under the terms of the Mental Capacity Act 2005. In the case of an order about a thing, the owner or person with custody or control of it is to be notified. For an order about premises, the requirement will apply to the owner and/or occupier.

58. In the case of an application for an order involving a body or human remains, the next of kin is to be notified. The next of kin is to be decided from the same list as given above. However, we propose that only one person from the list should be notified - if there is more than one person at the same ranking, then only one of them need be notified. The same arguments apply with regard to the list as given above.

59. We recognise that it may not always be feasible for the local authority to carry out the notification. For example, the local authority might not know the person's address or how to contact them. We propose that the local authority should make reasonable enquiries, but if, having done so, the person concerned cannot be reached, then the authority need take no further action.

60. There is also an important health protection issue arising, in that a notification could defeat the purpose of the application, if, for example, it is feared that the person might abscond. We think it is right that the regulations should allow for this eventuality. The draft regulations therefore only require the local authority to notify people who are not expected to undermine the order applied for by absconding or otherwise.

61. We think these proposals will allow the local authority to notify those who need to know about an application, whilst also being practical to administer.

Question for consultation

J- Will the proposed requirements concerning who must be notified of an application for a JP order ensure that those who most need to know are notified? If not, have you suggestions as to what the regulations should require here?

New duties for local authorities (i): to provide explanations and information to anyone who is the subject of a JP order

62. We recognise that there are concerns that an order might be made affecting someone who has difficulty, for whatever reason, in understanding the order and how to apply for variation or revocation if they wish. The welfare of anyone in this position would be taken into consideration by the local authority and the JP as a matter of course as part of their usual

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responsibilities. However, we do propose measures to provide a further safeguard for vulnerable people. This measure meets a commitment given in Parliament: to place in regulations a duty on local authorities to ensure that a person subject to an order is made aware of his or her rights, relevant support services and how to access them.

63. Since different people might require different types of support according to their need (perhaps the person concerned has difficulty understanding English, or has a disability of some kind which affects their ability to understand or deal with a written order), we propose to allow the local authority to determine how best to help the individual. The local authority will be required to take reasonable steps to ensure the person understands what the order does, the reasons for it, the powers under which it was made, and their right to apply for variation or revocation. The authority must also ensure that the person knows how to access any suitable support services available. Under these draft regulations, the local authority can decide what services might be required in the light of the person's circumstances. These draft regulations do not require the authority to provide any new services not already available.

New duties for local authorities (ii): to consider the welfare needs of anyone whose liberty is restricted by an order

64. This measure provides an extra safeguard for individuals who may, as a result of an order restricting their liberty, have difficulty in meeting their own needs or those of any dependants. For example, a person confined to the home under an order may not easily be able to shop for food or other essentials. The local authority may therefore wish to provide such a service to this person. As well as ensuring that people's needs are met, this proposal should help to protect public health by removing obstacles to compliance with the order.

65. We do not think that the local authority will incur any appreciable costs as a result of this requirement. Nevertheless, we propose that the local authority should be able to make a charge for any services provided, where appropriate. These circumstances are likely to arise very infrequently, and any costs will be offset by the local authority's power to charge.

Question for consultation

K- Is a regulation requiring that local authorities consider the welfare needs of anyone whose liberty is restricted by an order necessary or desirable as an extra safeguard for vulnerable people?

New duties for local authorities (iii): to report applications for orders to the Health Protection Agency

66. This proposed new duty meets another commitment given in Parliament, to provide for the use of orders to be monitored at the national level. We have drafted the regulations to

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require the reporting of all applications for JP orders, not just actual orders made, so as to provide a fuller picture of health protection activity under the legislation.

67. The draft regulations specify that the report should cover the relevant local authority details, a copy of the application and the order, with all information relating to the identity of a person subject to the order removed. Reasons are to be given for any application not leading to an order.

68. We do not think this duty of application reporting should be onerous. The Health Protection Agency will advise local authorities where the reports are to be sent, and it will be possible for the information to be submitted electronically. In due course, the Department of Health and the Health Protection Agency will agree how and when the reports will be summarised for publication.

Question for consultation

L- Do the proposed contents of the report of an application for a JP order cover all the relevant information?

4: Draft Health Protection (Local Authority Powers) Regulations

Summary

The Health Protection (Local Authority Powers) Regulations will modernise standing powers for local authorities to enable them to exercise a health protection role in circumstances where judicial oversight from a Justice of the Peace (JP) is not necessary. The proposed regulations enable a local authority to:

- keep a child away from school;
- require a list of contact details of pupils attending a school;
- disinfect/decontaminate premises or articles;
- request co-operation for health protection purposes;
- restrict contact with dead bodies.

The draft Local Authority Powers Regulations can be found alongside this consultation document on the health protection regulations consultation website.

69. We have a significant opportunity to review the standing public health protection powers and duties of local authorities. We think that the proposed regulations strike the correct balance between action that only a JP order should be able to require, and measures that a local authority can require without reference to a JP.

70. Under Part 2 of the Public Health (Control of Disease) Act 1984, local authorities are given powers and requirements in relation to their public health role. These powers and requirements are very specific, and this makes them less effective.

71. The new Part 2A, which will replace Part 2 in its entirety, gives powers to JPs so they may make an order specifying actions to be taken to protect public health, on application by a local authority. However, there are some circumstances where the judicial oversight given by a JP is not necessary. In these cases, the local authority should be able to act without applying for a JP's order. Therefore, we think it is necessary for local authorities to retain, in an updated form, some of the powers and duties from the 'old' Part 2, as outlined below. The exercise of any restrictive powers by a local authority will still be subject to strict criteria regarding their use, equivalent to the requirements that must be satisfied to get a JP order. It is important to remember that the new Part 2A does impose limits on the standing powers that local authorities can be given to protect human health.

72. Part 2A allows regulations to be made to give local authorities the power to prohibit or restrict the holding of an event or gathering. We do not feel that local authorities need this potentially quite broad power at this time. Rather, other, more flexible or suitable powers (for

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example, the 'request' power outlined below, or JP order-making powers), could be employed to restrict gatherings if necessary.

Local authority power to keep a child away from school

73. Part 2 of the 1984 Act gives a local authority the power to require a parent to keep their child away from school if that child is suffering from or has been exposed to a notifiable disease. The updated regulations presented here create a similar provision. The objective of this updated regulation is to help prevent the transmission of infection or contamination in an environment where children are in close contact with their peers for much of the day. This is particularly relevant to younger children who may not have as strong an immune response or may not maintain as high standards of hygiene as older children or adults.

74. The updated regulation gives a local authority the power to keep a child off school - here, the definition of school is an educational institution providing primary or secondary education, or a maintained nursery school. The power can only be used if the child's attendance could cause significant harm to the health of other children because of a risk of infection or contamination. If a further restriction on the child's movements or contact with others is required, then the local authority would need to apply for a JP order, or make a formal request using the 'request' power outlined below.

75. The parent of the child (including someone who is not a biological parent but who has parental responsibility for or care of the child) must be informed of the requirement to keep the child away by a notice. This notice must set out what the parent is being asked to do, for how long, and why they are being asked to do it. In a change to the existing Part 2 power, the headteacher of the school the child must stay away from will also have to be informed of the notice. This simple action helps ensure the school remains informed of the situation.

76. How long a child should be required to 'stay off' varies by infection or contamination, duration of the illness and the risk posed by the individual circumstances. Under the existing legislative arrangements in Part 2, a child can only re-attend school after a further notice is issued. We are proposing a new maximum period of effect of a notice of 28 days. This new maximum period of effect provides assurance that a requirement to stay away from school is not indeterminate or indefinite. If evidence suggests that a child still presents a risk after the expiry of a notice, the local authority may serve a further notice - but the need to serve a further notice ensures that the child's situation is appropriately reviewed.

77. The updated regulations provide a duty for local authorities to review the measure if asked to do so by the parent. The first review must take place within five working days of the local authority issuing the notice. Further reviews are at the local authority's discretion. This new measure ensures that the parent can take action to affect the duration of the effect of the notice.

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78. This regulation does not affect a child's right to an education. Local authorities have a standing duty under the Education Act 1996 to ensure that educational provision for the unwell child (or a child prevented from attending school for any reason) is appropriate. This regulation also prevents other children from missing school by helping to protect them from significant harm to their health. The new time-limited nature of the notice ensures that the requirement to stay away is no longer indefinite or indeterminate.

Questions for consultation

M- Do you think five days is a suitable timeframe in which a local authority should be expected to review a requirement that a child be kept off school? If not, how long should the timeframe be, and why?

N- Will the requirement for a local authority to review a notice to keep a child off school work fairly in practice? If not, what changes should be made to the requirement?

Section 19 of the Education Act 1996

Section 19 of the Education Act 1996 states that: "Each local education authority shall make arrangements for the provision of suitable education at school or otherwise than at school for those children of compulsory school age who, by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them."

79. Under the current Part 2, a parent's failure to comply with a notice to keep a child away from school can result in a level 1 fine. The updated regulation makes provision for a level 2 fine - a higher level of fine to promote compliance with a notice. A further fine is payable (50% of level 1 on the standard scale) for every subsequent day that the parent fails to comply with the notice. We believe this new, ongoing fine for non-compliance is necessary, although should this situation of non-compliance arise, other action may be needed to mitigate any continuing risk to human health.

Fines: the standard scale

Some of the local authority powers are enforceable with fines. These associated fines are modernised in the new regulations. The maximum levels of fines for offences are set by reference to the standard scale. The current levels on the standard scale are:

Level 1	£200
Level 2	£500
Level 3	£1000
Level 4	£2500
Level 5	£5000

For comprehensive details of the fines associated with these regulations, please see the Legal/Justice Impact Test within the Impact Assessment document.

Local authority power to require a list of contact details of pupils attending a school

80. Part 2 of the 1984 Act allows a local authority to require a headteacher of a school to provide the local authority with the names and contact details of all pupils at the school if a child in the school is suffering from certain diseases. The objective of this power is to enable a local authority to conduct contact-tracing exercises, to see who might have been exposed to a health risk and to help those exposed as necessary.

81. As it stands, this power is unnecessarily specific - contact details can only be required when a pupil in the school has a specified disease, but not when a member of staff in the school has a disease. The proposed regulations update this power, so that the local authority can require the headteacher to supply the contact details of attending children if the local authority has reason to believe they have been exposed to a serious infection or contamination from any member of staff or other child.

82. The level 1 fine, associated with the failure of the person in charge to comply with the request to supply contact details, is retained in these updated regulations. This low fine relies on the person's professional sense of responsibility for the children in their care and their general duty to comply with the law.

Local authority power to disinfect/decontaminate premises or articles

83. Part 2 of the 1984 Act allows a local authority to provide a disinfection station and allow any article brought there to be disinfected free of charge. The draft regulations update this

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power, so local authorities have the discretionary power (not the duty) to disinfect or decontaminate an article or a premises or arrange for this to happen (perhaps by using contractors), at the request of the owner of the article or the premises, or the legal tenant of a premises.

84. Under this regulation, the local authority will have the power to charge for the service, but the requester must be informed of the charge and agree to proceed before the disinfection/decontamination can take place.

Question for consultation

O- Is there a need for a local authority power for disinfection/decontamination to be retained in an updated form in these regulations? What are your reasons for thinking so?

Local authority power to request co-operation for health protection purposes

85. Part 2 of the 1984 Act gives a local authority the power to request that a person stops working if they are suffering from a specific disease, and requires the local authority to compensate them if they suffer any loss because of complying with such a request. Part 2 also gives local authorities general powers to take actions to get people to do things in order to protect public health.

86. The updated regulations modernise these 'request' powers, by giving local authorities a general, more flexible power to ask people or groups of people to take or refrain from any action to protect human health. The wider nature of this regulation will be useful in ensuring these regulations provide a flexible response to unforeseen threats to public health. This updated power to make a voluntary request is linked to a discretionary power for the local authority to offer a compensation or incentive payment to encourage the individual to comply.

87. It is worth noting that a local authority need not make a request before applying for a JP order, if the circumstances justify this.

Support for the request power

"I do think there is value in developing this. I have had a number of TB cases where we have struggled to get them to clinic/hospital for investigation and/or follow up. I have written to them in the past -- but think a formal proper officer letter and local authority back up (including the possibility of 'incentive' support) would be something I would use quite often - compared to the very infrequent occasions where JP orders would be indicated."

Comment from health protection professional

Question for consultation

P- Do you agree the local authority power to request co-operation for health protection purposes could be a helpful component of the modernised local authority standing powers for health protection? What are your reasons for thinking so?

Local authority power to restrict contact with dead bodies

88. Part 2 of the 1984 Act outlines various provisions aimed at limiting contact with a body of a person that has died from a notifiable disease.

Part 2 powers to restrict contact with dead bodies	
Relevant section of Part 2 and brief description	Associated offence punishable by
43 Person dying in hospital with notifiable disease If a person dies in hospital while suffering from a notifiable disease, the body can be held there until burial.	Level 1 fine
44 Isolation of body of person dying with notifiable disease The person in charge of a premises where there is a body of someone who has died whilst suffering from a notifiable disease must take reasonable steps to restrict contact with the body.	Level 1 fine
45 Restriction of wakes Holding wakes over a body of a person who has died whilst suffering from certain diseases is prohibited.	Level 1 fine

89. The policy objective of the local authority powers regulations is to modernise these powers to allow the prevention of unnecessary contact with a body that, due to possible or actual infection or contamination, could present a risk to human health.

90. These regulations achieve this by allowing the local authority to:

- a) move the body to a location where contact with a body can be effectively restricted;
- b) issue a notice in relation to the body, stating that contact with the body, or if necessary, entry to the room it is located in, is prohibited without prior authorisation of the local authority.

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91. There is a need to manage this issue sensitively - the death of a relative is an emotional time for a family. There may also be cultural and religious considerations concerning an individual's death and burial. We have not simply allowed the local authority to 'forbid unnecessary contact' with the body. The power can only be used by a local authority as a proportional response when strict criteria are satisfied regarding the risk the body represents. The frontline health protection professional is best placed to make a judgement on what sort of contact with the body presents a risk (perhaps by getting advice from other professionals as appropriate). As such, when this regulation is used to prevent contact with a dead body, it also allows the local authority to authorise certain specific contacts with the body when the local authority considers this is appropriate. The local authority can use this latitude to ensure that this power is employed sensitively.

92. Breaches of a notice made under Part 2 prohibiting contact with a body were punishable by a low-level fine. We believe these fines should be higher to compel compliance with the notice. The updated local authority powers regulations state that it should be an offence punishable with a level 3 fine to have unauthorised contact with a body when a prohibition is in place. There is also a level 3 fine payable by a person in charge of a premises if they fail to cooperate with a local authority exercising the power to relocate a dead body.

Local authority powers under the Public Health (Infectious Diseases) Regulations 1988

93. The repeal of local authority powers under the Public Health (Infectious Diseases) Regulations 1988 was discussed as part of the March 2007 consultation. However, it is worth emphasising here two specific local authority health protection powers from these 1988 regulations that we are not proposing to include in the Health Protection (Local Authority) Powers regulations.

94. The first of these 1988 regulations powers allows a local authority to issue a notice requiring a person to 'discontinue or to refrain from engaging in any occupation associated with food, with the intention of limiting the spread of an infectious disease.' The introduction of other legislation since 1988 means this power is no longer necessary. The Food Hygiene Regulations 2006 prohibit certain infected individuals working in food handling if there is a risk of their passing on an infection. The new Part 2A allows a local authority to apply for a JP order to keep someone off work; or the local authority can use the standing powers updated by the local authority powers regulations to request that someone stay off work. We do not believe it is appropriate for local authorities to continue to be able to exercise the power to keep someone off work without a degree of judicial oversight, particularly where other more appropriate legislation addresses the public health risk of ill individuals continuing to work- therefore we do not propose to carry this 1988 regulations power forward.

95. The 1988 regulations also enable the proper officer of a local authority to arrange immunisations. This power was created before there was a national NHS immunisation

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programme, possibly to let local authorities address local outbreaks of smallpox. We are not aware of this power ever being used, and cannot envisage local authorities would ever use it now - therefore, we do not propose carrying it forward.

Questions for consultation

Q- Do you agree that there is no need for an updated power to allow a local authority to arrange for immunisation? If you disagree, could you please explain why you feel there is a need for this power to be retained and updated?

5: The costs and benefits of the proposed draft regulations

96. The preceding chapters have explained the rationale for the regulations as drafted. We have aimed to assess comprehensively the extra costs and benefits of the proposed regulations in the draft impact assessments. These draft impact assessments are available on the health protection regulations consultation website, alongside this consultation document and the draft regulations, and we welcome comments on them as part of this consultation.

Question for consultation

R- Do the assumptions in the Impact Assessment appear reasonable? If not, what assumptions should be used? Please provide evidence for your response.

97. Overall, we believe that there are minimal extra costs (above those already incurred under existing legislation) associated with these proposed regulations (as set out in the Impact Assessment) and that they are outweighed by the benefits:

- There is a potential for substantial benefit in the event that an infectious disease or contamination is controlled effectively as a result of effective notification arrangements.
- The new requirements in the draft Part 2A orders regulations will provide extra safeguards for anyone who is the subject of an application for a JP order.
- The local authority powers are likely to be needed only rarely, but it is important that they should be available as a means to prevent spread of disease and the resultant adverse effect on people and the economy.

98. The impact of implementing the new Part 2A has already been assessed and is not discussed further here. For further details, see the Impact Assessments for the Health and Social Care Bill: public health protection measures, available [here](#) on the DH website.

Annex 1: Form for consultation responses

A version of this form which can be filled out in Microsoft Word is available on the health protection regulations consultation website, alongside this consultation document. Electronic submission of the response form would be helpful.



Health Protection Regulations Consultation Response Form

We would prefer this form to be returned to us electronically as an email attachment. The email address for responses or queries is healthprotectionregulations@dh.gsi.gov.uk. You can provide a covering letter by email if you wish.

Postal responses can be sent to:

Robert Parsons
Health Protection Regulations Consultation
Department of Health
Room 514 Wellington House
133-155 Waterloo Road
London SE1 8UG

Email responses to the consultation will receive an acknowledgement of receipt. Postal responses will not receive an acknowledgement.

Telephone contact for enquiries:

020 7972 4048 - Robert Parsons or Janet Whybrow.

YOUR CONTACT DETAILS

Name

Contact address

Postcode

Contact Telephone

Email

Freedom of Information

HEALTH PROTECTION REGULATIONS

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes. The relevant legislation in this context is the Freedom of Information Act 2000 (FOIA) and the Data Protection Act 1998 (DPA).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties. However, the information you send us may need to be passed on to colleagues within the UK Health Departments and/or published in a summary of responses to this consultation.

I do not wish my response to be passed to other UK Health Departments (please mark with an 'x')

I do not wish my response to be published in a summary of responses

Please delete as appropriate. I am responding:

- *as a member of the public*
- *as a health care or health protection professional or expert*
- *on behalf of an organisation.*

HEALTH PROTECTION REGULATIONS

If you are responding as a professional, please supply the following details:

Name of Profession:

Area of work (please mark with an 'x')

NHS

Social Care

Health Protection

Private Healthcare

Third Sector

Regulatory Body

Professional Body

Education

Trades Union

Local Authority

Trade Body

Other (please give details):

If you are responding on behalf of an organisation, please supply the following details:

Name of Organisation:

Area of work (please mark with an 'x')

NHS

Social Care

Private Healthcare

Third Sector

Regulatory Body

Professional Body

Education

Trades Union

Local Authority

Trade Body

Other (please give details):

Health Protection Regulations

Consultation Questions

Please mark your answers with an “x” as necessary.

Chapter 2: The Health Protection (Notification) Regulations

A- Is the list of notifiable diseases for clinical reporting at Schedule 1 (attached at the end of chapter 2) to the draft notification regulations appropriate?

The Schedule 1 list is appropriate ()

The Schedule 1 list is not appropriate ()

If you answered that it is not appropriate, what changes would you make and why?

B- Is there any health protection benefit in Primary Care Trusts receiving from the proper officer of the local authority copies of individual notifications from registered medical practitioners?

There is a benefit ()

There is not a benefit ()

Comments

C- Is the information to be reported by registered medical practitioners, as far as it is known to them, appropriate?

It is appropriate ()

It is not appropriate ()

HEALTH PROTECTION REGULATIONS

If you answered that it is not appropriate, what changes would you make and why?

D- Is the list of specified microorganisms (“causative agents”) for laboratory reporting at Schedule 2 (attached at the end of chapter 2) to the draft regulations appropriate?

It is appropriate ()

It is not appropriate ()

If you answered that it is not appropriate, what changes would you make and why?

E- Is the information to be reported by laboratories, as far as it is known to them, appropriate?

It is appropriate ()

It is not appropriate ()

If you answered that it is not appropriate, what changes would you make and why?

Chapter 3: The Health Protection (Part 2A Orders) Regulations

F- Will the proposed requirements for evidence to be given to a JP be helpful to the JP?

Yes, they will be helpful ()

HEALTH PROTECTION REGULATIONS

No, they will not be helpful ()

If you consider that the evidence requirements will be unhelpful, what evidence should be required, in addition to, or instead of, the requirements identified?

G- Are the proposed requirements for evidence sufficiently flexible to allow action to protect public health in all circumstances?

Yes, they are flexible enough ()

No, they are not flexible enough ()

If you do not think they are flexible enough, what changes would you make? Please give your reasons.

H- Does the list of “affected persons” in the Act cover everyone who might be personally affected by a JP order?

Yes, the list is appropriate ()

No, the list is not comprehensive enough ()

If not, who else should be included?

I- Is the proposed list of next of kin who are to have the right to apply for variation or revocation of any JP order applying to a body adequate for this purpose?

Yes, the list of next of kin is adequate ()

HEALTH PROTECTION REGULATIONS

No, the list of next of kin is not adequate ()

If not, have you suggestions as to what the regulations should require here?

J- Will the proposed requirements concerning who must be notified of an application for a JP order ensure that those who most need to know are notified?

Yes, the proposed requirements are adequate ()

No, the proposed requirements are not adequate ()

If not, have you suggestions as to what the regulations should require here?

K- Is a regulation requiring that local authorities consider the welfare needs of anyone whose liberty is restricted by an order necessary or desirable as an extra safeguard for vulnerable people?

It is desirable ()

It is not desirable ()

What are your reasons for thinking so?

L- Do the proposed contents of the report of an application for a JP order cover all the relevant information?

The proposed contents do require all the relevant information ()

HEALTH PROTECTION REGULATIONS

The proposed contents do not require all the relevant information ()

Comments

Chapter 4: Draft Health Protection (Local Authority Powers) Regulations

M- Do you think five days is a suitable timeframe in which a local authority should be expected to review a requirement that a child be kept off school?

Yes, it is a suitable timeframe ()

No, it is not a suitable timeframe ()

If not, how long should the timeframe be, and why?

N- Will the requirement for a local authority to review a notice to keep a child off school work fairly in practice?

Yes, it will work fairly in practice ()

No, it will not work fairly in practice ()

If not, what changes should be made to the requirement?

O- Is there a need for a local authority power for disinfection/decontamination to be retained in an updated form in these regulations?

Yes, such a power is needed ()

HEALTH PROTECTION REGULATIONS

No, such a power is not needed ()

What are your reasons for thinking so?

P- Do you agree the local authority power to request co-operation for health protection purposes could be a helpful component of the modernised local authority standing powers for health protection?

Yes, such a power could be helpful ()

No, such a power is not needed ()

What are your reasons for thinking so?

Q- Do you agree that there is no need for an updated power to allow a local authority to arrange for immunisation?

I agree there is no need for such a power ()

I disagree- there is a need for such a power ()

If you disagree, could you please explain why you feel there is a need for this power to be retained and updated?

Chapter 5 and Impact Assessment: The costs and benefits of the proposed regulations

R- Do the assumptions in the Impact Assessment appear reasonable?

Yes, the assumptions in the impact assessment appear reasonable ()

No, the assumptions in the impact assessment do not appear reasonable ()

If not, what assumptions should be used? Please provide evidence for your response.

Please feel free to submit any further comments on these draft regulations below.

Further comments

Annex 2: Additional Information

Criteria for consultation

This consultation follows the Government's Code of Practice on Consultation. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome
- consult for at least 12 weeks
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence, and the expected costs and benefits of the proposals
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process
- analyse responses carefully and give clear feedback to participants following the consultation
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:
www.berr.gov.uk/whatwedo/bre/consultation-guidance/page44420.html

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Co-ordinator, Department of Health, 3E48 Quarry House, Leeds, LS2 7UE

email: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.